STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525532	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	750 E Louisiana St St Croix Falls, WI 54024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility did not complete comprehensive weekly wound assessments for 1 of 3 residents (R)1 to ensure that residents receive treatment and care in accordance with professional standards of practice. R1 did not receive comprehensive assessment of a skin injury upon discovery and did not initiate timely interventions to promote healing. This is evidenced by: Facility's policy titled Documentation of Wound Treatments with the last reviewed date of 09/24, read in part, 1. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound .b .if non-pressure (partial or full thickness) c. measurements; height, width, depth, undermining, tunneling d. Description of wound characteristics . R1 was admitted on [DATE]. Current diagnoses of Alzheimer's disease, type 2 diabetes mellitus, dementia with behavioral disturbance, weakness, depression, and reduced mobility. Minimum Data Set (MDS) dated [DATE] a quarterly assessment: documented brief interview status (BIMS) score of 12 out of 15 meaning R1 has moderate cognitive impairment. R1 has no impairment to upper or lower extremities. R1 requires moderate staff assistance for oral care, toilet hygiene, dressing, personal hygiene, and transfers. R1 is dependent on staff assistance for bed mobility and showers. R1 had no behaviors of rejections of cares provided by staff. R1 was assessed to be at risk for PI, no current open PI, and has moisture associated skin damage (MASD). MDS dated [DATE] a significant change assessment: documented BIMS 8 out of 15 meaning R1 has moderate cognitive impairment. R1 has no impairment to upper or lower extremities. R1 is dependent on staff assistance for all Activities of Daily Living (ADLs), including bed mobility and transfers. R1 had no behaviors of rejections of cares provided by staff. R1 is at risk for PI, no current open PI, and has MASD. Physician orders: 02/11/25 Meals for low intake magic cup served with dinner meal. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/30/24: Wound coccyx 1) Cleanse with warm soapy water, 2) Rinse with plain warm water 3) Pat Dry 4) Apply Medihoney 5) Lay ABD pad over top Change daily and PRN one time a day for wound care. Care plans read in part, I have potential for impairment to my skin r/t fragile skin Date Initiated: 04/15/2022. Interventions included, Provide me with pressure relieving devices pressure relieving/reducing mattress, cushion, pillows, sheepskin padding, wheelchair cushion. Date Initiated: 04/15/2022 Revision on: 07/11/2024 Care plan read in part, I have the potential for pressure ulcer development r/t Immobility. Date Initiated: 04/25/2024. Interventions included, Air mattress on bed. Date Initiated: 02/10/2025, If resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. Date Initiated: 04/25/2024 Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 04/25/2024, Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Date Initiated: 04/25/2024 Care plan read in part, I have bladder incontinence r/t Dementia . date initiated on 04/25/23. Intervention to toilet 1 assist approximately every 2 hrs. while awake and every 4 hrs. at night, assist to change pull-up if required. Resident voids in large amounts and doesn't realize his pants are wet. May use an additional liner if resident allows, initiated on 11/07/24. R1 was admitted to the hospital and was readmitted to the facility on [DATE]. The facility staff did not complete a readmission skin assessment upon R1's return to the facility. Two days later the facility completed a skin observation note on 12/25/24 at 1:47 p.m., which read, Skin Observation Note Text: Skin reviewed on this day and remains intact. On 12/29/24 at 8:39 p.m., Nurses Notes Note Text: Notified [Name], daughter, of open area noted over coccyx via detailed VM. Of note, on 12/29/24 upon initial discovery of the wound, the facility did not complete a comprehensive wound assessment. On 12/30/2024 at 7:31 p.m., Communication/Visit with Provider Note Text: New orders received from NP: 1. Wound on coccyx: cleanse with warm, soapy water; Rinse; Pat Dry; Apply MediHoney; Lay on ABD pad. Change daily and PRN 2. Tylenol 325mg take 2 orally every 12 hours x7 days 3. Cough syrup 10mL give per S.O. for cough up to QiD x7 days. R1 aware. Pharmacy notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound clinic nurse practitioner documentation on 01/02/25, read in part, Sacrococcygeal, facility acquired, MASD, measurements 7.45 cm by 4.15 cm, Multiple comorbidities affecting wound healing and wound progression, as well as risk for wounds including: reduced mobility, difficulty in walking, muscle weakness. Wound