STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , Casper, Wyoming, 82601**

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F0000	INITIAL COMMENTS A complaint investigation was performed on 5/14/25 to 5/16/25. The survey was prompted by complaints WY00004382, WY00004389, and WY00004395. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant MA-C: Medication Aide - Certified TAR: Treatment Administration Record cm: centimeter Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies	F0684	It is the facility's policy to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Corrective Action for Affected Residents:	06/30/2025

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 reverse for further 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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F0684 SS = G	Continued from page 1 to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to implement treatment to maintain or improve conditions for 1 of 4 sample residents (#1) reviewed with non-pressure wound care. This failure resulted in actually harm to resident #1 who was transferred to the hospital and treated for an infection related to the wound. The findings were: 1. Review of the admission MDS assessment dated 3/23/25 showed resident #1 admitted to the facility on 3/18/25 and had a BIMS score of 15 out 15, which indicated the resident was cognitively intact. The resident had diagnoses which included congestive heart failure, hypertension, renal insufficiency, benign prostatic hyperplasia, and encephalopathy. Further review showed the resident was at risk of pressure injury development with no pressure injuries present and no wounds, venous ulcers, or arterial ulcers present. The following concerns were identified: a. Review of a physician note dated 3/27/25 showed the resident was seen for an initial evaluation of multiple wounds to his/her bilateral lower extremities. The wound assessment showed "...1. RLE [right lower extremity] lateral non-pressure ulceration stage 2-onset 3/27/25 -16.0cm x [by] 8.0cm x 0.2cm - cluster of open areas with + [positive] slough, minimal granulation. Large amount of SS [serosanguious] drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 2. RLE [right lower extremity] anterior non-pressure ulceration - stage 2 - onset 3/27/25 -3.5cm x 2.5cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s [signs or symptoms] of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 3. RLE posterior non-pressure ulceration - stage 2 - onset 3/27/25 - 4.5cm x 1.0cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound	F0684	Continued from page 1 Resident #1 was transferred to the hospital and is no longer in the facility. Resident #14's wounds were reassessed by the Wound Care Nurse Practitioner (NP) on 5/20/25, with new treatment orders implemented and documented in the medical record. A comprehensive skin assessment was completed for Resident #14 with updated care plan interventions. Identifying other Residents having the Potential to be Affected: BY 6/29/25 the wound care company will do 100% skin sweep of current residents to identify any residents with wounds. Any identified wounds will be assessed by the NP and documented. The Wound Care Nurse Practitioner will review current residents with wounds to ensure appropriate treatments are in place. Measures put into place or Systemic Changes: The Director of Nursing implemented a new wound care program on 5/17/2025, which includes: Only licensed nurses will perform wound care treatments and measurements. Weekly wound measurements and assessments will be documented in the electronic health in the electronic health record. Digital wound photos will be taken weekly with measurements Weekly wound care rounds by the wound care nurse practitioner and assigned RN with provided weekly report. The Admissions Nurse/designee will provide in-service education to all licensed nurses regarding:	

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F0684 SS = G	Continued from page 2 pink/edematous/moist. Wound edges are not well-defined. 4. LLE [left lower extremity] anterior non-pressure ulceration - stage 2 - onset 3/27/25 -0.6cm x 0.8cm x 0.1cm - 1 small open area with +slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 5. L 5th toe -stage 2 - onset 3/27/25 - 0.8cm x 0.5cm x 0.1cm - 1 small punched out appearing open area with m+ [sic] slough, no drainage. No odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are well-defined..." b. Review of a physician note dated 4/22/25 showed the resident was seen to evaluate the "chronic BLE [bilateral lower extremities] venous ulcerations." The wound assessment showed "...1. RLE lateral non-pressure ulceration - stage 2 - onset 3/27/25 -10.3cm x 7.5cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 2. RLE anterior non-pressure ulceration - stage 2 - onset 3/27/25 -18.0cm x 13.0cm x 0.1cm - cluster of open areas with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 3. RLE posterior non-pressure ulceration - stage 2 - onset 3/27/25 -11.4cm x 9.0cm x 0.1cm - cluster of open areas with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 4. LLE anterior non-pressure ulceration - stage 2 - onset 3/27/25 -17.0cm x 15.0cm x 0.1cm - 1 small open area with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 5. L 5th toe -stage 2 - onset 3/27/25 - 0.8cm x 0.5cm x 0.1cm - 1 small punched out appearing open area with m+ slough, no drainage. No odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are well-defined. 6. L Great toenail - the nail is only attached at the root. See below procedure. 7. R Great toe - stage 2 - onset 4/22/25 - 1.6cm x 3.2cm x 0.1cm - new onset circular open area d/t increased moisture exposure from large amount of drainage from BLE - +slough, light SS drainage, no erythema, no s/s of infection. 8. R foot 2nd toe - stage 2 - onset 4/22/25 - 3.0cm x 2.5cm x	F0684	Continued from page 2 Proper wound assessments Documentation requirements for wound care Recognition of wound deterioration Proper wound care techniques and infection control practices The facility has contracted with a wound care nurse practitioner who will: Proper documentation of wound assessments and treatments Process for reporting changes in wound conditions By 6/9/2025 The Director of Nursing will develop and implement competency assessments for licensed nurses regarding wound care procedures. The DON has implemented on 6/9/2025 a process requiring RN assessment of all wounds prior to treatment and weekly thereafter. Plan to Monitor Performance: The DON/Designee or the wound care company will audit wound care treatments weekly x4, then randomly 10 residents monthly x2. The IP Nurse/Designee will complete 5 random wound care competency monthly to include new nurses and DON will review to identify need for further education. Results of these audits will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations. The QAPI Committee will continue to monitor until substantial compliance is achieved and maintained for 3 consecutive months.	

