STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that services provided met professional standards of quality. Specifically, for 1 out of 30 sampled residents, a resident's nasogastric (NG) tube feed did not have the formula bag labeled with the complete date and time of the administration. Resident identifier: 54.Resident 54 was admitted to the facility on [DATE] with diagnoses which included, cerebral palsy, unspecified dysphagia, unspecified severe protein-calorie malnutrition, and cachexia. Resident 54's medical record was reviewed 1/26/26 through 1/29/26. On 1/25/26, resident 54's physician ordered an Enteral Feed every shift continuous tube feeding Jevity 1.2 with a rate of 30 mL (milliliter) an hour continuously for 24 hours. On 1/26/26 at 12:10 PM, an observation was made of resident 54's tube feed. The tube feed bag was labeled, 1/26 [two letter initials]. On 1/28/26 at 9:51 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 54 was on a continuous tube feeding. RN 1 stated that the night shift nurses switched the tube feed bags and that they should be labeled with the date, the time the tube feed started, and initial the tube feed bag. RN 1 stated that if the tube feed bag was not labeled with all of the information then you would not know when the tube feed was actually started. On 1/29/26 at 8:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that tube feeding bags should be labeled with the complete date and time it was started and signed by the nurse who started it. The DON stated that she expected staff to label tube feed bags with all of this information.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in ADLs do not diminish unless the resident's clinical condition demonstrates that diminution was unavoidable. This includes ensuring the resident is provided the necessary care and services to maintain personal hygiene. Specifically 1 of 30 residents sampled, the facility failed to provide timely incontinence care after staff were notified of a soiled condition, resulting in the resident remaining in soiled clothing for one hour and 44 minutes. Resident identifier: 13 Resident 13 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, muscle weakness, and dementia.On 1/26/26 at 11:55 AM, an observation was made of resident 13 with soiled pants being assisted into room [ROOM NUMBER]. A staff member talked into their earpiece stating the resident needed assistance with a brief change. A continuous observation of resident 13 was then initiated.On 1/26/26 at 12:02 PM, an observation was made of a certified nursing assistant (CNA) entering room [ROOM NUMBER], asking resident 13 if she wanted her lunch in the dining room or her room. The CNA exited. Resident 13 was sitting in her recliner. On 1/26/26 at 12:21 PM, an observation was made of a CNA walking by resident 13's room. The CNA did not enter resident 13's room to check on or or change the resident.On 1/26/26 at 12:55 PM, an interview was conducted with resident 13. This surveyor asked resident 13 if she had her brief changed yet. Resident 13 initially replied yes, then reached down and felt her brief area and stated, Oh no they haven't, but they will soon.On 1/26/26 at 1:23 PM, an observation was made of a CNA who knocked on the door for room [ROOM NUMBER], entered the room, placed a meal tray in front of resident 13 and exited.On 1/26/26 at 1:23 PM, an observation was made of a staff member knocking and entering room [ROOM NUMBER]. The staff member stated to resident 13 she was there making sure the correct activities calendar was posted. The staff member exited.On 1/26/26 at 1:28 PM, an observation was made of staff bringing resident 13's roommate into room [ROOM NUMBER]. A CNA took a Hoyer lift into the room and closed the door.On 1/26/26 at 1:38 PM, a CNA exited room [ROOM NUMBER] and then another CNA exited the room and stated, You're all good [resident 13].On 1/26/26 at 1:39 PM, an observation was made of resident 13 in her recliner and she had a different pair of pants on. The resident was in need of an incontinence brief change from 11:55 AM to 1:28 PM, a total of one hour and 33 minutes. Review of resident 13's medical record was completed on 1/26/26 through 1/29/26.An Annual Minimum Data Set (MDS) dated [DATE] revealed that resident 13 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated severely impaired cognition. On 4/15/19, a Care Plan was developed for resident 13 with the focus that she has bowel/bladder incontinence related to impaired mobility and dementia. The goal for resident 13 was to remain free from skin breakdown due to incontinence. Interventions were for brief use, and to change the incontinence briefs every two hours and as needed.On 1/28/26 at 3:47 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that rounding on residents happened every one to two hours. CNA 2 stated that during rounding the CNAs were to ask residents if they needed their brief