clinic nurse practitioner documentation on 01/09/25, read in part, Sacrococcygeal, facility acquired, MASD, measurements 4.11 cm by 2.78 cm, wound bed has epithelial, granulation, slough, islands of epithelium, goal of care is healable, progress is improving. Practitioner notified. R1's progress notes documented on 01/10/2025 at 3:08 p.m., Nurses Notes Note Text: Received orders from NP for hospice consult and mech soft diet downgrade as needed. Faxed to hospice. Wound clinic nurse practitioner documentation on 01/16/25 read in part, Sacrococcygeal, facility acquired, MASD, measurements 8.68 cm by 4.24 cm, wound bed 100% slough, islands of epithelium, moderate serosanguineous drainage, goal of care healable, progress is stable. Practitioner notified. Of note, MASD area is larger. On 01/15/25, R1 enrolled in hospice care. On 01/17/25, Hospice delivered an air overlay for the mattress. Of note, this mattress was delivered 19 days after the MASD area developed. Facility's weekly wound tracker on 1/20/25 at 2:50 p.m., read in part, Wound/Skin Healing Note, Wound Information: Coccyx - Other (specify): MASD: Width = , . Overall impression of wound is that it is improving. There is a small amount of wound exudate present. The wound exudate consistency is serosanguineous (thin, watery, pale, red/pink drainage. Wound Bed reviewed and as follows: Slough %:100 Wound bed Full Thickness. Periwound tissue area is: Macerated Excoriated/Denuded. Resident is exhibiting pain with the wound. Refer to wound form for further details. Current interventions include, Supplements, Pressure Relieving Wheelchair Cushion, Pressure relief/reduction mattress, Toileting Program. R1's progress notes documented on 01/23/25 at 12:43, read in part, Wound/Skin Healing Note, Note Text: Weekly wound tracker completed for resident. Wound Information: Coccyx - Other (specify): MASD: Length = 8.77, Width = 5.21, Overall impression of wound is that it is improving. The wound exudate consistency is serosanguineous (thin, watery, pale, red/pink drainage. There is no wound odor present. Wound Bed reviewed and as follows: Slough %: 100 . Periwound tissue area is: Macerated Excoriated/Denuded. Resident is exhibiting pain with the wound. Refer to wound form for further details. Of note, the MASD is larger on 1/23/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound clinic nurse practitioner documentation on 01/23/25, read in part, Sacrococcygeal, facility acquired, MASD, measurements 8.75 cm by 5.21 cm, wound bed 40% granulation . goal of care healable, progress is deteriorating. Facility's weekly wound tracker on 01/31/25 documented in part, Wound Information: Coccyx - Other (specify): MASD: Length = 8.8, Width = 5.2. Overall impression of wound is that it is improving. There is a moderate amount of wound exudate present. The wound exudate consistency is serosanguineous (thin, watery, pale, red/pink drainage. Wound Bed reviewed and as follows: Periwound tissue area is: Macerated Excoriated/Denuded. Resident is exhibiting pain with the wound. Refer to wound form for further details. Wound clinic nurse practitioner documentation on 02/07/25 read in part, Sacrococcygeal, facility acquired, MASD, measurements 8.19 cm by 5.66 cm, wound bed has epithelial, granulation, slough, bleeding and islands of epithelium, moderate serosanguineous drainage, goal of care healable, progress is deteriorating, limited mobility, decreased nutrition, and receiving hospice benefits, dietician notified, practitioner notified and POA notified. Wound clinic nurse practitioner documentation on 02/14/25 read in part, Sacrococcygeal, facility acquired, MASD, measurements 8.9 cm by 4.42 cm, wound bed has epithelial, granulation, slough, bleeding and islands of epithelium, moderate serosanguineous drainage, goal of care healable, progress is stable, dietician notified, practitioner notified and POA notified. On 02/18/25 at 1:00 p.m., Surveyor interviewed Director of Nursing (DON) B about the facility assessing this MASD. DON B indicated that it was not staged as it was considered MASD. On 02/18/25 at 3:59 p.m., Surveyor interviewed Wound Clinic (NP) C about R1's wound and staging. NP C indicated the area on the coccyx started out as MASD. Nutrition, mobility, and general failing contributed to the skin breakdown. The wound started out as a butterfly shape from coccyx to cheeks of buttocks, wound had a dark purple effect. It is expected for the wounds to decline with the resident's overall decline. NP C indicated the wounds are unavoidable and not surprised this happened. R1 was in bed for the month of January and believes R1 had an air mattress in bed. R1 before was always in his recliner so when seen in bed NP C knew R1 was declining as R1 did not use his bed. It would be beneficial to offload to