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F0684 SS = G	Continued from page 3 0.1cm - small circular open area with +slough, light SS drainage, no erythema, no s/s of infection..." The procedure indicated the resident's left great toenail was cut back to the root, betadine painted and wrapped with kerlix..." c. Review of a wound picture of the resident's left foot 5th toe dated 3/27/25 showed a yellow area near the toenail which measured 0.8 cm by 0.5 cm by 0.1 cm. Further review showed the resident's surrounding skin on his/her foot was pink in color, which was normal for him/her, with slight edema and there were no additional wounds observed at that time, the 5th toenail was light yellow; however, the other nails appeared normal in color. d. Review of wound picture of the resident's left foot 5th toe dated 4/22/25 showed a yellow/brown area near the toenails which measured 0.8 cm by 0.5 cm by 0.1 cm. The review showed the resident's foot appeared darker in color with more edema present and the resident's 5th toenail was dark yellow. Further review showed open areas to the 3rd toe and great toe and a discoloration present on the 4th toe which was red, yellow, orange, and brown in color. Review of a wound picture for the resident left foot 3rd toe dated 4/22/25 showed the open area had a light pink wound bed which appeared wet, the edges appeared to be rolled up and were white with some yellow discoloration noted. The wound measured 1.5 cm by 2.3 cm by 0.1 cm. The review showed an open area on the 2nd toe near the nail bed and an open area on the nail bed of the great toe where a large portion of the nail had been removed. Further review showed discoloration to 2nd toenail with a dark area near the cuticle and large dark discoloration on the tip of the great toe. Review of a picture of the resident's left foot 2nd toe showed the open area measured 1.9 cm by 1.0 cm by 0.1 cm. Further review of the resident's medical record showed no evidence the open area to the resident's great toe, where the toenail was missing, was measured. e. Review of a wound picture of the resident's right lateral leg dated 3/27/25 showed scattered areas which varied in color including yellow, red, and pink. The yellow areas were located near the resident's ankle and the surrounding tissue appeared normal in color for the resident. Further review showed the area measured 16.0 cm by 8.0 cm by 0.2 cm. Review of a wound picture of the resident's right anterior leg dated 3/27/25 showed an area which had scattered open areas and the wound	F0684	Continued from page 3 Plan to Monitor Performance: The Director of Nursing/Designee will audit wound care treatments weekly for 4 weeks, then randomly select 10 residents monthly for two months. Date of Compliance: 06/30/2025	

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F0684 SS = G	Continued from page 4 beds were red in color. Further review showed the area measured 3.5 cm by 2.5 cm by 0.1 cm and the surrounding skin was normal for the resident. Review of a wound picture of the resident's right posterior leg showed an area with some light brown discoloration and the area measured 4.5 cm by 1.0 cm by 0.1 cm. Further review showed the surrounding skin was normal for the resident. f. Review of a wound picture of the resident's right lateral leg dated 4/22/25 showed a large open area with a bright red wound bed. There were small scattered areas that appeared pink with yellow edges and some with white tissue. Further review showed the wound appeared wet and measured 18 cm by 13 cm by 0.1 cm. Review of a wound picture of the resident's right posterior leg dated 4/22/25 showed the wound bed bright red with area of shiny white tissue. The wound bed appeared wet and draining. Further review showed the wound measured 11.4 cm by 9.8 cm by 0.1 cm. g. Review of a wound picture of the resident's left anterior leg dated 3/27/25 showed an open area with a wound bed that was yellow and slightly tan in color. Further review showed the area measured 0.6 cm by 0.8 cm by 0.1 cm. h. Review of a wound picture of the resident's left anterior leg dated 4/22/25 showed a large open area that was bright red and dark red in color. There were other areas of intact tissue in the wound bed that had yellow and white color. The wound appeared wet with drainage noted and measured 17.0 cm by 15.0 cm by 0.1 cm. i. Review of a wound picture of the resident's right 2nd toe showed the resident's toenail was dark yellow in color and there was an open area which had a white wound bed. The surrounding tissue was darker in color and the wound appeared to be draining fluid. Further review showed the wound measured 3.0 cm by 2.5 cm by 0.1 cm. There were no previous pictures of the right 2nd toe wound in the medical record. j. Review of a wound picture of the resident's right great toe dated 4/22/25 showed the toenail was very thick and yellow with some black areas noted to the lateral nail fold. Further review showed an open area on the top of the foot with a slightly yellow wound bed	F0684		