changed, make sure the call light was within reach of the resident, and ask the resident if they were in need of anything. CNA 2 stated that they did not go around and check on residents prior to meals being served unless it was during the round time frame. CNA 2 stated that when she was rounding on resident 13, she would ask to check her brief because the resident did not typically self-report the need for a change. On 1/29/26 at 9:33 AM, an interview was conducted with the Activities Director (AD). The AD stated that, during the activity, she offered and encouraged residents to drink fluids. The AD stated that it was very common for resident 13 to have a wet brief at the conclusion of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity. The AD stated that, whenever a resident needed a brief change, she or her staff radioed the nursing team to request a brief change. On 01/29/2026 at 9:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected brief changes to be completed as soon as possible, or within approximately 10 to 15 minutes. The DON further stated that while earpieces sometimes did not transmit, she expected that if Activities or Physical Therapy staff brought a resident back to their room, they would also push the call light to ensure a double system was in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all residents received the treatment and care in accordance with professional standards of practice. Specifically, for 1 out of 30 sampled residents, staff were not monitoring changes in skin conditions with a resident or documenting bandage changes. Resident identifier: 50.Resident 50 was admitted to the facility on [DATE] with diagnoses which included, Type 2 Diabetes and restless leg syndrome. Resident 50's medical record was reviewed 1/26/26 through 1/29/26. On 1/26/26 at 2:31 PM, a concurrent interview and observation was conducted with resident 50. Resident 50 stated that he had open sores on his lower leg and that he had them for at least a week. Resident 50 stated that he had informed a nurse a week ago and she had put bandages on his legs, but that he was bleeding through the bandages onto his socks. It should be noted that there was no documentation regarding any leg wounds, or treatment for the wounds for resident 50. An observation was made of resident 50's lower right extremity. The right extremity below the knee was observed to be reddish-purple in color and had a large bandage that was covering a wound that was draining a serosanguineous fluid through the bandage and onto the resident's sock. There were two additional areas that were draining a serosanguineous fluid that were not covered. On 1/26/26 at 2:42 PM, an observation was made of resident 50 getting a dressing change by Registered Nurse (RN) 2. RN 2 was observed to tell resident 50 that she needed to make sure that his wounds were documented in the computer to be assessed every day. RN 2 was observed to apply bandages to 3 wounds. On 1/27/26 at 2:56 PM, an interview was conducted with resident 50. Resident 50 stated that the nurse had not assessed his legs or changed the bandages on his leg for today. [It should be noted that there was no order for wound care or a progress note that documented resident 50's skin condition located in the medical record.] A review of resident 50's care plan goal initiated on 8/6/25 revealed that resident 50 would have intact skin, free of redness, blisters or discoloration through the review date. Interventions for resident 50 included, daily body checks, notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. On 1/28/26 at 10:32 AM, an interview was conducted with RN 2. RN 2 stated that skin checks were done usually every shift. RN 2 stated that if she noted any abnormal skin condition then she would notify the doctor and the staff wound nurse. RN 2 stated that on 1/26/26 she was notified by resident 50 about his wounds. RN 2 stated that she had thought she had put in an order for wound care, but was unable to locate the order in resident 50's medical record. RN 2 stated that a different nurse should have documented that they had applied bandages to resident 50 before 1/26/26 when she had changed them. On 1/28/26 at 10:44 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that he was the wound nurse for the facility. The ADON stated that RN 2 had informed him about resident 50's legs on 1/27/26, but he had not assessed them yet. The ADON stated that if nurses noticed any skin changes on residents they would have to put in a risk management note which would alert him to assess the resident. The ADON stated that the nurses were supposed to notify the physician about any skin conditions changes, dress the wounds, and place a standard order for wound dressing changes in the resident's medical record. The ADON stated that he did not know why RN 2 had not put in an order for dressing changes or a risk management note for resident 50. On 