STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515117	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Healthcare Center	462 Kenmore Drive Danville, WV 25053

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form to (2) one of three (3) residents reviewed for the facility's beneficiary protection notification practice and failed to issue the required Notification of Medicare Non-Coverage (NOMNC) in a timely fashion for two (2) of three (3) residents reviewed for beneficiary protection notification during an annual survey. Resident identifiers: #48 and #346. Facility census: 90 Findings included: a) Resident #48 On 04/16/25 at 12:00 PM, a review was completed regarding the beneficiary protection notification liability notices given for the following resident who remained at the facility following their last covered day of Medicare Part A services: - Resident #48 began Medicare Part A skilled services on 12/23/24. The last covered day of Part A service was 12/23/24 for Occupational Therapy. Medicare Part A skilled services began on 02/11/25 and the last day of 02/12/25 for Physical Therapy. There was no evidence that a Notice of Medicare Non-Coverage (NOMNC) was signed and no evidence a SNF ABN form had been provided and signed for either date. Review of discharge summaries for the following services were reviewed and revealed reasons for discharge: -Occupational Therapy: discharge date [DATE] reason for discharge- Highest Practical Level Achieved -Physical Therapy: discharge date [DATE] reason for discharge- Highest Practical Level Achieved (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice on Non-coverage (SNF ABN) Form CMS-10055 (2018) denoted Medicare requires Skilled Nursing Facilities to issue the SNF ABN to Medicare beneficiaries prior to providing care that Medicare usually covers, but may not pay for because the care is: - not medically reasonable and necessary; or - considered custodial. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 state: The NOMNC must be delivered at least two calendar days before Medicare covered services end . The instructions also state: A NOMNC must be delivered even if the beneficiary agrees with the termination of services. In an interview on 04/16/25 at 1:50 PM, Social Worker #99 acknowledged the facility failed to provide SNF ABN and NOMNC forms to Resident #48 prior to her last covered day of Medicare Part A skilled services. She reported that resident went home for Christmas and they had to discharge her. She stated that therapy did not make them aware that resident was at her max potential and would be completing services. In an interview with Therapy Manager #54 on 04/16/25 at 2:10 PM the resident was discharged from services due to meeting maximum potential and that residents were made aware that services would end when their goals were completed. b) Resident #346 On 04/16/25 at 12:15 PM, a review was completed regarding the beneficiary protection notice(s) given for Resident #346 who was discharged to home with a family member following his last covered day of Medicare Part A services. Resident #346's last covered day of Part A Services was on 11/21/24. There was no evidence in the electronic medical record that the required Notification of Medicare Non-Coverage (NOMNC) was issued. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 state: The NOMNC must be delivered at least two calendar days before Medicare covered services end . The instructions also state: A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Review of therapy discharge summaries (physical therapy and occupational therapy), completed on 11/21/24 at 9:40 revealed the following details: -The Physical Therapy Discharge Summary stated the discharge reason was All Goals Met. -The Occupational Therapy Discharge Summary stated the discharge reason was Highest Practical Level Achieved. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/25 at 1:50 PM, Social Worker #99 acknowledged the facility failed to provide NOMNC forms to Resident #346 prior to her last covered day of Medicare Part A skilled services. She reported that she was not aware that a NOMNC had to be presented to resident due to their decision to go home. She stated that therapy did not make them aware that resident was at her max potential and would be completing services. In an interview with Therapy Manager #54 on 04/16/25 at 2:10 PM the resident was discharged from services due to meeting maximum potential and that resident was made aware that services would end when their goals were completed.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure Cardio-Pulmonary Resuscitation (CPR) interventions were initiated and continued until the arrival of emergency medical personnel for a resident observed with absence of vital signs with a Full Code status, resulting in death for one (1) of two (2) residents reviewed for death in the facility. This had the potential to affect all residents in the facility with a Full Code status. This immediate jeopardy began on [DATE] at approximately 3:00 AM when Resident #194 was observed with absence of vital signs. LPN #125 and Nurse Aide #126 reportedly initiated CPR but discontinued it prior to the arrival of EMS. The facility Administrator was informed of the Immediate Jeopardy (IJ) tag on [DATE] at 2:55 PM. The IJ tag was removed and the deficient practice corrected on [DATE], prior to the start of the survey, and was therefore Past Noncompliance. Findings included: a) Resident #194 The closed record for Resident #194 was reviewed on [DATE] at 8:30 AM. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Chronic Pain Syndrome, Anemia, Major Depressive Disorder, Chronic Kidney Disease, personal history of Transient Ischemic Attack (TIA), Cerebral Infarction (Ischemic Stroke) without residual deficits, and Atrial Fibrillation. A Physician Determination of Capacity form, completed on [DATE], indicated that Resident #194 had capacity. A Physician Orders for Scope of Treatment (POST) form, signed by resident's physician on [DATE], indicated Resident #194 had checked the box stating she wished to receive CPR in the event she was found with no pulse and was not breathing. Review of the facility's Cardiopulmonary Resuscitation (CPR) policy revealed the following: - The facility will follow current American Heart Association (AHA) guidelines regarding CPR and ensure there are an adequate number of staff present who are properly trained/certified in CPR. - If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), licensed nurses will provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the physician order and Advance Directives. The date and time of the incident was on [DATE] at approximately 3:00 AM. LPN #125 and Nurse Aide #126 entered the resident's room to complete a dressing change and found the resident to be unresponsive. CPR was reportedly started on Resident #194 but stopped prior to the arrival of EMS. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The two (2) staff members were immediately suspended pending the outcome of the facility's investigation into the incident. Per the Administrator's statement, the facility had a meeting with ambulance authority in which the EMS Supervisor stated the arriving crew for the emergency call stated to him that facility staff did not initiate CPR on the resident. The EMS call from the facility was received at 3:12 AM. Per her statement, LPN #125 entered the resident's room with Nurse Aide #125 and found the resident unresponsive and without vital signs. CPR was initiated with the help of Nurse Aide #126. They allegedly did three (3) to four (4) rounds of CPR and couldn't do anymore. Per her statement, Nurse Aide #126 began CPR with LPN #125. They reportedly stopped about five (5) minutes before EMS arrived. The Nurse Aide stated she left the room to answer another resident's call light after that. Per her statement, the crash cart (used to provide healthcare professionals with immediate access to life-saving medications and equipment during a medical crisis) was obtained by LPN #22. LPN #22 called 911 at approximately 3:12 AM. Per her statement, RN #46 was on the other side of the building and was never aware Resident #194 was not doing well until resident was taken out of the building by EMS. LPN #125 reported to her that the resident was unresponsive and was a full code. RN #46 informed staff that when there is a code in the building to call / yell / page overhead for staff to come perform CPR until EMS arrives. Throughout the facility's investigation, it was determined that the LPN #125 and Nurse Aide #126 started CPR but stopped minutes before EMS arrived. It was determined that the facility's CPR policy was not followed. Written statements were obtained from staff working at that time. LPN #125 was terminated. Nurse Aide #126 was suspended and received disciplinary action for following the LPN ' s lead and stopping CPR prior to the arrival of EMS staff. Both the LPN and the Nurse Aide were reported to their respective licensing boards. During an interview on [DATE] at 12:35 PM, the Administrator confirmed the facility initiated the following abatement plan to correct the identified deficient practice: 1. The facility completed a timeline of when the initial change in condition occurred, all events/occurrences, staff assigned, actions taken, staff interactions, communication, family interaction/comments, list of all staff involved, and when EMS was called. COMPLETED [DATE]. 2. The facility performed an audit of licensed nursing staff for current CPR cards. COMPLETED [DATE]. 3. The facility completed an audit of all POST forms / advance directives to ensure they match, and the code status order is accurate. COMPLETED [DATE]. 4. All licensed nursing staff (beginning [DATE], then upon return to work, then quarterly thereafter) completed CPR education in Relias (an online learning management system). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The facility provided education to all direct nursing staff on [DATE] to all staff present (and thereafter upon a staff member's return to work) on the facility's CPR policy and the fact CPR should not be stopped until EMS arrives to relieve facility staff. 6. Mock codes were performed one (1) time a week for four (4) weeks. 7. Findings were reported to the Quality Assurance Committee monthly for three (3) months then as directed by the Quality Assurance Committee. On [DATE], beginning at 3:33 PM, the Surveyor interviewed ten (10) members of the nursing staff that were on duty. During each individual interview, staff were able to outline the expectations of successfully performing CPR on a resident who had a full code order. Each individual identified the need to immediately begin CPR, call out for help so the crash cart could be delivered and someone could call 911. They were able to state that it is the expectation that all available staff be available to continue CPR in the event a staff member needed to be relieved. Each staff member emphasized that CPR was to continue up until EMS arrived in the building and took over CPR efforts. During an interview on [DATE] at 4:51 PM, the Director of Nursing explained that all new hires are provided orientation on the facility ' s CPR policy and what their role would be if a code were to be called while they are in the building. Additionally, it was reported that each employee completes an electronic training course that covers the full code process. Although the facility was not in compliance with the regulatory requirement at the time the incident occurred on [DATE], there was evidence that the facility was in substantial compliance on [DATE]. Therefore, this was considered Past Noncompliance.

