STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on resident representative interview, record review, observation, and staff interview, the facility failed to treat each resident with respect and dignity and to care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility failed to ensure Resident #13 was wearing her glasses and also failed to ensure Resident #13's legs were covered when she was in a public area. Additionally, the facility failed to honor Resident #65's right to vote. This failed practice was true for one (1) of three (3) residents reviewed in the area of dignity throughout the complaint process and one (1) of five (5) residents reviewed in the area of activities and voting. Resident identifiers: #13 and #65. Facility census: 109. Findings included: a) Resident #13 During a telephone interview, on 05/05/25, Resident #13's legal representative stated she had discussed with the Administrator the need for Resident #13 to wear glasses for her to be able see. The legal representative stated when not in use, Resident #13's glasses were kept in the medication cart for safekeeping. Observations on the following dates and times revealed Resident #13 was not wearing her glasses. -- 05/05/25 at 11:25 AM -- 05/05/24 at 12:42 AM -- 05/05/25 at 1:33 PM -- 05/05/25 at 2:45 PM -- 05/05/25 at 4:30 PM -- 05/06/25 at 8:25 AM -- 05/06/25 at 11:45 AM -- 05/06/25 at 2:20 PM (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 05/06/25 at 4:15 PM Review of Resident #13's electronic medical record, on 05/06/25 at 4:00 PM, demonstrated that although the resident was care planned for refusals to wear her glasses on a routine basis, there was no documentation in the chart verifying that staff had offered resident her glasses and she had refused or that they had reapproached her throughout each day in an attempt to be successful in getting resident to wear her glasses. During an interview on 05/06/25, the Administrator spoke to the nurse on duty who confirmed that Resident #13's glasses were locked in the medication cart. The nurse stated she had put resident's glasses on her in the morning, but that resident had taken them off and sat them down. The nurse reported she had locked the glasses back up in the medication cart to safeguard them. The nurse on duty was unable to produce any documentation regarding her statement but did say that resident's legal representative was called by the nursing staff each time resident refused to wear her glasses. A subsequent call to Resident #13's legal representative was made. The resident's legal representative denied ever receiving a call from the facility staff stating they had been unsuccessful in getting her to wear her glasses. Observations on 05/07/25 and 05/08/25 found Resident #13 was wearing her glasses after surveyor intervention on 05/06/25. During a telephone interview, on 05/05/25, Resident #13's legal representative stated she had discussed with several staff members the fact that Resident #13 was a very religious individual all her life and would never have her legs showing while she was in a public area. Resident #13's legal representative stated she had requested that staff safeguard her dignity and ensure that they cover her legs if she is taken out of her room and in a public area. Observation, on 05/07/25 at 11:18, found Resident #13 sitting by the nurses' station. She was dressed in a pink nightgown and had a sweater over the nightgown. Resident #13's knees were visible as well as her legs down to her ankles where the resident had on non-slip socks. LPN #19 confirmed that the resident's legs were uncovered in a public area. c) Resident #65 During a record review on 05/07/25 at 9:50 AM, the following details were found: -- A quarterly Recreation Progress Note and Care Plan Evaluation assessment, dated 08/04/24, which read, It is important for me to vote. -- Resident #65's care plan listed the following goal, Resident will plan and choose to engage in preferred activities. The care plan listed the following intervention, It is important for me to vote. During an interview, on 05/07/25 at 11:30 AM, the Director of Recreation stated that the facility could produce no evidence that Resident #65 had been offered the opportunity to vote in the November 5, 2024, election.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility failed to secure and keep confidential residents personal and medical information. The facility failed to safeguard private information that was placed in a clear acrylic wall file holders located in the hallway outside of the Medical Records office and the Physician's office. These were random opportunities for discovery. Facility census: 109. Findings included: a) Identifiable Patient Information Visible Outside the Medical Records Office On 05/05/25 at 1:00 PM, a random observation for discovery found an acrylic wall file holder mounted outside of the Medical Records to the left of the door. The file holder pocket had: -- A determination later regarding a resident being cut from skilled care therapy which indicated the resident no longer met the Medicare coverage requirements for skilled nursing services. --A hospital progress note on a resident which outlined the results of an x-ray done to the resident's right foot and the results an MRI of the resident's right foot. -- A hospital discharge summary on a resident which included her primary discharge diagnoses, current medication list, reason for hospitalization, and post-discharge follow-up appointments. -- An after-visit summary on a resident which outlined which medications had changed and which medications resident should stop taking. Regulatory Compliance Advisor #98 acknowledged the above-mentioned information was stored in the acrylic wall file holder mounted outside the Medical Records office. The Regulatory Compliance Advisor stated staff should not leave health information records unattended in areas accessible to the public. b) Identifiable Patient Information Visible Outside the Physician's Office On 05/06/25 at approximately 1:12 PM, a random observation for discovery found an acrylic wall file holder mounted outside of the physician's office. The file holder pocket had: -- Pharmacy reviews on a new admission dated 04/30/25, 05/01/25, 05/02/25, and 05/04/25. -- A hospice plan of care for a resident who had been referred to hospice services. -- Standing orders for hospice for the above-mentioned patient. -- Two (2) admission certifications stating that the physician certified that a post-hospital skilled nursing placement was required for each patient. -- A faxed request for the physician's signature for a female resident's ordered chest x-ray. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- A faxed request for the physician's signature for a male resident's ordered chest x-ray. -- A resident's admission record face sheet which listed resident's name, date of birth , home address, and Medicare beneficiary ID. -- A physician's Discharge Summary for a resident which listed resident's history of illness, past medical history, surgical history, immunizations, diagnoses As she was walking by, Physical Therapist #122 confirmed the above-mentioned information was stored in the acrylic wall file holder outside the physician's door.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment. The facility failed to keep the 100 Hall hallway at a comfortable temperature level. Additionally, the facility failed to keep the Maple Dining area at a comfortable temperature level. These were random opportunities for discovery. These practices had the potential to affect more than an isolated number of residents. Facility census: 109. Findings included: a) Temperature on 100 Hall and the Maple Dining Room Observation, on 05/06/25 at 8:25 AM, revealed Resident #13 was in the hallway by the nurses' station covered with a blanket. Observation, on 05/06/25 at 10:35 AM, revealed Resident #13 was up in a wheelchair wearing a sweater and was propelling around the Maple Dining Room. The Director of Maintenance took the ambient temperature [the temperature of the surrounding air] in the 100 Hallway on 05/06/25 at approximately 1:50 PM. The temperature was found to be 69.4 degrees Fahrenheit. The Director of Maintenance then took the ambient temperature of the Maple Dining. The temperature was found to be 68.7 degrees Fahrenheit. The Director of Maintenance indicated that she would address the temperatures immediately so they would meet the minimum requirement of 71 degrees.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to protect the resident's right to be free from neglect. The facility failed to care for the resident's skin conditions and percutaneous endoscopic gastrostomy (PEG). The facility also failed to ensure the resident received bathing activities. The resident was hospitalized for a wound infection. The resident's PEG tube was adhered to her skin. This caused actual harm to the resident. Resident Identifiers: #110. Facility census: 109. a) Resident #110 Resident #110 was discharged from the hospital and returned to the facility on [DATE]. On 03/25/25, Resident #110 was transferred back to the hospital. Hospital records stated upon admission to the hospital, the resident was generally soiled with dirt and feces in her skin folds. She also had yeast appearing exudate.The hospital record also stated the resident had heart monitor lead stickers from her last hospitalization ending 03/18/25. The emergency room physician's note written on 03/25/25 stated, I spoke with daughter by phone has [sic] comfortable with quality of care her [sic] facility either .I feel it is in the patient's best interest [to be] admitted to the hospital today [to] involve case management to try to find an alternative placement. Review of Resident #110's bathing activities from 03/19/25 through 03/25/25 showed no showers documented during this time. Bed baths were documented on 03/24/25 and 03/25/25. On 05/07/25 at 1:00 PM, the Center Nurse Executive (CNA) confirmed the bathing activities task reports for 03/19/25 through 03/25/25 showed no showers documented for Resident #110. Review of Resident #110's electronic health records showed the resident returned to the facility from the hospital on [DATE]. A nursing note written on 03/18/25 at 11:45 PM documented the resident had the following pressure ulcers: - Sacrum According to the nursing note, Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer/injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 3 pressure ulcer/injury - full thickness skin loss. Wound was present on admission. Wound is new. Signs and symptoms of infection: None. Staged by: In-house nursing. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: will assess with Swift wound photo application. Undermining: No. Tunneling: No. Epithelial: 80%. Granulation: 20%. Exudate amount: Light. Exudate type: Serosanguinous.: mixture of serous and sanguinous fluid, typically pale, red and watery. Odor after cleansing: None. Other: pink or red. Periwound: Attached. Surrounding tissue: Erythema. Surrounding tissue: Excoriated. Surrounding tissue: Fragile. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. - Left lateral foot (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the nursing note, Skin issue has not been evaluated .Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound was present on admission. Wound is new. Staged by: In-house nursing. Undermining: No. Tunneling: No. The nursing note also stated, Wounds dressed and assessed today. Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. A skin evaluation performed on 03/24/25 reported the same pressure ulcers as on 03/18/25. The wounds were described exactly the same as they were described in the note written on 03/18/25. The note even contained the same notation that Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT to try and resolve issue so that wound photos can be taken. Resident #110's Treatment Administration Record (TAR) showed the following pressure ulcer wound treatments written after the resident returned to the facility on [DATE]: Cleanse stage 3 pressure ulcer injury to sacrum with IHWC [wound cleanser]. Pat dry. Apply plurogel thoroughly to wound, ensuring application to small open area at top of sacrum, every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. Cleanse stage 3 pressure ulcer injury to sacrum with IHWC [wound cleanser]. Pat dry. Apply plurogel thoroughly to wound, ensuring application to small open area at top of sacrum, every day shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. Cleanse DTI [deep tissue injury] to left lateral foot with IHWC. [NAME] dry. Apply sureprep rapid dry to wound. Leave open to air. Notify provider and wound team with any changes in wound status immediately. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. Cleanse DTI [deep tissue injury] to left lateral foot with IHWC. [NAME] dry. Apply sureprep rapid dry to wound. Leave open to air. Notify provider and wound team with any changes in wound status immediately. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. The resident had the following focus on her comprehensive care plan, Resident/patient is resistive to care related to: Refusing wound treatments. The TAR did not indicate the resident had refused any of the treatments discussed above. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident's comprehensive care plan also included the following focus, Resident at risk for skin breakdown related to incontinence, morbid obesity, decreased activity, limited mobility secondary to acute illness with recent hospitalization, h/o [history of] pressure injuries and multi-disease processes, h/o skin tears, actual pressure ulcer, frail fragile skin, impaired cognition, impaired sensation, incontinence, informed refusal to aspects of care, moisture, nutritional concerns, poor safety awareness, and shear/friction risks AND pressure to sacrum and left lateral foot. Skin tears to left elbow, right inner forearm, right antecubital space, left outer forearm, front right knee, front right lateral lower leg. The focus was created on 12/25/2021 and revised on 02/28/25. On 03/25/25, the resident was transferred to the hospital after having low blood pressure during her dialysis treatment. The resident's sacral pressure ulcer was found to be infected with the organisms proteus and enterococcus. The resident was also given a diagnosis of septic shock, which the physician believed was caused by a combination of pneumonia and sacral wound infection. The resident required antibiotics for the wound infection through 04/04/25. The resident remained in the hospital until 04/07/25. On 05/07/25 at 11:00 AM, the Center Nurse Executive (CNE) confirmed the resident's pressure ulcer care and dressing changes had not been signed off on the TAR to indicate the care and dressing changes had been performed. No further information regarding Resident #110's pressure ulcer dressing changes or assessments was provided by the facility during the investigation. Review of Resident #110's electronic health records showed the resident was receiving enteral feeding through a percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is a surgically-placed tube that allows a person to receive nutrition directly through the stomach. Review of Resident #110's Treatment Administration Records (TARs) for February and March 2025 showed no orders for PEG tube treatment. According to Medline Plus, an online health information resource maintained by The National Library of Medicine, PEG tube sites should be cleaned one (1) to three (3) times a day. On 03/25/25, Resident #110 was transferred to the hospital. Hospital records stated upon admission to the hospital, the resident's PEG tube dressing was adhered to the skin by drainage. A photograph taken at the hospital showed the PEG tube dressing with beige-colored dressing on it. On 05/07/25 at 11:00 AM, the Center Nurse Executive confirmed Resident #110 did not have an order for PEG tube care. Through the completion of the investigation, no documentation was provided that Resident #110's PEG tube site had been cleaned. Review of Resident #110's electronic health records showed the resident returned to the facility from the hospital on [DATE]. A nursing note written on 03/18/25 at 11:45 PM documented the resident had the following skin tear wounds: - Front right lateral lower leg. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the nursing note, Skin issue has been evaluated .Type 1: No skin loss. Wound was present on admission. Wound is new .Staged by: In-house nursing. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: will assess with Swift wound photo application. Undermining: No. Tunneling: No. Epithelial: 50%. Granulation: 50%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red and watery. Odor after cleansing: None. Other: bleeding. Periwound: Attached. Surrounding tissue: Fragile. Surrounding tissue: Denuded. Surrounding tissue: Excoriated. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. - Right inner forearm. According to the nursing note, Skin issue has not been evaluated .Type 2: Partial flap loss. Wound was present on admission. Wound is new. Staged by: In-house nursing. Undermining: No. Tunneling: No. Additionally, an open lesion to the left chest was noted to be resolved, healed and/or closed. The nursing note also stated, Wounds dressed and assessed today. Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. A skin evaluation performed on 03/24/25 reported the same non-pressure wounds as on 03/18/25. The wounds were described exactly the same as they were described in the note written on 03/18/25. The note even contained the same notation that Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. Resident #110's Treatment Administration Record (TAR) showed the following non-pressure ulcer wound treatments written after the resident returned to the facility on [DATE]: - Cleanse open lesion to left chest with IHWC [wound cleanser]. Pat dry. Sureprep wound and then leave open to air every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse open lesion to left chest with IHWC [wound cleanser]. Pat dry. Sureprep wound and then leave open to air every day and evening shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The order was not signed off as performed on 03/24/25. On 03/25/25 evening shift, the TAR indicated the resident was in the hospital. - Cleanse skin tear to front right lateral lower leg with IHWC. Pat dry. Apply sureprep to periwound and cover wound with calcium alginate sheet. Cover with super absorbent 6x6 foam dressing. If drainage is scant or not present, notify skin tear, every day and evening shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Cleanse skin tear to front right lateral lower leg with IHWC. Pat dry. Apply sureprep to periwound and cover wound with calcium alginate sheet. Cover with super