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F0684 SS = G	Continued from page 5 and white tissue surrounding the wound and an area on the later toe which was white and yellow in color. The tip of the resident's toe was bright red in color. Further review showed the wound measure 1.6 cm by 3.2 cm by 0.1 cm. There was no previous picture of the right great toe in the medical record. k. Review of the progress notes showed no evidence of wound monitoring or identification of new wounds. j. Review of the TAR for April 2025 showed resident #1 had an order for "...Saturate Kerlix with Vashe and wrap R leg and L leg for 15min followed by light scrub. Pat dry. Resta Lotion to legs. K2 Lite [compression wraps] to both legs starting at base of toes to below knee. one time a day every Fri for wound care" which began on 4/3/25. The review showed treatments on 4/4 and 4/18 were performed by a MA-C and no treatment was performed on 4/11 or 4/25. Further review showed no evidence of as needed dressing changes, refusals of dressing changes, or dressing changes performed by the wound team. l. Interview with MA-C #1 on 5/16/25 at 10:38 AM revealed she was not able to perform wound measurements or assessment because she was not a nurse. Further interview revealed the "wound team" measured and assessed wounds on Tuesdays. Interview with MA-C #1 on 5/16/25 at 11:43 AM revealed the resident's wounds had gotten worse during his/her stay and as needed dressing changes and refusals of dressing changes should be documented on the treatment administration record. m. Review of a hospital history and physical note dated 4/25/25 and timed 9:46 PM showed the resident arrived to the hospital in "very poor condition" and his/her dressing to the bilateral lower extremities were saturated. The resident reported increasing leg pain with his/her right leg being worse than the left. The note showed "...On arrival [s/he] was noted to be covered in feces, [s/he] had dressings on [his/her] lower extremities that were feces soaked as well. Patient is supposed to have wound care changes every Tuesday but [s/he] is unclear when [his/her] last change was..." The physical exam showed "...[his/her] lower extremities have wounds from the knees down, skin is sloughed off, [his/her] right lower extremity is erythematous up to med thigh, [s/he] has wounds on [his/her] toes. No heel wounds..." The "Assessment/Plan" showed "...Sepsis (WBC, HR) Right	F0684		

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F0684 SS = G	Continued from page 6 lower extremity cellulitis. Likely secondary to multiple lower extremity wounds. Follow-up blood cultures. Wound care consult for wounds. Continue vancomycin and ceftriaxone..." 2. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed if wound care was not performed or if additional PRN [as needed] dressings were performed, the nurse should document the care in the progress notes or in a note on the TAR. She revealed she was not able to oversee wound care in the facility and the facility did not have a staff performing oversight for the wound program. Further interview confirmed both residents experienced wound deterioration. 3. Review of the facility policy titled "Wound Treatment Management" dated 2024 showed "...8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. lack of progression towards healing. b. Changes in characteristics of the wound..."	F0684		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F0726	It is the facility's policy to ensure that nursing staff, including licensed nurses and nurse aides, have the specific competencies and skill sets necessary to provide care and services in accordance with resident assessments and care plans, and that staff perform only those duties within their scope of practice as defined by state regulations. Corrective Action for Affected Residents: On 5/16/25, the Director of Nursing immediately discontinued all wound care treatments by MA-Cs. for Residents #14 The Nurse Practitioner (NP) from Wound Company reviewed and revised the wound care orders to ensure only licensed nurses perform wound care treatments involving topical medications. Resident # 1 was discharged from the facility. Identifying other Residents having the Potential to be Affected: The NP from wound company will conduct a facility-wide audit of residents receiving wound care treatments to identify any instances where MA-Cs are performing wound	06/30/2025