1/28/26 at 11:59 AM, a follow-up interview was conducted with the ADON. The ADON stated that RN 2 had not completed the incident report correctly or put in a progress note about resident 50's legs. The ADON stated that there was no order put in for wound care for resident 50 on 1/26/26, but that RN 2 had put in a late entry progress note and order on 1/28/26. The ADON stated that he had put in a new wound order (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for resident 50 to have his dressings changed three times a week and updated resident 50's care plan. On 1/29/26 at 8:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a nurse found any skin abnormalities they should clean and dress the area, notify the family and the physician, and complete a risk management form. The DON stated the nurse should put in an order for dressing changes until the wound nurse assessed it and changed the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents who were continent of bladder received services and assistance to maintain continence unless his or her clinical condition was or became such that continence was not possible to maintain. Specifically, for 1 out of 30 sampled residents, the resident was given a PureWick external catheter without an order or directions for use. Resident identifier: 53. Resident 53 was admitted to the facility on [DATE] with diagnoses which included, unsteadiness on feet, difficulty in walking, and muscle weakness. Resident 53's medical record was reviewed 1/26/26 through 1/29/26. On 1/26/26 at 1:44 PM, a concurrent interview and observation was made of resident 53 and her room. There was a suction canister on the bedside table with a suction tube that contained a dark amber fluid. Resident 53 stated that she was continent when she came to the facility, but was non-weight bearing for a few weeks and was given a PureWick catheter to use so she did not have to get up to use the toilet. Resident 53 stated that staff changed the PureWick device a few times a week. A review of resident 53's medical record did not contain an order for a PureWick device or directions for use. Resident 53's care plan did not include a PureWick device. On 1/28/26 at 10:21 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 53 was continent of urine when she was first at the facility, but now had a PureWick device. CNA 1 stated that she was told of resident 53 using a PureWick through a CNA report. CNA 1 stated that resident 53 wore briefs in addition to the PureWick, On 1/28/26 at 11:18 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that there was a resident that used a PureWick in the facility and that this was a newer thing. The CNA Coordinator stated that CNAs had been trained on how to use the device and if CNAs had questions they could ask. On 1/28/26 at 2:04 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that resident 53 had a PureWick device and had been using it for a couple of weeks. RN 2 stated that resident 53 did not want to have brief changes and was non-weight bearing for a couple of weeks. RN 2 stated that resident 53 was now weight bearing and was in physical therapy. RN 2 stated that PureWicks should have a doctor's order. RN 2 stated that she had not received any training from the facility regarding the use of the PureWick. RN 2 stated that she was unsure how often the PureWick device should be changed. On 1/28/26 at 2:06 PM, an interview was conducted with RN 3. RN 3 stated that the PureWick device should be changed every 24 hours and that the canister was cleaned once a week. RN 3 stated that a resident should have the use of a PureWick care planned. On 1/28/26 at 2:53 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 53 had been using a PureWick for the past two weeks and it was a new thing for the facility to use. The DON stated that resident 53 was using the PureWick device for dignity as she had been bed bound and non-weight bearing for a short period of time. The DON stated that they had tried to use the bed pan for resident 53, but she did not like it. The DON stated that a PureWick device required a doctor's order and resident 53 did not have an order. The DON stated that the use of a PureWick should be care planned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility did not ensure that the physician reviewed the resident's total program of care, including medications and treatments during visits. Specifically, for 1 out of 30 sampled residents, the physician did not include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen. Resident identifier: 53. Resident 53 was admitted to the facility on [DATE] with diagnoses which included, unsteadiness on feet, difficulty in walking, and muscle weakness. Resident 53's medical record was reviewed 1/26/26 through 1/29/26. A review of resident 53's progress notes revealed: a. On 12/4/25 at 3:23 PM, a nursing note documented, Resident was seen by [Name redacted]. b. On 