promote healing. NP C indicated she did not order for repositioning as R1 was on an air mattress and expected the facility to follow manufacturer's guidelines. R1 would help to roll and has some mobility in bed when asked. On 02/19/25 at 10:45 a.m., Surveyor interviewed Registered Nurse (RN) D and asked about R1's wound assessments and interventions. R1's coccyx was MASD. RN D indicated there was no full skin assessment upon R1's return from hospital on 12/23/24 and no assessment of the wound on 12/29/24. Surveyor asked when pressure relief devices were in place prior and after wound development. RN D indicated the cushion to the recliner was a foam cushion that was started in November 2024. On 02/19/25 at 1:44 p.m., Surveyor interviewed Certified Nursing Assistant (CNA) E about R1 urinary habits and positioning. CNA E indicated prior to R1's decline he was able to go to bathroom on his own and R1 would be incontinent of urine. Staff now are to check R1's brief every two hours and reposition every two hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note, Surveyor noted no new interventions for the urinary incontinence to promote healing of the MASD.

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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 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** 31086 Based on observation, interview and record review, the facility did not ensure 1 of 3 residents (R) reviewed for pressure injuries (PI) received care consistent with professional standards of practice to prevent the development of a new pressure injury and promote healing of existing PIs (R1). R1 was admitted to the facility without a PI and was assessed to be at risk for PI development. R1 developed one PI a deep tissue injury (DTI) on 01/22/25. The facility did not have preventive measures of heel boots in place prior to the development of the DTI. The facility did not complete a comprehensive assessment with staging of the PI upon discovery and did not care plan new interventions timely to promote healing. This is evidenced by: Facility's policy titled Pressure Injury Prevention and Management with last reviewed date of 09/24, read in part, 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .C. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse and documented on the Weekly Wound Tracker. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. 4. Interventions for Prevention and to Promote Healing. A. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Guidelines from the National Pressure Injury Advisory Panel (NPIAP) Quick Reference Guide 2019 indicate in part: 2.1 Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries: As soon as possible after admission/transfer to the health care service .5.1 Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated .5.5 Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved . NPIAP Classification deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear . R1 was admitted on [DATE]. Current diagnoses of Alzheimer's disease, type 2 diabetes mellitus, dementia with behavioral disturbance, weakness, depression, and reduced mobility. R1's Minimum Data Set (MDS) dated [DATE] a quarterly assessment: documented brief interview status (BIMS) score of 12 out of 15 meaning R1 has moderate cognitive impairment. R1 has no impairment to upper or lower extremities. R1 requires moderate staff assistance for oral care, toilet hygiene, dressing, personal hygiene, and transfers. R1 is dependent on staff assistance for bed mobility and showers. R1 had no behaviors of rejections of cares provided by staff. R1 was assessed to be at risk for PI, no current open PI, and has moisture associated skin damage (MASD). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's MDS dated [DATE] a significant change assessment: documented BIMS 8 out of 15 meaning R1 has moderate cognitive impairment. R1 has no impairment to upper or lower extremities. R1 is dependent on staff assistance for all Activities of Daily Living (ADLs), including bed mobility and transfers. R1 had no behaviors of rejections of cares provided by staff. R1 is at risk for PI and no current open PI. Physician orders: 03/28/23 Elevate legs as able every shift for edema Care plans read in part, I have potential for impairment to my skin r/t fragile skin Date Initiated: 04/15/2022. Interventions included, Provide me with pressure relieving devices pressure relieving/reducing mattress, cushion, pillows, sheepskin padding, wheelchair cushion. Date Initiated: 04/15/2022 Revision on: 07/11/2024. Care plan read in part, I have the potential for pressure ulcer development r/t Immobility. Date Initiated: 04/25/2024. Interventions included, Air mattress on bed. Date Initiated: 02/10/2025. If resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. Date Initiated: 04/25/2024. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 04/25/2024. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Date Initiated: 04/25/2024. R1 was admitted to the hospital on 12/20/24 and was readmitted to the facility on [DATE]. The facility staff did not complete a readmission skin assessment upon R1's return to the facility. Two days later the facility completed a skin observation note on 12/25/24 at 1:47 p.m., which read, Skin Observation Note Text: Skin reviewed on this day and remains intact. On 01/15/25, R1 enrolled in hospice care. On 01/17/25, Hospice delivered an air overlay for the mattress. Of note, the air overlay manufacturer's product sheet did not describe the stage of wounds the mattress prevents or promotes healing. The manufacturer's product sheet did not describe or recommend positioning schedules. On 01/22/25, the facility completed a Braden pressure injury risk assessment with R1 scoring an 8, meaning high risk for PI. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility documented in R1's progress notes, which read in part, on 01/22/25 at 2:27 p.m., Nurses Notes, Note Text: Hospice RN and HHA (Home Health Aide) visit was conducted today, 01/22/25. Noted new pressure injury to left heel related to terminal status and skin failure. Intervention to float heels as tolerated. Incident report completed. Of note, the facility did not complete a comprehensive PI assessment or add additional interventions to promote healing to the care plan. Facility documentation in R1's progress note, read in part, 01/26/25 at 10:33 a.m., Nurses Notes, Note Text: Writer in room doing coccyx dressing, noted to have area to left heel. Purple in color measuring 7 cm by 5 1/2 cm. intact at this time. Hospice notified of new skin issue. Placed posey boots on at all times and then elevate when in bed. 01/26/25 Physician order: Elevate heels at all times, posey boots in place with pillow under. Every shift. Of note, the heel boots were added on 01/26/25, after the DTI developed on 1/22/25. R1 was noted to be at risk to develop a PI on the 1/10/25 MDS. R1 was noted to be at high risk for developing a PI on the braden assessment completed on 1/22/25. Facility's weekly wound tracker, dated 01/31/25, read in part, Wound Information: Left heel - Pressure: Length = 4.56, Width = 2.91, - Stage Suspected Deep Tissue Injury. This is the first time writer has observed the wound. The skin/wound is showing no s/s infection at this time. There is currently no wound exudate present. There is no wound odor present. Wound Bed reviewed and as follows: Skin %: 100, Wound edges appear as: Epithelializing, Peri wound tissue area is: Intact/Uninvolved tissues Current Treatment includes: OTA, float heels Current interventions include, Supplements, Pressure Relieving Wheelchair Cushion, Pressure relief/reduction mattress, Toileting Program, Refer to wound eval tracker for further details. Will continue the current plan of care for resident. Wound clinic nurse practitioner (NP) C documentation on 02/07/25, read in part, Left heel, facility acquired, deep tissue injury, measurements 4.51 cm by 4.23 cm, wound bed with epithelial and eschar, goal of care slow to heal, progress of PI improving. Dietician notified, practitioner notified, POA notified. Physician order: 02/11/25 Meals for low intake magic cup served with dinner meal. NP C documentation on 02/14 /25, read in part, Left heel, facility acquired, deep tissue injury, measurements 4.57 cm by 4.29 cm, wound bed with epithelial and eschar, goal of care slow to heal, progress of PI improving. Dietician notified, practitioner notified, POA notified. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility's weekly wound tracker dated 02/14/25, read in part, Wound Information: Left heel - Pressure: Length = 4.57, Width = 4.29, - Stage Suspected Deep Tissue Injury. There is currently no wound exudate present. There is no wound odor present. Wound Bed reviewed and as follows: Skin %: 100, Wound edges appear as: Epithelializing, Peri wound tissue area is: Intact/Uninvolved tissues Current Treatment includes: OTA, float heels. Current interventions include, Supplements, Pressure Relieving Wheelchair Cushion, Pressure relief/reduction mattress, Toileting Program, Refer to wound eval tracker for further details. Will continue the current plan of care for resident. On 02/18/25 at 1:00 p.m., Surveyor interviewed Director of Nursing (DON) B about the facility assessing pressure injuries and staging. DON B indicated NP C gave the diagnoses of the type of wound and is the expert of the wounds to stage. On 02/18/25 at 3:59 p.m., Surveyor interviewed Nurse Practitioner (NP) C about R1's wound and staging. It is expected for the wounds to decline with the resident's overall decline. NP