STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525405	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Wausau	1010 E Wausau Ave Wausau, WI 54403

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure money in the resident's fund account were returned back to the resident and/or Resident Representative (RP) within 30 days after discharge or resident expiring for three of four Residents (R) reviewed for money due after discharge (R6, R7, R8). Findings include:1. Review of R6's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R6 was readmitted to the facility on [DATE], with diagnoses that included diabetes mellitus and multiple sclerosis.Review of R6's Nursing Notes, dated [DATE] at 7:12 AM and located under the Progress Note tab in the EMR, revealed, . Resident found to be deceased . No HR [heart rate], No respirations [sic]. Hospice updated .Review of R6's Resident Fund Statement Quarterly Statement for the Period of [DATE] thru [sic] [DATE], provided by the facility, indicated R6's balance was $0.40.Review of R6's Resident Fund Management Service indicated R6's Account Status was open and the Balance was $0.40.2. Review of R7's undated Face Sheet, located under the Profile tab in the EMR indicated R7 was admitted to the facility on [DATE], with the diagnosis of hemiplegia following a cerebrovascular accident affecting the right dominant side. Review of R7's Nursing Notes, dated [DATE] at 12:35 PM and located under the Progress Note tab in the EMR, revealed, . Called resident's [name of guardian] and [name of employee] at [name of county] Social Services to let them know that resident did discharge this morning and they were already aware of the upcoming discharge .Review of R7's Resident Fund Statement Quarterly Statement For the Period of [DATE] thru [sic] [DATE], provided by the facility, indicated R7's balance was $100.04.Review of R7's Resident Fund Management Service indicated R7's Account Status was open and the Balance was $100.07. 3. Review of R8's undated Face Sheet, located under the Profile tab in the EMR, indicated R8 was readmitted to the facility on [DATE], with the diagnosis of heart failure.Review of R8's Nursing Notes, dated [DATE] at 3:02 PM and located under the Progress Note tab in the EMR, revealed, . [name of hospice] notified regarding patient. At [sic] approximately 1450 [2:50 PM] patient found unresponsive, pupils fixed and VS [vital signs] absent .Review of R8's Resident Fund Statement Quarterly Statement for the Period of [DATE] thru [sic] [DATE], provided by the facility, indicated R8's balance was $0.81.Review of R8's Resident Fund Management Service indicated R8's Account Status was open and the Balance was $0.81.During an interview on [DATE] at 8:00 PM, the Nursing Home Administrator (NHA) A stated, When we were finally able to get into the RFMS [Resident Fund Management Service] records, I saw where these accounts were still open with balances that have not been returned to the resident and/or RP. I will get this completed by the end of this week. NHA A was asked for the policy of returning funds to residents and or RP within 30 days of discharge or resident expiring. NHA A stated that they had looked for this policy but could not find one.An interview could not be conducted with the Business Office Manager due to being out on FMLA for surgery. R8) reviewed for resident trust funds out of a total sample of 10. This had the potential for money not to be returned to the resident and/or RP within 30 days of discharge or resident expiring.

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

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess the need for a Wander Guard alarm, failed to assess if the Wander Guard alarm was a restraint, and failed to obtain a physician's order and written consent prior to the use of a Wander Guard alarm for one of one sampled resident (Resident (R) 4) reviewed for restraints out of a total sample of 10. These failures placed R4 at risk of having a physical restraint without indication for use Findings include:Review of the facility's policy titled, Elopement/Unsafe Wandering, revised 07/2025, indicated, . Alarms are not a replacement for necessary supervision, Staff are to be vigilant in responding to alarms in a timely manner . Monitoring and Managing Residents at Risk for Elopement or unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission, quarterly, and with a significant change in condition. b. If a resident is deemed at risk for elopement, complete the Elopement Risk Identification Form and keep available to staff in case of elopement. c. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan .Review of R4's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R4 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease and mild cognitive impairment of uncertain or unknown etiology.Review of R4's admission Minimum Data Set (MDS), located under the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 06/16/25, indicated R4 had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R4 was severely cognitively impaired. Review of R4's NRSG: Elopement Risk Evaluation, located under the Forms tab in the EMR, indicated on 06/09/25 at 2:20 PM, the score of this evaluation was 3.0 which was documented as Not at risk.Review of R4's Care Plan, provided by the facility and dated 07/17/25, indicated a Focus of The resident is an elopement risk . The interventions included, .WANDER ALERT: Device # [number] Model Check function per facility guidelines .During an observation on 08/19/25 at 5:00 PM, R4 was sitting in her wheelchair in the dining room. R4 had a wander guard attached to her left ankle. Licensed Practical Nurse (LPN)2 confirmed R4 had a wander guard on her left ankle at this time.During an interview on 08/19/25 at 5:15 PM, LPN2 was asked if R4 had a consent for the use of the wander guard. LPN2 reviewed the medical record and stated, I do not see one. LPN2 was asked if R4 had an elopement risk assessment for the use of the wander guard. LPN2 reviewed the medical record again and stated, She had one on 06/09/25 and the score was a 3, which means the resident is not at risk for elopement. LPN2 was asked if there had been another elopement risk assessment completed since that date, and LPN2 stated, No, just the one on 06/09/25.During an interview on 08/19/25 at 8:10 PM, the Social Service Director [SSD] stated, I called the resident's son and told him that the resident was packing things up at times and wanting to go home. He thought it was a good idea to place a wander guard on to prevent this. The SSD also provided documentation dated 07/17/25 at 5:05 PM which indicated, Called and spoke with resident's POA [Power of Attorney] [name of POA] to let him know that staff was reporting that resident is ambulatory and at times will pack up and say she is going home. Spoke about placing a wander guard on her left ankle to alert staff if she should try to exit a door or even leave the unit and he thought this was a great idea. Wander guard placed on left ankle. Nurse and CNA [certified nursing assistant] aware. Picture taken and placed in elopement book. The SSD was asked if a written consent explaining the risks and benefits of a wander guard had been obtained after the verbal consent had been obtained from R4's POA. The SSD stated, No, I have never gotten a written consent before.During an interview on 08/19/25 at 8:20 PM, the Interim Director of Nursing (IDON) confirmed R4 did not have a physician's order or consent for the use of the Wander Guard. The IDON confirmed there was not an elopement risk assessment that warranted the use of a Wander Guard. The IDON confirmed an order, and consent should be in place prior to the use of a Wander Guard. The IDON stated R4 should have had an updated elopement risk assessment.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to review and revise the comprehensive person-centered care plan to include refusal of pressure ulcer treatments and management for one of three residents (Resident (R) 1) reviewed for pressure ulcers out of a total sample of 10. This failure had the potential for R1 to experience adverse effects from refusing care.Findings include:Review of the facility's policy Care Plans, Comprehensive Person-Centered dated March 2022 indicated, . The comprehensive person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .Review of R1's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R1 readmitted to the facility on [DATE], with diagnoses that included type two diabetes mellitus and pressure ulcer of sacral region, unstageable.Review of R1's Care Plan, located under the Care Plan tab in the EMR and dated 03/05/25, revealed a Focus of . The resident has skin impairment to skin integrity . Interventions were Follow facility protocols for treatment of injury . Turn and reposition every 2 [sic] hours from side to side in bed to avoid [sic] pressure to coccyx/sacrum region . Weekly treatment documentation to include measurement of each skin breakdown's width, length, type of tissue and exudate and any other notable changes or observations . There was no documentation to reflect the resident refused to have dressing changes performed, have wound vac dressings assessed, or have wet to dry dressings applied to the left buttock area if the wound vac continued to alarm.Review of R1's admission Minimum Data Set (MDS), located under the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 03/21/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R1 was cognitively intact. R1 was coded as having an unstageable pressure ulcer that was present on admission/entry or reentry to the facility. The MDS indicated R1 had a pressure reducing device for the chair and bed, was on the turning/repositioning program, had nutrition and/or hydration interventions to help manage skin problems, and was receiving pressure ulcer/injury care.Review of R1's Nursing Notes, located under the Progress Notes tab of the EMR, revealed:03/20/25 at 12:49 PM - . Staff report that resident has hx [history] of non-compliance of dressing changes however [sic] non-compliant with turning . and sitting in her chair longer than 2 hours at a time . 04/03/25 at 4:25 PM - . Continues with wound care to buttock, legs and sacrum [sic] as ordered by wound clinic. Refused wound care today . 04/04/25 at 4:58 PM - . Continues with wound care to buttock, legs and sacrum [sic] as ordered by wound clinic. Refused wound care today . 