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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. 49465 Based on record review and staff interview the facility failed to address recommendations made by the wound care service. This failed practice was found true for (1) one of (3) three residents reviewed for pressure ulcers during the Long-Term Care Survey Process. Resident identifier #17. Facility Census 90. Findings Include: a) Resident #17 During the initial interview on 04/14/25 at 11:51 AM, Resident #17 stated, I have a couple places on my butt. I feel like they are getting better. I am not sure how they got there. A record review on 04/15/25 at 11:35 AM, revealed a progress note dated 03/11/25 from the wound care service recommending adding modular protein and multivitamin with zinc supplements. Further record review of Resident #17's orders revealed that the modular protein and the multivitamin with zinc supplements had not been added. No information could be found as to why the supplements had not been added. During an interview on 04/16/25 at 10:54 AM, The Director of Nursing (DON) stated, I cannot find anything in the chart to indicate why he did not get the modular protein. Our doctor typically does not do the multivitamin with the Zinc and Vitamin C. During an interview on 04/16/25 at 1:07 PM, The DON stated, I did not find out anything else. I guess we just got to do better.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49465 Based on record review and staff interview the facility failed to provide adequate supervision to prevent avoidable accidents. This failed practice caused harm to Resident #245. Resident #245 fell from the shower bed and received hematoma and laceration to the head requiring sutures. The incident was corrected and will be sighted at past non-compliance. This failed practice was found true for (1) one of (6) six residents reviewed for accidents during the Long-Term Care Survey Process. Resident identifier: #245. Facility census: 90. Findings Include: a) Resident #245 A review of the facility reportable log on 04/15/25 at 11:30 AM, found a reportable for Resident #245 dated 09/29/24 at 9:45 AM, that summarized the incident as follows: Nursing Assistant (NA) #69 had Resident #245 in the shower room giving her a shower. Resident was laying on the shower bed when NA #69 put the rails down on the shower bed and then turned to place a blanket on the shower chair beside the shower bed and resident sat up and slid off of the shower bed onto the floor. Resident struck her head on the floor causing a laceration to the left temple area. Resident was sent to the emergency room (ER) for sutures. Resident had bruising and lacerations to her left temple area. Further record review of the Hospital emergency room (ER) report on 09/29/24 is summarized as follows: Resident had a scalp laceration requiring sutures and a hematoma to forehead, no other injuries related to the fall. A record review of the report on 04/16/25 at 9:00 AM, revealed that risk factors for Resident #245 included: Resident undergoing changes in medications, resident has a fall history, poor safety awareness, and impulsive movements. A record review on 04/16/25 at 9:15 AM revealed that Resident #245 had the diagnoses that included the following: Epilepsy, Early onset of Dementia, Altered mental status, and muscle weakness Further record review of Resident #245's fall care plan reads as follows: Focus: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident has had falls and is at risk for further falls due to early onset Dementia, muscle weakness, and Epilepsy disorder. Goal: Resident will not sustain major injury related to falls through review date. Interventions: Bed in lowest position DEVICE: Bilateral Fall mats Device: hipsters on at all times. may be removed for hygiene. every shift for falls Device: Perimeter Mattress to bed to help identify edges Dycem to the left side of bed. Educate resident or resident representative, if applicable how to operate bed controls/call light/television Ensure resident is wearing appropriate non-skid footwear Ensure the resident's room is free of accident hazards. Ensure residents room is free of potential visible hazards Ensure that the bed locks are engaged Initiate neuro checks if fall is unwitnessed, or the head is involved. Lab work ordered Medication adjustment by NP NP to review medication Place call bell within reach, remind resident to call for assistance. Provide adequate lighting at night PT/OT eval and treat, as needed. Rearrange the room / personal items are within reach (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the reportable investigation on 04/15/25 at 11:30 AM found that the incident happened on 09/29/24 at 9:45 AM in the shower room. The incident was reported on 09/29/24 at 1:30 PM. All staff working were interviewed to rule out abuse. The perpetrator, Nursing Assistant (NA) #69's statement read as follows: I was showering (Resident #245 name) around 