absorbent 6x6 foam dressing. If drainage is scant or not present, notify skin tear, every day and evening shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse skin tear to right inner forearm with IHWC, pat dry, and apply sureprep to periwound and adhesive contact area. Cover with foam dressing every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse skin tear to right inner forearm with IHWC, pat dry, and apply sureprep to periwound and adhesive contact area. Cover with foam dressing every day shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. The resident had the following focus on her comprehensive care plan, Resident/patient is resistive to care related to: Refusing wound treatments. The TAR did not indicate the resident had refused any of the treatments discussed above. The resident's comprehensive care plan also included the following focus, Resident at risk for skin breakdown related to incontinence, morbid obesity, decreased activity, limited mobility secondary to acute illness with recent hospitalization, h/o [history of] pressure injuries and multi-disease processes, h/o skin tears, actual pressure ulcer, frail fragile skin, impaired cognition, impaired sensation, incontinence, informed refusal to aspects of care, moisture, nutritional concerns, poor safety awareness, and shear/friction risks AND pressure to sacrum and left lateral foot. Skin tears to left elbow, right inner forearm, right antecubital space, left outer forearm, front right knee, front right lateral lower leg. The focus was created on 12/25/2021 and revised on 02/28/25. On 03/25/25, the resident was transferred to the hospital after having low blood pressure during her dialysis treatment. The hospital records had an emergency room nursing note dated 03/25/25 at 4:22 PM, While performing pericare it is noted patient has other mepilex dressings on various areas of her skin, dressings are dated for 03/13/25. The hospital records included a photograph of a dressing dated 03/13/25 on what appeared to be the resident leg. The emergency room physician's note stated, Also there was concerned [sic] that patient has dressing from 03/13 is [sic] not been changed. On 05/07/25 at 11:00 AM, the Center Nurse Executive (CNE) confirmed the resident's skin tear care and dressing changes had not been signed off on the TAR to indicate the care and dressing changes had been performed. The CNE and the Administrator stated the facility was not aware of the hospital's allegation that skin tear dressing changes had not been performed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interview, the facility failed to ensure a complete and accurate Minimum Data Set (MDS) assessment in the area of pressure ulcers. This was a random opportunity for discovery during the investigation. Resident identifier: #7. Facility census: 109. Findings included: a) Resident #7 Review of Resident #7's electronic health record showed a skilled evaluation was performed on 04/29/25. The skilled evaluation included assessments of pressure ulcers on the sacrum, left heel, and left elbow. Further review of Resident #7's electronic health record showed a quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 04/30/25. Item M0100 stated the resident had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. However, item M0210 answered No to the question, Does this resident have one or more unhealed pressure ulcer/injuries? Because this question was answered no, there was no response for item M0300, the current number of unhealed pressure ulcers/injuries at each stage. On 05/06/25 at 3:00 PM, the Coordinator for Clinical Reimbursement (CCR) confirmed Resident #7's MDS with ARD 04/30/25 was incorrect and should have indicated the resident had pressure ulcers. No further information was provided through the completion of the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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(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 - Some	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 record review and staff interview, the facility failed to provide care and services for skin tears in accordance with professional standards of practice. This deficient practice had the potential to affect four (4) of four (4) residents reviewed for skin tears. Resident identifiers: #110, #26, #58, #90. Facility census: 109. Findings included: a) Policy review Review of the facility's policy and procedure titled, Skin Integrity and Wound Management, with effective date 07/01/01 and revision date 05/01/25 stated wound evaluations would be performed weekly. b) Resident #110 Review of Resident #110's electronic health records showed the resident returned to the facility from the hospital on [DATE]. A nursing note written on 03/18/25 at 11:45 PM documented the resident had the following skin tear wounds: - Front right lateral lower leg. According to the nursing note, Skin issue has been evaluated .Type 1: No skin loss. Wound was present on admission. Wound is new .Staged by: In-house nursing. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: will assess with Swift wound photo application. Undermining: No. Tunneling: No. Epithelial: 50%. Granulation: 50%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red and watery. Odor after cleansing: None. Other: bleeding. Periwound: Attached. Surrounding tissue: Fragile. Surrounding tissue: Denuded. Surrounding tissue: Excoriated. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. - Right inner forearm. According to the nursing note, Skin issue has not been evaluated .Type 2: Partial flap loss. Wound was present on admission. Wound is new. Staged by: In-house nursing. Undermining: No. Tunneling: No. Additionally, an open lesion to the left chest was noted to be resolved, healed and/or closed. The nursing note also stated, Wounds dressed and assessed today. Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. A skin evaluation performed on 03/24/25 reported the same non-pressure wounds as on 03/18/25. The wounds were described exactly the same as they were described in the note written on 03/18/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The note even contained the same notation that Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. Resident #110's Treatment Administration Record (TAR) showed the following non-pressure ulcer wound treatments written after the resident returned to the facility on [DATE]: - Cleanse open lesion to left chest with IHWC [wound cleanser]. Pat dry. Sureprep wound and then leave open to air every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse open lesion to left chest with IHWC [wound cleanser]. Pat dry. Sureprep wound and then leave open to air every day and evening shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The order was not signed off as performed on 03/24/25. On 03/25/25 evening shift, the TAR indicated the resident was in the hospital. - Cleanse skin tear to front right lateral lower leg with IHWC. Pat dry. Apply sureprep to periwound and cover wound with calcium alginate sheet. Cover with super absorbent 6x6 foam dressing. If drainage is scant or not present, notify skin tear, every day and evening shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse skin tear to front right lateral lower leg with IHWC. Pat dry. Apply sureprep to periwound and cover wound with calcium alginate sheet. Cover with super absorbent 6x6 foam dressing. If drainage is scant or not present, notify skin tear, every day and evening shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse skin tear to right inner forearm with IHWC, pat dry, and apply sureprep to periwound and adhesive contact area. Cover with foam dressing every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse skin tear to right inner forearm with IHWC, pat dry, and apply sureprep to periwound and adhesive contact area. Cover with foam dressing every day shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. The resident had the following focus on her comprehensive care plan, Resident/patient is resistive to care related to: Refusing wound treatments. The TAR did not indicate the resident had refused any of the treatments discussed above. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's comprehensive care plan also included the following focus, Resident at risk for skin breakdown related to incontinence, morbid obesity, decreased activity, limited mobility secondary to acute illness with recent hospitalization, h/o [history of] pressure injuries and multi-disease processes, h/o skin tears, actual pressure ulcer, frail fragile skin, impaired cognition, impaired sensation, incontinence, informed refusal to aspects of care, moisture, nutritional concerns, poor safety awareness, and shear/friction risks AND pressure to sacrum and left lateral foot. Skin tears to left elbow, right inner forearm, right antecubital space, left outer forearm, front right knee, front right lateral lower leg. The focus was created on 12/25/2021 and revised on 02/28/25. On 03/25/25, the resident was transferred to the hospital after having low blood pressure during her dialysis treatment. The hospital records had an emergency room nursing note dated 03/25/25 at 4:22 PM, While performing pericare it is noted patient has other mepilex dressings on various areas of her skin, dressings are dated for 03/13/25. The hospital records included a photograph of a dressing dated 03/13/25 on what appeared to be the resident leg. The emergency room physician's note stated, Also there was concerned [sic] that patient has dressing from 03/13 is [sic] not been changed. On 05/07/25 at 11:00 AM, the Center Nurse Executive (CNE) confirmed the resident's skin tear care and dressing changes had not been signed off on the TAR to indicate the care and dressing changes had been performed. The CNE and the Administrator stated the facility was not aware of the hospital's allegation that skin tear dressing changes had not been performed. No further information regarding Resident #110's skin tear dressing changes or assessments was provided by the facility during the investigation. c) Resident #26 On 03/28/25 at 6:00 AM, a change of condition was written because Resident #26 was noted to have a skin tear to the right forearm. A dressing was applied. On 03/30/25 a change in condition form was initiated for some edema and redness to the right arm skin tear. The wound was evaluated by the telemedicine service who did not feel the skin tear was infected. An order was written on 03/30/25 to monitor the right forearm for worsening redness and swelling. An order for a dressing change to the skin tear was written on 04/01/25. The order was to cleanse right outer forearm with IHWC [wound cleanser], pat dry, sureprep periwound, cover with foam bandage. every day shift every Tuesday for skin tear and as needed for skin tear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/25 at 11:00 AM, the Center Nurse Executive confirmed that the order for a dressing change to the skin tear had not been ordered until 04/01/25. She confirmed a wound care order was not initiated at the time the skin tear was observed on 03/28/25. She stated the initial assessment indicated a dressing had been applied to the wound. She stated the dressing had been changed before the order was written on 04/01/25 because assessments of the wound are documented. However, she confirmed an order was not written by the physician until 04/01/25 to specify the specific wound treatment and dressing to be applied. d) Resident #58 Resident #58 returned to the facility from the hospital on [DATE] with a skin tear to his left outer forearm. Treatment to the skin tear was initiated upon his return to the facility. An assessment of the skin tear was performed on 05/02/25. The skin tear measured 7.3 centimeters (cm) x 5. 9 cm. Other characteristics of the wound, such as evidence of infection, exudate (drainage), periwound (around the wound), and pain were not completed on the skin and wound evaluation. On 05/07/25 at 1:00 PM, the Center Nurse Executive confirmed no assessments of Resident #58's skin tear had been documented until 05/02/25, and that this assessment had not been completed. e) Resident #90 Resident #90 had a skin tear on the front left leg that developed in January 2025. An assessment on 4/16/25 measured the wound as 6.75 centimeters (cm) x 5.9 cm with heavy purulent exudate. The resident was prescribed an antibiotic, doxycycline, twice a day for cellulitis from 04/16/25 through 04/23/25. On 04/24/25, a skin check was documented. The skin check stated the skin tear to the front left later lower leg has not been evaluated. An assessment on 5/6/25 measured the wound as 13.8 cm x 6.8 cm. Other characteristics of the wound, such as evidence of infection and exudate were not documented. On 05/07/25 at 11:30 AM, the Center Nurse Executive confirmed assessments of Resident #90's skin tear had not been documented from 04/16/25 through 05/06/25.