04/13/25 at 2:36 PM - . Is non-complaint with only being up in w/c [wheelchair] for 2 hours at a time. Gets up before lunch and insists on staying up until just before supper .04/18/25 at 2:54 PM - . Resident up to w/cat 1130 [sic] and wound vac began alarming air leak when she sat in w/c. Requested resident stand so writer could access wound vac and resident refused. Approached second time to ask resident if writer could assess wound vac as it was still alarming air leak and resident refused .05/11/25 at 10:59 AM - . Treatment to BLE [bilateral lower extremity) refused by resident today .05/16/25 at 2:04 PM - . resident back from [name of wound clinic]. Orders [sic] to take off and replace with wet to dry dressing if machine continues to sound .05/24/25 at 11:23 AM - . Resident up to w/c at 1030 [sic] and wound vac began alarming 'leak/blockage.' Asked resident if she would allow writer to assess wound vac dressing per wound clinic instruction and resident refused. Asked if could removeand [sic] place wet to dry dressing per wound clinic instruction and resident refused . During an interview on 08/19.25 at 8:20 PM, the Interim Director of Nursing (IDON) stated, The resident's refusals should have been care planned.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and document review, the facility failed to administer pain medications per physician orders for one of three residents (Resident (R)1) reviewed for pain medications out of a total sample of 10 residents. This failure had the potential for R1 to have negative outcomes from receiving too much or too little pain medication. Findings include:Review of the facility's policy titled, Administering Medications, dated April 2019, indicated, . The individual administering the medication checks the label THREE (3) [sic] times to verify the right person, right medication, right dosage, right time, and the right method (route) of administration before giving the medication .Review of the National Library of Medicine's website, located at https://www.ncbi.nlm.nih.gov/books/NBK593215/, indicated, . The six rights of medication must be verified by the nurse at least three times before administering a medication to a patient. These six rights include the following: 1. Right Patient 2. Right Drug 3. Right Dose 4. Right Time 5. Right Route 6. Right Documentation [sic] .Review of R1's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R1 was readmitted to the facility on [DATE], with diagnoses that included type two diabetes mellitus and unstageable pressure ulcer to the coccyx/sacral region.Review of R1's admission Minimum Data Set (MDS), located under the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 03/21/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R1 was cognitively intact. R1 was also coded as having an unstageable pressure ulcer that was present on admission/entry or reentry to the facility.Review of R1's Care Plan, located under the Care Plan tab in the EMR and dated 05/22/25, revealed a Focus of . The resident is at risk/potential for pain r/t [related to] Disease Process [sic]. Interventions included, Administer analgesics as per orders. Anticipate Resident's [sic] need for pain relief .Review of R1's Physician's Orders, dated 03/04/25 and located under the Orders tab in the EMR indicated orders dated for Hydrocodone-Acetaminophen 5-325 milligrams (mg)give one tablet by mouth every four hours as needed for pain and Hydrocodone-Acetaminophen 5-325 mg give two tablets by mouth as needed once daily for wound care. Review of R1's Medication Administration Record (MAR), dated May 2025 and located under the Orders tab in the EMR, indicated on 05/04/25 at 9:35 AM, R1 received Hydrocodone 5-325 mg one tablet by mouth. Review of R1's Progress Note, dated 05/04/25 at 9:35 AM and located under the Progress Note tab in the EMR, indicated Hydrocodone-Acetaminophen 5-325 mg one tablet was given . for preventive pain from wound care .Review of R1's MAR, dated 08/11/25 and located under the Orders tab of the EMR, revealed R1 was administered Hydrocodone-Acetaminophen 5-325 mg two tablets by mouth at 12:27 AM and at 9:10 PM. Review of R1's Progress Notes, dated 08/11/25 at 12:27 AM and at 9:10 PM, revealed, . Hydrocodone-Acetaminophen Tablet 5-325 mg Give 2 [sic] tablet by mouth as needed once daily for wound care .Review of R1's MAR, dated 08/15/25 at 7:01 AM and at 7:55 PM and located under the Orders tab of the EMR, revealed - R1 was administered Hydrocodone-Acetaminophen 5-325 mg two tablets. Review of R1's Progress Note, dated 08/15/25 at 7:01 AM and located under the Progress Notes tab of the EMR, revealed, . Hydrocodone-Acetaminophen Tablet 5-325 mg Give 2 [sic] tablet by mouth as needed for once daily for wound care [sic] Given before wound clinic appointment. At 7:55 PM, documentation indicated . Hydrocodone-Acetaminophen 5-325 mg Give 2 [sic] tablet as needed for once daily for wound care .Review of R1's MAR, dated 08/16/25 at 12:13 AM and located under the Orders tab of the EMR, revealed - R1 was administered Hydrocodone-Acetaminophen 5-325 mg two tablets by mouth.Review of R1's Progress Note, dated 08/16/25 at 12:13 AM and located under the Progress