

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2025
NAME OF PROVIDER OR SUPPLIER  Resolve at West Allis Respiratory and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  9047 W Greenfield Ave West Allis, WI 53214	

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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1 (R3) of 4 residents reviewed for pressure injuries.</p> <p>*R3 is dependent for all cares and mobility, is at high risk for developing pressure injuries and has a history of pressure injuries. On 5/2/25, facility documented that R3 had developed a pressure injury to R3's left ear. The pressure injury was not comprehensively assessed and there is no documentation that R3's MD was contacted until 5/4/25 when a treatment order was put in place. From 5/7/25 through 5/14/25, R5 was admitted to the hospital for a different change of condition. The initial skin evaluation on readmission to the facility documented that R3 had a stage 2 pressure injury of the left ear, and a treatment was ordered to be completed every Monday, Wednesday and Friday. On 5/16/25, the facility's Wound Nurse Practitioner (NP)-C documented that R3 has a full thickness stage 3 pressure injury to the left ear. NP-C recommended daily treatment for this pressure injury. Facility staff continued to complete treatments every Monday, Wednesday and Friday. On 5/30/25, the pressure injury doubled in length and the wound NP recommended again that treatments should be done daily. The facility did not reevaluate the need for additional interventions after the wound worsened. Facility staff continued to complete treatments every Monday, Wednesday and Friday. On 6/6/25, R3's wound was evaluated by NP-C and NP-C recommended a new treatment to be completed daily. The new recommendations were followed by facility staff and by 6/20/25, the stage 3 pressure injury was healed.</p> <p>On 5/4/25, facility staff entered a care plan intervention that R3 should have a neck pillow around neck at all times to ensure ear offloaded. While on survey, Surveyor observed R3 multiple times without his neck pillow on and direct pressure on R3's left ear.</p> <p>Findings include:</p> <p>The facility policy, with a last reviewed date of 11/7/24, titled Skin Integrity and Wound Policy documents, in part: Based on the comprehensive assessment of a resident, the facility must ensure that A resident receives care, consistent with professional standards of practice to prevent pressure ulcers/injuries and does not develop pressure ulcers/injuries unless the individual's clinical condition demonstrates that they were unavoidable and a resident with pressure ulcers/injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers/injuries from developing .</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R3 was admitted to the facility on [DATE] with diagnosis including non-traumatic intracranial hemorrhage (bleeding within the skull), Tracheostomy (a surgically placed breathing tube in the windpipe), Gastrostomy (a tube inserted through the abdominal wall into the stomach to provide a way to deliver nutrition and fluids), Epileptic seizures, Chronic Kidney disease, Chronic Respiratory failure.</p> <p>R3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R3 is severely cognitively impaired and is rarely/never understood. R3 is dependent for all cares, mobility and transfers. R3 is at risk for pressure injuries but has no unhealed pressure injuries.</p> <p>R3 Care Area Assessment for pressure ulcers/injuries dated 9/19/24 documents, in part: Resident is at risk for pressure ulcer development [related to] history of [pressure injuries], impaired mobility, feeding tube, trach with oxygen, incontinence. Due to respiratory failure, [R3] is dependent upon staff for bed mobility, incontinence care .</p> <p>R3's Braden scale for predicting pressure ulcer risk dated 2/19/25 documents a score of 10 indicating that R3 is at high risk for developing pressure ulcers.</p> <p>R3's potential for skin impairment care plan initiated on 9/21/23 documents the following pertinent interventions: Attempt to off load bony prominences by turning and using pillows, wedges, or other positioning devices as resident allows and tolerates. Nursing will assess skin upon admission, weekly on day of scheduled shower, [as needed], and with any change of condition. Any abnormalities will be documented in chart and reported to primary physician and Wound Care team for follow up. Reposition every 2-3 hours when in bed.</p> <p>R3's actual impairment to skin integrity care plan initiated on 6/11/24 documents the following pertinent interventions: Air mattress to bed. Function checked every shift. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Reposition every 2 hours and [as needed]. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.</p> <p>R3's Skin observation tool assessment entered by wound nurse LPN-E, dated 5/2/25 documents: site-Left ear, type-pressure. Surveyor noted that the fields for measurement of the wound, stage of the wound and notes were all left blank.</p> <p>Surveyor noted that a comprehensive assessment with measurements, description of wound including type of tissue and staging was not completed when the pressure injury was found on 5/2/25.</p> <p>Surveyor reviewed R3's electronic medical record (EMR) for evidence that a provider was notified on 5/2/25, a treatment was completed and that an order for treatment was obtained. Surveyor did not locate any of this documentation.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/25 at 2:29 PM, Surveyor interviewed LPN-E and Nursing Home Administrator (NHA)-A. NHA-A informed Surveyor that LPN-E was not working at the facility on 5/2/25. LPN-E stated that LPN-E was working at a different building. NHA-A stated that NHA-A is looking into who entered the charting under LPN-E's name. NHA-A instructed LPN-E to change passwords to ensure this doesn't happen again. NHA-A indicated that NHA-A would let Surveyor know if anything was found. Surveyor was not informed who was using LPN-E's sign in to document the finding of a new pressure injury.</p> <p>R3's Change in condition evaluation entered by Licensed Practical Nurse (LPN)-D dated 5/3/25 documents, in part: Change in skin color or condition started on 5/3/25 . The primary care clinician was notified on 5/3/25 at 5:30 AM .Site-Left ear. Description-pressure area.</p> <p>R3's progress note entered by LPN-D, dated 5/3/25 at 6 AM documents: Writer awaiting on call back [in] regards to new open area found to left ear pressure related. Resident shows no discomfort or complaints of pain. Little clear drainage to open area.</p> <p>On 6/26/25 at 2:29 PM, Nursing Home administrator informed Surveyor that a New Pressure Injury form was submitted on 5/3/25. This form does not appear in the EMR.</p> <p>R3's New Pressure injury form submitted by LPN-D, dated 5/3/25 documents, in part: Awaiting on call back from NP, voicemail left for family. Cleansed area with normal saline. Neck pillow in place and ears offloaded. Left ear 0.8 centimeters (cm) x 0.5 cm x 0.1cm. Skin intact, scant serous drainage . [Power of Attorney (POA)] aware .</p> <p>Surveyor noted that measurements of the wound were obtained but a comprehensive assessment including the description of the type of tissue and staging was not completed by LPN-D.</p> <p>On 6/26/25, Surveyor attempted to interview LPN-D by phone. LPN-D did not return Surveyor's phone call.</p> <p>Surveyor noted that there is no further documentation on 5/3/25 stating that R3's NP returned a call or gave treatment orders.</p> <p>R3's Change in Condition evaluation dated 5/4/25 documents, in part: Skin wound or ulcer started on 5/4/25 . During AM cares, noted dried blood on pillowcase. Upon body assessment, noted a dried abrasion to left ear. NP was updated and new orders received for wound care . Primary care clinician notified on 5/4/25 at 10 AM. Wound [treatment] (floor nurse to complete): Left ear- Cleanse with [normal saline, pat dry, apply calcium alginate. Cover with a border gauze dressing. Change [Monday, Wednesday, Friday and as needed] . Site-left ear. Description-abrasion noted to area . POA aware .</p> <p>R3's progress note dated 5/4/25 at 1:05 PM documents, in part: . During cares, abrasion was noted to Left Ear. NP was updated. New orders received for wound care and message left for wound nurse in the am to assess. Resident tends to always lay on his Left ear. Head was positioned with a pillow to keep pressure off Left ear. POA aware of new abrasion to Left ear and new treatment orders.</p> <p>Surveyor noted that a comprehensive assessment with measurements, description of wound including type of tissue and staging was not completed when the pressure injury was documented on 5/4/25. Surveyor noted that the documentation on 5/4/25 does not refer to any of the documentation of the wound from 5/2 or 5/3/25 and actually documents that the left ear wound was found on 5/4/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R3's MD order with a start date of 5/5/25 documents: . Left ear cleanse with [Normal saline], pat dry. Apply calcium alginate. Cover with a border gauze dressing. Change [Monday, Wednesday, Friday and as needed].</p> <p>R3's actual impairment to skin integrity care plan has an added intervention initiated on 5/4/25: Neck pillow around neck at all times. Ensure ear offloaded.</p> <p>R3's Certified Nursing Assistant (CNA) Kardex documents: Neck pillow around neck at all times. Ensure ear offloaded.