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide care and services for pressure ulcers in accordance with professional standards of practice. This deficient practice had the potential to affect three (3) of three (3) residents reviewed for pressure ulcers. Pressure ulcers were not assessed weekly for Residents #110, #58, and #90. Additionally, Resident #110's pressure ulcers were not treated as ordered. This deficient practice caused actual harm to Resident #110, who was admitted to the hospital with a pressure ulcer infection. The hospital physician also diagnosed the resident with septic shock, believed to be caused by a combination of pneumonia and sacral pressure ulcer wound infection. Resident identifiers: #110, #58, #90. Facility census: 109. Findings included: a) Policy review Review of the facility's policy and procedure titled, Skin Integrity and Wound Management, with effective date 07/01/01 and revision date 05/01/25 stated wound evaluations would be performed weekly. b) Resident #110 Review of Resident #110's electronic health records showed the resident returned to the facility from the hospital on [DATE]. A nursing note written on 03/18/25 at 11:45 PM documented the resident had the following pressure ulcers: - Sacrum According to the nursing note, Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer/injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 3 pressure ulcer/injury - full thickness skin loss. Wound was present on admission. Wound is new. Signs and symptoms of infection: None. Staged by: In-house nursing. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: will assess with Swift wound photo application. Undermining: No. Tunneling: No. Epithelial: 80%. Granulation: 20%. Exudate amount: Light. Exudate type: Serosanguinous.: mixture of serous and sanguinous fluid, typically pale, red and watery. Odor after cleansing: None. Other: pink or red. Periwound: Attached. Surrounding tissue: Erythema. Surrounding tissue: Excoriated. Surrounding tissue: Fragile. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. - Left lateral foot According to the nursing note, Skin issue has not been evaluated .Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound was present on admission. Wound is new. Staged by: In-house nursing. Undermining: No. Tunneling: No. The nursing note also stated, Wounds dressed and assessed today. Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT [information technology] to try and resolve issue so that wound photos can be taken. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A skin evaluation performed on 03/24/25 reported the same pressure ulcers as on 03/18/25. The wounds were described exactly the same as they were described in the note written on 03/18/25. The note even contained the same notation that Issue signing on to SWIFT photo app on personal device and facility device. Will contact IT to try and resolve issue so that wound photos can be taken. Resident #110's Treatment Administration Record (TAR) showed the following pressure ulcer wound treatments written after the resident returned to the facility on [DATE]: - Cleanse stage 3 pressure ulcer injury to sacrum with IHWC [wound cleanser]. Pat dry. Apply plurogel thoroughly to wound, ensuring application to small open area at top of sacrum, every day shift. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse stage 3 pressure ulcer injury to sacrum with IHWC [wound cleanser]. Pat dry. Apply plurogel thoroughly to wound, ensuring application to small open area at top of sacrum, every day shift. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse DTI [deep tissue injury] to left lateral foot with IHWC. [NAME] dry. Apply sureprep rapid dry to wound. Leave open to air. Notify provider and wound team with any changes in wound status immediately. The order had been written to start on 03/19/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. - Cleanse DTI [deep tissue injury] to left lateral foot with IHWC. [NAME] dry. Apply sureprep rapid dry to wound. Leave open to air. Notify provider and wound team with any changes in wound status immediately. The order had been written to start on 03/24/25. The order was discontinued 03/26/25. The treatment had not been signed off as performed on the TAR for any of the days. The resident had the following focus on her comprehensive care plan, Resident/patient is resistive to care related to: Refusing wound treatments. The TAR did not indicate the resident had refused any of the treatments discussed above. The resident's comprehensive care plan also included the following focus, Resident at risk for skin breakdown related to incontinence, morbid obesity, decreased activity, limited mobility secondary to acute illness with recent hospitalization, h/o [history of] pressure injuries and multi-disease processes, h/o skin tears, actual pressure ulcer, frail fragile skin, impaired cognition, impaired sensation, incontinence, informed refusal to aspects of care, moisture, nutritional concerns, poor safety awareness, and shear/friction risks AND pressure to sacrum and left lateral foot. Skin tears to left elbow, right inner forearm, right antecubital space, left outer forearm, front right knee, front right lateral lower leg. The focus was created on 12/25/2021 and revised on 02/28/25. On 03/25/25, the resident was transferred to the hospital after having low blood pressure during her dialysis treatment. The resident's sacral pressure ulcer was found to be infected with the organisms proteus and enterococcus. The resident was also given a diagnosis of septic shock, which the physician believed was caused by a combination of pneumonia and sacral wound infection. The resident required antibiotics for the wound infection through 04/04/25. The resident remained in the hospital until 04/07/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/07/25 at 11:00 AM, the Center Nurse Executive (CNE) confirmed the resident's pressure ulcer care