Notes tab of the EMR, revealed, . Hydrocodone-Acetaminophen 5-325 mg Give 2 [sic] tablet as needed for once daily for wound care .During an interview on 08/19/25 at 1:34 PM, Licensed Practical Nurse (LPN) 2 stated, The order for Hydrocodone two tablets was to be given prior to wound care once a day. The other order for Hydrocodone one tablet was to be given every four hours as needed for pain other than wound care. LPN2 was asked if she knew of wound care to be completed by the nurse after midnight. LPN2 stated, We always try to do the wound care while the residents are still awake unless ordered differently by the MD [Medical Doctor]. LPN2 was asked if the wound care for R1 had been ordered by the MD for times after midnight. LPN2 stated, Not that I can remember.During an interview on 08/19/25 at 8:15 PM, the Interim Director of Nursing (IDON) reviewed the orders for R1's pain medication and stated, The two tablets of Hydrocodone were to be given once a day prior to wound care to prevent pain. The resident had wound care ordered at times twice a day. If the nurses

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to have physician ordered medication available to be administered to two of three (Resident (R)1 and R2) residents reviewed for medication administration out of a total sample of 10 residents. This failure had the potential for R1 and R2 to experience unmet care needs.Findings include:Review of the undated facility policy Medication Orders and Receipt Record indicated, .Medications should be ordered in advance, when indicated, based on the dispensing pharmacy's required lead time.1.Review of R1's undated Face Sheet indicated R1 was readmitted to the facility on [DATE], with the diagnosis of an unstageable pressure ulcer to the sacral region. Review of R1's Care Plan located under the Care Plan tab in the EMR dated 03/05/25 indicated a Focus of The resident has actual impairment to skin integrity. Interventions were .Encourage good nutrition and hydration in order to promote healthier skin. Supplements as ordered.Review of R1's Physician Orders located under the Orders tab in the EMR indicated orders dated 03/05/25 for Arginaid Oral Packet (Nutritional Supplement) give one packet by mouth two times a day for supplement, Levothyroxine Sodium Tablet 175 mcg [microgram] give one tablet by mouth one time a day for low thyroid hormone, Eliquis (blood thinner) oral tablet 2.5 milligrams (mg), give one tablet by mouth two times a day for prevention, and Oxybutynin Chloride tablet 5 mg, give one tablet by mouth two times a day for incontinence.Review of R1's Medication Administration Record (MAR) dated July 2025 indicated the following:On 07/05/25, and scheduled to be administered to R1 on night shift, Levothyroxine Sodium Tablet 175 mcg was coded on the MAR as 9 (unavailable) and Oxybutynin Chloride Tablet 5 mg scheduled to be administered to R1 in the mornings was coded as 9. Arginaid Oral Packet scheduled to be administered in the morning and evenings indicated beginning on 07/14/25 mornings through 07/15/25 evenings, it was coded as 9 for these administration times. From 07/19/25 evenings through 07/21/25 evenings, the Arginaid was coded as 9. Beginning on 07/28/25 evenings through 07/30/25 mornings, Arginaid was coded as 9. Eliquis 2.5 mg to be administered to R1 in the mornings and evenings indicated on 07/30/25 for both administration times, the nurse documented 9. Review of R1's Nursing Progress Notes located under the Progress Note tab in the EMR indicated the above medications were not administered due to not being available. During an interview on 08/19/25 at 1:34 PM, Licensed Practical Nurse (LPN)2 revealed the process was that the nurse will see if there are five packets of Arginaid left and then they will order if. For the other medications, the nurse will wait until the medication gets into last column on the medication card and then the nurse will order the medication. LPN2 was unaware if the physician was notified of Levothyroxine, Oxybutynin, Arginaid, and Eliquis not being available to be administered as ordered. During an interview on 08/19/25 at 6:15 PM, the Scheduler (SCH) stated, on 07/01/25 we started ordering from a different company for Arginaid. It is now ordered from [name of company]. We found out that we were not able to get Arginaid, however we could get a substitute for it and that is what I ordered. It is called Juven. The SCH revealed she usually asked the nurse working on the floor for that day if the substitute was equivalent. The SCH confirmed she did not call the Director of Nursing (DON) B or called the physician or pharmacist to see if these two medications were the equivalent to each other. She was unaware if anyone else did. During an interview on 08/19/25 at 8:15 PM, the Interim Director of Nursing (IDON) revealed the provider or the pharmacist are the two people who can direct the staff in what to use if the ordered medication is not available and cannot be ordered from the company the facility uses. IDON stated she aware that we began using another company for the Arginaid, however IDON wasn't made aware of the issues the nurses were having in not being able to administer this to the resident. The nurse should notify the physician when they are not able to administer the first dose of medication that has been ordered by the provider. 