</p> <p>R3's late entry Interdisciplinary Team (IDT) note dated 5/5/25 at 8:45 AM documents: IDT clinical review of new open area to left ear. Resident with no pain behaviors or [signs and symptoms] of infection to site. Medical history includes non-traumatic intracranial hemorrhage, [hypertension], cognitive communication deficit, dysphagia, seizure, presence of cerebrospinal fluid drainage device, [chronic kidney disease] and chronic respiratory failure. Resident is dependent on staff for repositioning [every] 2-3 hours . Resident is frequently turned side to side for offloading and perspires due to medications and with being warm. Neck pillow to be used at all times ensuring ears are offloaded. Maintain a comfortable temperature in resident room to prevent increased perspiration.</p> <p>Surveyor noted that the IDT team reviewed R3's new ear pressure injury and still no comprehensive assessment of the wound was completed and documented.</p> <p>R3's potential for skin impairment care plan has an added intervention initiated on 5/5/25: Ensure room at a comfortable temperature for resident to reduce perspiration.</p> <p>R3's progress note dated 5/7/2025 at 1:30 PM documents, in part: Abnormal lab results received and reported to NP. Left foot was cool to touch, no pedal pulse was felt. NP attempted to find a pulse with doppler and was unable. Order received to send to [local hospital] for Eval and treat. POA was called and gave permission to send to ER .</p> <p>Surveyor noted that R3 was hospitalized on [DATE] through 5/14/25 with a Left lower extremity occlusion. Surveyor noted that the facility did not complete a comprehensive assessment of R3's left ear pressure injury anytime between 5/2 and 5/7/25 before R3 went to the hospital.</p> <p>R3's admission re-admission nursing evaluation dated 5/14/25 documents, in part: . Skin integrity: Left ear pressure 1 cm x 0.5 cm x 0.1cm stage II.</p> <p>Surveyor noted that admission skin evaluation did not include a description of the pressure injury, or the type of tissue visualized on assessment.</p> <p>On 6/26/25, Surveyor interviewed NHA-A. NHA-A informed Surveyor that the admission assessment was incorrectly staged. NHA-A stated that the pressure injury on R3's left ear should have been staged a 3.</p> <p>R3's MD order initiated on 5/14/25 documents: Wound [treatment]: Left ear cleanse with [Normal Saline]. Pat dry. Apply calcium alginate. Cover with a border gauze dressing. Change [Monday, Wednesday, Friday and as needed].</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Wound evaluation by NP-C dated 5/16/25 documents, in part: . Left ear stage 3 pressure injury. Full thickness wound measuring 0.5 cm x 0.5 cm x 0.1cm. 100% granular tissue. Moderate serosanguineous [fluid discharge from a wound that contains both blood and serum] drainage. Peri wound is dry, intact. No [signs and symptoms] of infection . Plan: silver alginate and bordered foam daily and [as needed].</p> <p>Surveyor noted NP-C recommended that the treatment of R3's ear pressure injury be completed daily. Surveyor reviewed R3's MD orders and the previous treatment order was not changed. From 5/16/25 to 5/23/25, facility staff completed the treatments every Monday, Wednesday and Friday and not daily as recommended by NP-C.</p> <p>Surveyor reviewed R3's EMR for a Wound evaluation by NP-C for the week of 5/23/25. None was found.</p> <p>R3's Wound observation tool, completed the Wound nurse at the facility, dated 5/23/25 documents, in part: . Left ear. Pressure ulcer stage 3. Granulation tissue present (beefy red) . Moderate Serosanguineous drainage. 0.5 cm x 0.5 cm x 0.1 cm. No signs and symptoms of infection . Treatment: [Normal Saline], Silver alginate bordered foam dressing daily and [as needed].</p> <p>Surveyor noted that the treatment of R3's ear pressure injury was again recommended to be completed daily. Surveyor reviewed R3's MD orders and the treatment order was not changed. From 5/23/25 to 5/30/25, facility staff completed the treatments every Monday, Wednesday and Friday and not daily as recommended by the facility wound nurse.</p> <p>R3's wound note dated 5/30/25, entered by a wound NP covering for NP-C while NP-C was on vacation, documents, in part: . Left ear stage 3 pressure injury. Full thickness wound measuring 1.0 cm x 0.5 cm x 0.1cm. 100% granular tissue. Moderate serosanguineous drainage. Peri wound is dry. No [signs or symptoms] of infection . Plan: silver alginate and bordered foam daily and [as needed].</p> <p>Surveyor noted that length measurement in the wound doubled in size. The pressure injury went from 0.5 cm which was measured last on 5/23/25 to 1 cm. Surveyor reviewed R3's care plan for an additional intervention after R3's ear wound worsened. No intervention was found.