and dressing changes had not been signed off on the TAR to indicate the care and dressing changes had been performed. No further information regarding Resident #110's pressure ulcer dressing changes or assessments was provided by the facility during the investigation. c) Resident #58 Resident #58 had a pressure ulcer to his left elbow that had healed and reoccurred several times. According to the Center Nurse Executive (CNE), the left elbow pressure ulcer reoccurred 03/17/25. At the last assessment on 05/02/25, the area was recorded as facility acquired, stage II, with measurements of 5.9 centimeters (cm) x 5.3 cm x 0.1 cm. Prior assessments could not be located in the resident's electronic health record. Per the Center Nurse Executive on 05/07/25 at 1:00 PM, no previous assessments were located in the medical record of the left elbow pressure ulcer that occurred 03/17/25. d) Resident #90 Resident #90 had a sacral pressure ulcer that developed 04/09/25. Upon discovery, the pressure ulcer was assessed and treatment was initiated. The pressure ulcer was reassessed on 04/16/25. On 04/24/25, a skin check was recorded but the sacral pressure ulcer was not assessed. The Nurse Practitioner assessed Resident #90's pressure ulcer on 04/29/25. On 05/07/25 at 11:30 AM, the Center Nurse Executive confirmed an assessment of Resident #90's pressure ulcer had not been documented between 04/16/25 through 04/29/25.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review and staff interview, the facility failed to ensure percutaneous endoscopic gastrostomy (PEG) tube care in accordance with professional standards of care for one (1) of three (3) residents reviewed for PEG tube care. Resident identifier: #110. Facility census: 109. Findings included: a) Resident #110 Review of Resident #110's electronic health records showed the resident was receiving enteral feeding through a percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is a surgically-placed tube that allows a person to receive nutrition directly through the stomach. Review of Resident #110's Treatment Administration Records (TARs) for February and March 2025 showed no orders for PEG tube treatment. According to Medline Plus, an online health information resource maintained by The National Library of Medicine, PEG tube sites should be cleaned one (1) to three (3) times a day. On 03/25/25, Resident #110 was transferred to the hospital. Hospital records stated upon admission to the hospital, the resident's PEG tube dressing was adhered to the skin by drainage. A photograph taken at the hospital showed the PEG tube dressing with beige-colored dressing on it. On 05/07/25, the Center Nurse Executive confirmed Resident #110 did not have an order for PEG tube care. Through the completion of the investigation, no documentation was provided that Resident #110's PEG tube site had been cleaned.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident interviews, anonymous nursing staff interviews, and hours per patient day review, the facility failed to ensure sufficient qualified nursing staff were available to provide nursing and related services to meet the residents' needs safely and in a manner that promoted resident rights, physical, mental and psychosocial well-being. The low staffing had the potential to affect all residents in the facility. Facility census: 109. Findings included: a) Anonymous Resident Interviews During an anonymous resident interview the resident reported, There are times when there is only one aide to a hall which means I need to wait a very long time to receive care when I put my call light on. Sometimes, it takes over an hour or more for the aide to get to me. b) Anonymous Nursing Staff Interviews During an anonymous Nurse Aide interview, the aide reported that she frequently rushes through her job in getting residents up and ready for the day stating, It makes me want to not work here. The aide explained that she feels as though it affects her residents because she is unable to pay attention to small things like hair care and things that would matter to a resident's overall dignity. During another anonymous Nurse Aide interview, the aide stated, Some days I go home feeling terrible. They [the residents] deserve so much more care. The aide explained being rushed and unable to do things like braiding a resident's hair when she requests or remembering to deliver more ice water to a resident who has requested it. The aide stated on days the nurse aides are working short, residents who require a mechanical lift to get out of bed are frequently given a bed bath instead of being taken to the shower room for a shower. That is because it takes two (2) staff members to operate the mechanical lift. During a third anonymous Nurse Aide interview, the aide stated, During Easter Sunday, there was only one (1) nurse aide to a hall until Noon. That meant that breakfast wasn't served until about 10:00 AM for those who required staff assistance because the aides were going from hall to hall helping to pass the meal trays. Only after all the meal trays had been served on all the hallways did the staff begin to sit down with residents who required assistance with eating their meals. The nurse aide also stated that when they are short-staffed it affects resident showers in a negative way simply because there are not enough staff in the building to get everything done. A fourth anonymous Nurse Aide interview revealed aides frequently are rushed and hurried. The nurse aide stated there is frequently not enough time to perform showers when they are short staffed. c) Review of Hours per Patient Day (HPPD) Review of the Daily Time Detail by Department reports for eight (8) sampled days demonstrated the following times direct care hours per resident day were below the state minimum of 2.25 hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2.20 hours per resident day on 03/16/25. -2.21 hours per resident day on 03/22/25.