2.Review of R2's undated Face Sheet located under the Profile tab in the EMR indicated R2 had been admitted to the facility on [DATE]. with the diagnosis of incomplete and multiple sclerosis (immune system eats away at the protective coverings of the nerves and can cause muscle weakness).Review of the Physician Orders located under the Orders tab in the EMR indicated an order dated 08/16/25 for Methocarbamol oral tablet 500 mg, give one tablet by mouth four times a day for muscle spasms.Review of R2's MAR for August 2025 revealed beginning on 08/17/25 at the morning administration through 08/17/25, bedtime on 08/18/25, and in the evening and at bedtime indicated 9 was documented for the Methocarbamol. Review of R2's Nursing Progress Notes located under the Progress Note tab in the EMR indicated the Methocarbamol was on hold due to pending delivery. During an

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and facility policy review, the facility failed to follow infection control practices during a dressing change for one of one resident (Resident (R)2) observed for a dressing change, and failed to follow infection control practices when a suprapubic catheter drainage bag was laying on the floor for one of two residents (Resident (R)3) reviewed for catheters out of a total sample of 10 residents. This failure had the potential for R2 and R3 to be exposed to infections.Findings include:1.Review of R2's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R2 was admitted to the facility on [DATE] with a diagnosis of gangrene not elsewhere classified. Review of R2's Physician's Orders located under the Orders tab in the EMR indicated an order dated 08/18/25 for wound care to the resident's right heel and left heel. During an interview on 08/19/25 at 9:30 AM, Licensed Practical Nurse (LPN)1 revealed R2 was admitted with stage four pressure injuries to both heels.During an observation on 08/19/25 at 2:05 PM, of R2's treatment to her heels revealed LPN1 wheeled the treatment cart into R2's room. LPN1 then placed a towel (clean barrier) on the bed, under R2's heel which still had on booties. After removing the booties, the LPN placed R2's wrapped heels on the clean barrier on the bed. LPN1 proceeded to remove the ace wrap and old dressings of the right heel and then placed the right heel on the clean barrier where the booties had been on the clean barrier area. LPN1 cleaned the wounds and then placed the clean dressings on the right heel. LPN1 placed the right heel on the same barrier where the old dressings had been removed. LPN1 continued to the left heel and proceeded to perform the dressing change as ordered, however made the same failures with the dressing as documented above with the right heel.During an interview on 08/19/25 at 3:00 PM, LPN1 confirmed she did take the treatment cart into R2's room. She also revealed she did not think that placing the right and left heel on the clean barrier while they were wrapped was a problem. I was so nervous I could not think and that caused me to make mistakesDuring an interview on 08/19/25 at 8:15 PM, the Interim Infection Preventionist (IIP) stated, I expect the nurse performing the wound care keeps in mind to keep clean and dirty areas on the clean barrier separate. The wound cart is not to be taken into the resident's rooms. The nurse is expected to gather the wound care supplies before entering the room, then take these into the resident's room. 2. Review of R3's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R3 had been readmitted to the facility on [DATE] with the diagnosis urine retention.Review of R3's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with Assessment Reference Date (ARD) of 07/29/25 indicated R3 had a suprapubic catheter.Review of R3's Care Plan located under the Care Plan tab in the EMR indicated a Focus dated 12/04/24 for The resident has supra pubic [sic] catheter related to retention to obstructive uropathy [sic]. Interventions were Catheter per protocol. Position catheter bag and tubing below the level of the bladder and away from the entrance room door.During an observation on 08/18/25 at 5:30 PM and on 08/19/25 at 9:35 AM, R3's drainage bag was hanging on the side of the bed with the bag touching the floor.During an interview on 08/19/25 at 9:37 PM, Certified Nursing Assistant (CNA)1 stated, You have to make sure the tubing and drainage bag is located below the level of the resident's bladder, and the drainage bag cannot touch the floor. CNA1 went to R3's room and confirmed the drainage bag was touching the floor.During an interview on 08/19/25 at 9:45 AM, LPN2 revealed the drainage bag was not supposed to touch the floor. LPN2 went to the R3's room and confirmed the drainage bag was touching the floor.During an interview on 08/19/25 at 8:15 PM, the Interim Director of Nursing (IDON) confirmed the drainage bag of a suprapubic catheter is not to touch the floor.Review of the facility's policy Catheter, Urinary dated September 2014 indicated .Infection Control. Be sure the catheter tubing and drainage bag are kept off the floor.