1/13/26 at 5:26 PM, a nursing note documented, [Name redacted] in to see resident. MD [medical doctor] reviewed labs, medication and answered all questions. Will continue to monitor. It should be noted that the physician progress note for 1/13/26 was unable to be located in resident 53's medical record. On 1/29/26 at 8:06 AM, an interview was conducted with the Health Information Management (HIM) Director. The HIM Director stated that one of the facility physicians does not write or dictate any medical records for the residents that he sees. The HIM Director stated that she would have to call the physician's office and request resident progress notes. The HIM Director stated that it was hard to track the resident's records down because the physician did not write in the resident's medical record. On 1/29/26 at 8:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility would send a form with the resident and the physician would write what he did at that appointment. The DON stated if the facility required in-depth notes they would call the physician's office and ask for the progress notes. The DON stated that the physician would send a worksheet back with the resident that included orders. The DON stated that after they requested the physician notes they would then scan the records into the resident's medical record. The DON stated that it was hard to get progress notes from the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Nursing and Rehabilitation Center	1340 East 300 North Price, UT 84501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 1 out of 30 sampled residents, Enhanced Barrier Precautions (EBP) were not worn for a resident with a Nasogastric (NG) feeding tube and the end of the NG tube was uncapped and touching an intravenous pole. Resident identifier: 54. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, cerebral palsy, unspecified dysphagia, unspecified severe protein-calorie malnutrition, and cachexia. Resident 54's medical record was reviewed 1/26/26 through 1/29/26. On 1/26/26 at 11:39 AM, an observation was made of resident 54. Resident 54 had an EBP sign on the door. On 1/26/26 at 2:52 PM, an observation was made of resident 54. Resident 54's tube feeding was beeping with a status of inactive. One end of the feeding tube was attached to an Intravenous (IV) pole uncapped and touching the metal pole. On 1/26/26 at 2:55 PM, an observation was made of Registered Nurse (RN) 1. RN 1 entered resident 54's room and donned gloves. RN 1 was observed to pick up the end of the feeding tube from the IV pole and reattached to the nasogastric (NG) tube. RN 1 was observed to not don a gown while attaching the tube feed. On 1/27/26 at 11:17 AM, an observation was made of resident 54 and the Speech Therapist (ST). The ST donned gloves and knelt on the floor. The ST began to administer different fluids and foods to resident 54. The ST was observed to feed multiple fluids and foods to resident 54 and to adjust resident 54 in her bed. On 1/27/26 at 11:47 AM, the ST was observed to exit resident 54's room. It should be noted that the ST did not wear a gown during the period of time she was in resident 54's room. A review of resident 54's speech therapy notes on 1/27/26 documented, . Patient was seen upright in bed with good alertness and attention. Patient tolerated x8 [times 8]trials of L4 [level 4] yogurt with anterior loss of bolus on 100% of trials. Patient tolerated x6 [times 6] trials of LO [level O] apple juice with anterior loss of bolus on right side (patient head was tilted more that way throughout trials). Patient trialed x1 L6 peach (cut in half} with some success, however, difficult to determine safety d/t [due to] patient unable to hold bolus in oral cavity as compared to other PO [oral] trials. Patient refused PO trials with applesauce and chocolate ensure. On 1/28/26 at 9:51 AM, an interview was conducted with RN 1. RN 1 stated that resident 54 had a feeding tube that was a continuous tube feed. RN 1 stated that whenever she was dealing with the feeding tube she needed to wear a gown and gloves. RN 1 stated that she reconnected resident 54's feeding tube on 1/26/26 and did not wear a gown. On 1/28/26 at 11:16 AM, an interview was conducted with the Certified Nursing Assistant (CNA) Coordinator. The CNA Coordinator stated that any resident with wounds, catheters, feeding tubes, or anything indwelling required Personal Protective Equipment (PPE). The CNA Coordinator stated that the sign on the door indicated to staff what PPE they were required to wear and for what activities. On 1/29/26 at 8:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP was to be followed when residents have any open area on the skin, a port, or a feeding tube. The DON stated that staff should be wearing gowns and gloves when they hooked up or handled a tube feeding. The DON stated that anytime resident 54 was being fed by the ST, a gown should be worn.