</p> <p>Surveyor noted the wound NP recommended that the treatment of R3's ear pressure injury be completed daily. Surveyor reviewed R3's MD orders and the treatment order was not changed. From 5/30/25 to 6/6/25, facility staff completed the treatments every Monday, Wednesday and Friday and not daily as recommended by the wound NP.</p> <p>R3's wound note dated 6/6/25, entered by NP-C, documents, in part: Left ear stage 3 pressure injury. Full thickness wound measuring 1.0 cm x 0.5 cm x 0.1cm. 80% granular tissue, 20% slough. Moderate serosanguineous drainage. Peri wound is dry. No [signs or symptoms] of infection. Plan: Medi honey and bordered foam daily and [as needed].</p> <p>R3's MD order with a start date of 6/7/25 documents: Wound treatment (floor Nurse to complete): Left ear cleanse with [normal saline], pat dry. Apply Medi honey to wound. Cover with a border foam dressing.</p> <p>From 6/7/25 through 6/20/25, facility staff completed the daily recommended treatment for R3's left ear wound. On 6/20/25, NP-C documented that the stage 3 left ear pressure injury had healed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/25 at 9:13 AM, 9:52 AM, 10:46 AM, and 11:55 AM Surveyor observed R3 in bed, laying on R3's back. The head of the bed is raised 30%. R3's head is resting on a regular pillow. R3's head is tilted to the left. R3's left ear is not visible. Surveyor noted that R3 is not wearing a neck pillow as care planned. Surveyor noted R3 had direct pressure on R3's left ear.</p> <p>Surveyor noted multiple observations of R3 in the same position and with pressure on R3's left ear.</p> <p>On 6/26/25 at 12:38 PM, Surveyor observed R3 in bed, laying on R3's back. The head of the bed is raised 15%. R3's head is resting on a regular pillow. R3's head is tilted to the right. Surveyor observed R3's left ear and noted a healed pressure injury. Surveyor noted that R3 is not wearing a neck pillow as care planned.</p> <p>Surveyor noted multiple observations of R3 without a neck pillow on at all times as care planned.</p> <p>On 6/26/25 at 12:45 PM, Surveyor interviewed LPN-H, CNA-I and CNA-J who were at the nurse's station together. Surveyor asked what interventions are in place for R3's skin. LPN-H stated that repositioning is completed. R3 has an air mattress. The nurses follow treatment orders. CNA-I stated again that repositioning is completed and R3 uses regular pillows. Surveyor asked if R3 had a neck pillow. LPN-H and CNA-I both stated no. Surveyor asked if R3 had ever had a neck pillow in the past. All 3 staff members stated no. LPN-H stated that LPN-H was not sure that a neck pillow would be beneficial because he coughs and moves his head.</p> <p>On 6/26/25 at 11:45 AM, Surveyor interviewed LPN-E. LPN-E stated that LPN-E has been the wound nurse at the facility for one month and is still training. Surveyor asked what the process is when a new pressure injury is found. LPN-E stated the floor nurse will report the wound to the wound nurse. The floor nurse will assess the wound. The assessment includes measurements and description of the wound. The MD/NP will be notified as well as the resident/resident representative will be notified. The floor nurse will do the initial assessment and then the Assistant Director of Nursing (ADON) and the wound nurse would assess the wound that day or the next time they are in the building.</p> <p>On 6/26/25 11:57 AM, Surveyor interviewed floor nurse, LPN-G. Surveyor asked what the process is when a new pressure injury wound is found on a resident. LPN-G stated that there are multiple forms that need to be filled out including the risk for and change of condition form. LPN-G would notify the resident or resident representative and notify the residents physician. LPN-G would get an order for treatment. LPN-G stated that measurements would be taken but the full assessment is done by a Registered Nurse (RN). The assessment would include a description of the wound tissue, the measurements and the kind of wound it is, like pressure or trauma.</p> <p>On 6/26/25 at 12:03 PM, Surveyor interviewed Register Nurse (RN)-F. Surveyor asked what the process is when a new pressure injury is found on a resident. RN-F indicated that the nurse caring for the resident would fill out the risk management form and change of condition form. The nurse would complete a pain assessment. The wound would be measured and fully assessed and staged. RN-F indicated the facility has a book of recommended treatments that they will use for an initial treatment and then will reach out to the provider for full treatment orders. The care plan should be updated, and the wound team notified to be added to the wound rounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/25 at 1:55 PM, Surveyor interviewed Wound NP-C. NP-C informed Survey