9:45 AM. I moved her rolling chair by the shower bed. I turned around to remove blankets, and she rolled out of the shower bed onto the floor. Later in the investigation it came out that NA #69 had lowered the rail to the shower bed, before he turned around to remove blankets from another chair. All staff working that were interviewed contested to the facts that NA #69 had Resident #245 in the shower room, he lowered the rail to the shower bed, turned around to remove blankets from the shower chair and Resident #245 rolled off the shower bed, hitting her head on the floor causing the laceration. Five-day follow-up was completed on 10/02/24 and the incident was substantiated by the facility. NA #69 was immediately suspended pending the investigation All floor staff were educated on the correct procedures of showering residents and safety the in-service reads as follows: When having residents on a shower bed do not lower rails on the shower bed until you are ready to transfer with all needed supplies. Do not turn your attention away from the resident until the transfer is complete. Sign-in sheets for the in-service were reviewed and it was verified that all floor staff received the in-service. One on one education provided to NA #69 and a disciplinary notice was put in place that is marked for the following: Violation of safety rules Unsatisfactory quality The disciplinary notice narrative reads as follows: Resident fell out of shower bed due to bed rail being down while NA turned his back to grab a blanket, resulting in a laceration to the head. During an interview, on 04/17/25 at 2:30 PM, The Administrator stated, It was just one of those accidental things. He turned his back, and the resident fell out of the shower bed. We did in-service all floor staff and did one on one education with the aide. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The State Agency feels that harm occurred to Resident #245 by NA #69 turning his back and allowing Resident #245 to fall off the shower bed acquiring a head laceration that required sutures. The State Agency further agrees that all corrective action has been taken by the facility to correct the situation and put plans in place to ensure an incident of this nature does not happen again.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50551 Based on observation, staff interview and record review, the facility failed to provide dental services by failing to schedule oral surgery in a timely manner as recommended by the dentist. This is true for Resident #7. Facility Census 90. Findings Included: a) Resident #7 On 04/14/25 at 3:18 PM Resident #7 was observed to have broken and missing teeth. On 04/15/25 at 09:08 AM a review of resident's medical records revealed the following: Resident #7's care plan stated that the resident had a potential for oral/dental health problems affecting ADLs r/t Poor oral hygiene, has own teeth, missing, requires assist of staff with oral care. The intervention included dental consult as needed. A review of resident's last Dental exam summary on 01/04/22 stated Recommending all remaining teeth to be extracted and attached a referral to see an oral surgeon. Nursing Note dated 01/4/22 at 11:12 am revealed, Referral for resident to see an oral surgeon for further tooth extractions. Resident denies mouth or tooth pain at current time. Will notify APS of dental request/referral along with NP. Resident and nursing aware. Will send referral (specific facial surgeon) to see if they will accept resident and if not will seek out another oral surgeon for further treatment. c) On 04/14/25 at 12:03 PM during an interview with Licensed Practical Nurse (LPN) #30 the LPN reported that she recently held a position in the medical records department of this facility. She reported that she had made a note that the resident had attended a dental consultation where the dentist made a referral for resident to see an oral surgeon for further tooth extractions. She reported that generally she would make these appointments with (a specific facial surgeon) but that she could not find any further information about whether she made any appointments.

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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. 49751 Based on observation and staff interview the facility failed to provide food that was palatable by serving scorched beans. This was a random opportunity of discovery had had the potential to affect a limited number of residents residing in the facility. Facility census: 90 Findings include: 04/15/25 01:40 PM the beans had a strong smoky smell and had small bits of black burnt substance in them. When tasting them they had an overcooked burnt taste to them. 04/15/25 01:55 PM The Culinary Account Manager (CAM) #101 stated the beans were cooked today and knew they were scorched. CAM #101 stated, Yeah she (the cook serving) scrapped the bottom of the pan. This confirmed the beans had been scorched and should not have been served.