C indicated the wounds are unavoidable and not surprised this happened. R1 was in bed for the month, moving very little as of January. NP C believes R1 had an air mattress in bed. R1 before was always in his recliner so when seen in bed NP C knew R1 was declining as R1 did not use his bed. It would be beneficial to offload to promote healing. NP C indicated she did not order for repositioning as R1 was on an air mattress and expected the facility to follow manufacturer's guidelines. On 02/19/25 at 10:45 a.m., Surveyor interviewed Registered Nurse (RN) D and asked about R1's wound assessments and interventions. RN D indicated NP C does the staging of the wounds. RN D indicated there was no full skin assessment upon R1's return from hospital on 12/23/24. Surveyor asked when pressure relief devices were in place prior and after heel PI development. RN D indicated floating heels was noted on 1/22/25, and the protective boots were on the care plan 01/26/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31086 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (R) (R1) observed when cares were provided. Facility staff did not conduct appropriate hand hygiene when providing personal cares. Facility staff did not wear personal protective equipment (PPE) for R2 who is on Enhanced Barrier Precautions (EBP). This is evidenced by: Facility's policy titled Hand Hygiene dated 12/24, read in part, 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hand Hygiene Table: .Between resident contacts. After handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves. Before and after handling clean or soiled dressings, liens, etc. Before performing resident care procedures. Before and after providing care to residents in isolation. When, during resident care, moving from a contaminated body site to a clean body site. After assistance with personal body functions. Facility's policy titled Enhanced Barrier Precautions, with last revision date of 01/2025, read in part, EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities .4. High-contact resident care activities include: .h. Wound care: any skin opening requiring a dressing . Example 1 On 02/18/25 at 9:36 a.m., Surveyor observed Certified Nursing Assistant (CNA) F and CNA G provide personal cares for R1. R1 is on EBP for open wounds. CNA F and CNA G, without conducting hand hygiene, applied gown and gloves and entered R1's room to transfer R1 to bed using a mechanical lift. CNA G assisted to roll R1 to each side for CNA F to lower R1's pants and removed brief. CNA F using wipes cleansed R1's bowel movement. CNA F removed gloves, did not perform hand hygiene and applied clean gloves. CNA G called for Registered Nurse (RN) to clean R1's wound as it was soiled with stool. RN H entered room wearing gown and gloves. RN H went to R1's bathroom and turned the faucet on with gloved hands to wet a washcloth. RN H turned the faucet off with the same gloved hands and proceeded to provide wound care to R1. RN H removed gown and gloves, washed hands, turned the faucet off with clean hands and left R1's room. (continued on next page)

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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	CNA F and CNA G then dressed R1 and positioned R1 on back with pillows slightly under R1's left side. CNA F and CNA G removed gloves and gown. CNA G sanitized hands and left R1's room. CNA F brought the garbage to the soiled utility room and sanitized hands. CNA F returned to sanitize the mechanical lift with sanitizing wipes. After completing cleaning, CNA F disposed of the wipes and did not perform hand hygiene. CNA G returned to R1's room to place a garbage bag in R1's trash can. CNA G exited room and did not perform hand hygiene. CNA F and CNA G entered R4's room to assist with personal cares and did not perform hand hygiene prior to entering. Example 2 On 02/18/25 at 11:27 a.m., Surveyor observed RN I and RN J provide wound care for R3. R3 is on EBP for multiple open wounds to both feet. During R3's wound care RN I or RN J did not wear PPE of a gown. Upon completion of wound care Surveyor interviewed RN I and RN J asked about R5 having EBP sign on door and if a gown should have been worn during wound care. RN I indicated R3's wounds are not infected, and a gown would not be needed during dressing change. On 02/18/25 at 1:00 p.m., Surveyor interviewed Director of Nursing (DON) B about hand hygiene and proper PPE to be worn during wound care for R3 who is on EBP. DON B indicated hand hygiene should be completed after glove changes. DON B indicated education to staff had been started for proper hand hygiene during personal cares. DON B indicated gowns are to be worn when a resident is on EBP and for any type of wound. DON B indicated education to staff had been started.