that NP-C comes to the facility every Friday to assess residents on the wound list. Surveyor asked if NP-C was aware that facility staff documented that R3 had developed an ear pressure injury on 5/2/25. NP-C looked back in documentation and NP-C was not aware on 5/2/25. NP-C stated that NP-C first evaluated R3's ear wound on 5/16/25 after R3 returned from the hospital. Surveyor asked what caused R3's ear wound. NP-C indicated that R3 always likes to lay R3's head to the left and the pressure on the ear caused the injury. Surveyor asked what interventions NP-C would expect to be in place. NP-C stated R3 is on an air mattress. NP-C stated a neck pillow is sometimes used, as well as other pillows; repositioning is important and NP-C stated that facility staff were doing that for R3. Surveyor asked if NP-C was aware that NP-C treatments were not followed as recommended, and the treatments were completed every Monday, Wednesday and Friday instead of daily from 5/16/25 through 6/6/25. NP-C was not aware. NP-C stated that NP-C will typically order a daily treatment on ears because the dressings fall off so easily but stated that 3 times a week could be appropriate. Surveyor asked if the 3 times a week treatment could have led to the decline in the ear wound noted on 5/30/25. NP-C stated it could've contributed but it is hard to say that is solely responsible for the change in the wound size.</p> <p>On 6/26/25 at 2:34 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what is the expectation when staff find a new pressure injury. DON-B indicated that RN would measure, do the comprehensive assessment and stage the wound. DON-B stated that the nurse supervisors are the point person and are also on call on weekends are available to consult. Surveyor shared the concerns that R3's ear pressure injury was found on 5/2/25. A comprehensive assessment was not completed by facility staff before the resident went to the hospital on 5/7/25. There is no documentation that a MD was aware of the pressure injury until 5/4/25 when a treatment order was obtained. When R3 returned to the facility after the hospital stay, NP-C recommended daily treatments be completed. Facility staff continued to complete 3 times a week treatment from 5/16/25 through 6/6/25 despite NP-C recommendations. Surveyor asked DON-B if DON-B would expect provider orders to be followed. DON-B indicated that DON-B would expect that they be followed. On 5/30/25, the wound doubled in length. No additional interventions were put in place when the wound worsened. During survey, R3 has been observed multiple times without a neck pillow on and 3 staff members interviewed stated that R3 has never had a neck pillow. DON-B stated that DON-B has personally adjusted R3's neck pillow and knows that that intervention has been in place. DON-B indicated that maybe the neck pillow is in the wash so DON-B will look for the pillow. Surveyor asked if the neck pillow should have been in place at all times, DON-B indicated yes.</p> <p>On 6/6/26 at 3:15 PM, Surveyor informed NHA-A of the above concerns.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (R5) of 3 residents observed with Enhanced Barrier Precautions (EBP).</p> <p>*R5 has a facility acquired pressure injury to the sacral area. On 6/26/25 Surveyor observed R5's wound treatment. Facility staff did not wear the proper Personal Protective Equipment (PPE) while performing R5's wound treatment.</p> <p>Findings include:</p> <p>On 6/26/25 at 11:40 AM, Surveyor observed Centers for Disease Control (CDC) signage outside of R5's room. CDC signage documented the following: Enhanced Barrier Precautions-Everyone must clean their hands before entering and prior to leaving room. Providers and Staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing.</p> <p>On 6/26/25 at 11:50 AM, Surveyor observed Licensed Practical Nurse (LPN)-G perform R5's wound treatment to the sacral area. Surveyor observed LPN-G don gloves prior to initiating R5's procedure. LPN-G did not don a disposable gown at this time. Surveyor observed LPN-G throughout R5's wound treatment. LPN-G performed hand hygiene appropriately throughout R5's wound treatment and when exiting R5's room. Surveyor did not observe LPN-G donning a gown at the time of R5's wound treatment.</p> <p>On 6/26/25 at 2:20 PM, Surveyor conducted interview with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked NHA-A and DON-B if staff should be donning gloves and gowns while performing high contact resident care activities such as wound treatments. NHA-A told Surveyor that they were aware that LPN-G did not properly don PPE while performing R5's wound treatment. Surveyor confirmed concern that LPN-G had failed to properly don appropriate PPE in accordance with CDC guidelines.</p>		