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on food tray temperatures and staff interview, the facility failed to serve food to residents that was at an appetizing temperature. This failed practice was true for one (1) of one (1) hallway tested for food tray temperatures throughout the complaint survey process. This had the potential to affect more than an isolated number of residents. Facility census: 109. Findings included: a) 100 Hall Lunch Time Meal Observation During an observation on 05/05/25 at 1:30 PM, the last meal tray on the 100 Hall was tested by the Director of Operations for the Healthcare Services Group with the following results: -- Ham and Pinto Beans: 140.0 degrees Fahrenheit (F) -- Pan-Fried Potatoes: 112.2 degrees F -- Mixed Vegetables: 123.0 degrees F -- Banana Pudding: 72.1 degrees F The Director of Operations for the Healthcare Services Group agreed the food temperatures obtained for the pan-fried potatoes and the banana pudding were not considered to be the appropriate desired temperature for the point of delivery to the residents. It was discussed that hot foods would typically be served at 120 degrees F or above and cold foods would be served at 40 degrees F or below.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Facility staff failed to follow contact precautions and enhanced barrier precautions. Staff also failed to perform appropriate hand hygiene during a dressing change. This deficient practice had the potential to affect more than a limited number of residents. Resident identifiers: #9 and #26. Facility census: 109. Findings included: a) Resident #9 The facility's policy and procedure titled Transmission Based Precautions with effective date 02/15/01 and revision date 05/01/25 stated that healthcare personnel caring for patients on contact precautions would wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. On 05/05/25 at 12:25 PM, Respiratory Therapy Nurse #99 was observed in Resident #9's room, listening to the resident 's lungs with a stethoscope. Resident #9 had a contact precautions sign on her door. On the sign was a Post-it note that stated, Please wear a MASK. Respiratory Therapy Nurse #99 was not wearing any personal protective equipment. The contact precautions sign was red, with a stop sign on it. The sign read as follows: Standard plus contact precautions to prevent the spread of infection. Please see the nurse before entering the patient's room. Thank you! - Patient may NOT come out of room. - Wash hands with SOAP and WATER BEFORE and AFTER patient contact, contact with environment and after removal of PPE [personal protective equipment]. - Wear gloves upon entering this room; remove prior to exiting and discard. - Wear gowns upon entering this room; remove prior to exiting and bag before leaving room. - Please do not remove dedicated or single use disposable equipment from this room. - When dedicated equipment is not possible, disinfect shared patient equipment with EPA approved sporicidal. Please ask your nurse or infection preventionist if you have any questions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When questioned after leaving the room, Respiratory Therapy Nurse #99 stated she didn't know Resident #9 was in contact isolation and a mask was also required for entering the room. Review of Resident #9's electronic health record showed a banner at the top of the record indicating the resident was in isolation precautions. However, the resident did not have an order for contact precautions. On 05/05/25 at 3:04 PM, the Center Nurse Executive (CNE) stated the resident was on isolation precautions for metapneumovirus. Metapneumovirus is a virus that usually causes symptoms of coughing, a runny nose, and a sore throat. The virus can be more serious in people over the age of 65. The virus is spread through direct contact with someone who has it or from touching things contaminated with the virus. b) Resident #26 Review of the facility's policy titled Enhanced Barrier Precautions with effective date 01/06/20 and revision date 12/16/24 stated enhanced barrier precautions (EBP) would be implemented for residents with wounds. The policy also stated a gown, and gloves would be worn by staff when performing wound care. The facility's policy titled Wound Dressings: Aseptic gave the following procedures: - Apply clean gloves .remove soiled dressing. - Discard soiled dressing and gloves in the appropriate receptacle. - Perform hand hygiene. - Apply gloves. Resident #26 had a right arm wound dressing. She had an order written on 04/11/15 for infection precautions-enhanced barrier. Outside Resident #26's door was a sign indicating she was in enhanced barrier precautions. The sign stated as follows: Stop Very Important Enhanced barrier precautions Attention: Caregivers, Staff & Visitors - Patient may come out of room. - Perform Hand Hygiene before and after patient contact, contact with environment and after removal of PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Wear Gown and Gloves prior to these activities: - During high-contact resident care activities - Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use of a device (i.e. central lines, urinary catheters, feeding tubes, tracheostomies, ventilators) - Wound care: any skin opening requiring a dressing - Change PPE before caring for another resident/patient - Face protection may also be needed if performing activity with risk of splash or spray - Use dedicated equipment is not possible, disinfect shared patient equipment with EPA [Environmental Protective Agency] approved disinfection. - See care plan for additional information. Please ask your Nurse or Infection Preventionist if you have any questions. On 05/06/25 at 09:44 AM, the resident's dressing change was observed by Licensed Practical Nurse (LPN) #55. LPN #55 did not follow Enhanced Barrier Precautions during the dressing change. She did not wear a gown at any time during the procedure. Additionally, LPN #55 did not perform hand hygiene as required during the dressing change. She applied gloves before removing the old dressing. LPN #55 then cleaned the wound without changing gloves and performing hand hygiene. She then changed gloves but did not perform hand hygiene before proceeding to apply a new dressing. During an interview on 05/06/25 at 10:10 AM, the Center Nurse Executive confirmed that gowns should be worn when changing dressings for residents in Enhanced Barrier Precautions. She also confirmed that nurses are taught to perform hand hygiene with glove changes when going from dirty to clean during a procedure. No further information was provided through the completion of the investigation.