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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. 39043 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. Resident identifiers: #29, #19, #17, #28, and #43. Facility census: 90. Findings included: a) Resident #29 On 04/16/25 at 8:45 AM, medication administration by Registered Nurse (RN) #12 to Resident #29 was observed. Resident #29 was ordered fluticasone nasal spray and allergy eye ophthalmic solution. RN #25 took the fluticasone nasal spray bottle out of the medication cart. She left the box for the nasal spray in the medication cart. RN #25 also took the box of allergy eye ophthalmic solution containing the bottle of solution out of the medication cart. RN #25 placed the bottle of nasal spray and the box containing the bottle of eye solution on a tissue on the resident's overbed table. The resident self-administered the nasal spray and RN #25 administered the eye solution. RN #25 then removed the bottle of nasal spray and box containing the bottle of eye solution from the overbed table and placed them on the edge of the sink while she washed her hands. She did not use a barrier between the bottle and box and the sink. She then placed the bottle and the box on top of the medication cart before returning them to the medication cart drawer. She put the nasal spray bottle back into the box upon returning it to the medication cart. RN #25 then prepared and administered Resident #29's oral medications. She then took a box containing Resident #29's fluticasone inhaler out of the medication cart. She placed the box containing the inhaler on Resident #29's bedside table. She did not use a barrier between the box and the resident's bedside table. After administering the inhaler, RN #25 placed the box containing the inhaler on the top of the medication cart before returning the box to the medication cart drawer. RN #25 was informed that infectious agents could have been transferred from the resident's room to the medication cart due to the failure to use barriers. She stated she understood. b) Resident #19 On 04/16/25 at 9:20 AM, medication administration by Licensed Practical Nurse (LPN) #30 to Resident #19 was observed. LPN #30 prepared Resident #19's oral medications and also took a box containing the resident's fluticasone inhaler out of the medication cart drawer. She placed the box with the inhaler on top of the resident's overbed table while she administered the resident's oral medications. She did not use a barrier between the overbed table and the box containing the inhaler. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515117	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Healthcare Center	462 Kenmore Drive Danville, WV 25053

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 - Some	Following administration of the inhaler to Resident #19, LPN #30 placed the box containing the inhaler on top of the medication cart before returning the box to the medication cart drawer. LPN #30 was informed that infectious agents could have been transferred from the resident's room to the medication cart due to the failure to use a barrier. She stated she understood. During an interview on 04/16/25 at 10:31 AM, the Director of Nursing (DON) stated it was standard practice to use a barrier between resident room surfaces and multi-dose medications to be returned to the medication cart. She stated the facility did not have a policy to reflect this policy. c) Resident #17 The facility's policy and standard procedure titled Enhanced Barrier Precautions, with no implementation given, stated Enhanced Barrier Precautions (EBP) would be used for residents with wounds without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any multidrug-resistant organisms. The policy also stated a sign would be posted on the resident door to indicate EBP were required. Review of Resident #17's physician's orders showed the resident had an order written on 03/11/25 for pressure ulcer dressing changes to the right buttock and sacrum. The resident did not have an order for EBP. On 04/16/25 at 11:04 AM, the resident's door did not have a sign to indicate the resident required EBP. On 04/16/25 at 11:17 AM, the Director of Nursing (DON) confirmed Resident #17 required EBP due to pressure ulcer wounds. She also confirmed the resident did not have an order for EBP or signage on his door. 50801 d) Resident #28 During an observation of Resident #28's room, on 04/15/25 12:45 PM, rips and tears on the top of the back plastic cover of his wheelchair, exposing the inner padding were observed. e) Resident #43 During an interview and observation with Resident #43 on 04/15/25 at 12:50 PM, it was observed his wheelchair had rips, and holes in the plastic coverings on the arm rest exposing the inner padding. In an interview with the Corporate Clinical Nurse, on 04/15/ 25 at 1:55 PM, she acknowledged both wheelchairs for Residents #28 and #43 had tears exposing the inner padding and agreed the chair could not be cleaned to prevent infection. She stated she understood it was an infection control issue.