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F0726 SS = D	Continued from page 7 implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff interview, and scope of practice review, the facility failed to ensure staff provided care appropriate for their scope of practice for 2 of 6 sample residents (#1, #14) reviewed for wound care. The findings were: 1. Observation on 5/16/25 at 10:38 AM showed MA-C #1 entered the room of resident #14. The MA-C performed hand hygiene, donned gloves, and placed a barrier under the resident's legs. She removed a dressing on the resident's left shin which exposed an open wound with visible discoloration and a pudding thick discharge which was yellow in color. The MA-C applied "Vashe" solution (hypochlorous acid) on a gauze pad and placed the gauze on the wound which she told the resident had to sit for 10 minutes. The MA-C doffed her gloves and washed her hands, donned clean gloves, and applied lotion to right leg. The MA-C removed her gloves and washed her hands, donned clean gloves, and removed the gauze from the resident's left shin wound. At that time, the yellow drainage was gone and the wound appeared red with dark colored edges. The staff member patted the wound bed with gauze then applied a border gauze. The MA-C doffed her gloves and donned clean gloves, removed xeroform (petrolatum and bismuth tribromophenate impregnated gauze), cut off a small section, placed it on the resident's left toe wound, and covered the wound with gauze. The MA-C doffed her gloves, donned clean cloves, wrapped the resident's left foot with kerlix, and secured the wrap with tape. Interview with the MA-C at that time she did not perform measurements or an assessment on the wounds due to not being a nurse. Further interview revealed the "wound team" measured and assessed wounds on Tuesdays. 2. Review of the treatment administration record for April 2025 showed resident #1 had an order for	F0726	Continued from page 7 care outside their scope of practice. wound care orders will be reviewed and revised as needed to ensure treatments are performed only by appropriate licensed staff by 6-29-25 Measures put into place or Systemic Changes: On 5/17/25, the DON revised the facility's wound care policy to clearly delineate which staff members may perform specific wound care procedures based on state scope of practice requirements. The Nursing assistants and Ma-cs will be in serviced by staff development coordinator/designee on new skin Audit policy by 6-29-25 and body audit communication tool in regard to communication in skin conditions and what needs to be reported. The Licensed Practical Nurses will be in serviced by Admissions nurse f on Policy for LPN participation in wound rounds and Dressing changes and then complete skin check off for wound competencies by 6-29-25 The Admissions nurse will in-service nursing staff by 06/29/25 on: Scope of practice requirements for each level of nursing staff Updated wound care policies and procedures Proper documentation of wound assessments and treatments Process for reporting changes in wound condition By 6/9/25 the Director of Nurses (DON) will develop and implement competency assessments for licensed nurses regarding wound care procedures. The DON implemented on 6/9/25 a process requiring RN assessment of all wounds prior to treatment and weekly thereafter.	

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F0726 SS = D	Continued from page 8 "...Saturate Kerlix with Vashe and wrap R leg and L leg for 15min followed by light scrub. Pat dry. Resta Lotion to legs. K2 Lite [compression wraps] to both legs starting at base of toes to below knee. one time a day every Fri for wound care" which began on 4/3/25. The review showed treatments on 4/4 and 4/18 were performed by a MA-C and no treatment was performed on 4/11 or 4/25. 3. Interview with MA-C #1 on 5/16/25 at 11:43 AM revealed she was unsure if the "Vashe" treatment was medicated; however, she confirmed she performed the treatments for resident #1 and resident #14 and she performed wound care for residents who had topical medications applied. 4. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed she was attempting to find competencies for MA-Cs to demonstrate their ability to perform wound care and she revealed MA-Cs were able to perform wound care which did not include applying topical medication. No MA-C wound competencies were provided by the facility. She confirmed the "Vashe" solution and xeroform would be topical medications and revealed she had not researched the treatments to determine what was a topical medication. Further interview revealed an RN did not complete a wound assessment prior to wound care by a MA-C. 5. Review of the Wyoming State Board of Nursing advisory opinion titled "CNA II Role & Course Requirements" last revised June 2024 showed "...Wound Care (only after assessment by a provider or RN) ...*The CNA II is NOT allowed to apply medication to any wound, including topical medications..." 6. Review of the Wyoming State Board of Nursing advisory opinion titled "Medication Assistant-Certified (MA-C) last revised August 2024 showed "...Role of the MA-C: The role of the Medication Assistant-Certified Role (MA-C), in addition to all functions of the CNA, is as follows provide routine medications by the following routes: oral, inhalation (nebulizer treatments must be pre-measured), topical, instillation into the eyes, ears, and nose, rectal, vaginal..." Further review showed no evidence the topical medication could be applied to an open wound during dressing changes.	F0726	Continued from page 8 Plan to Monitor Performance: The DON/designee or wound care company will audit wound care treatments weekly x4, then randomly 10 residents monthly x2. IP Nurse/designee will complete 5 random wound care competencies monthly to include new nurses. The DON will review to identify the need for further education. Results of these audits will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations. The QAPI Committee will continue to monitor until substantial compliance is achieved and maintained for 3 consecutive months. The Director of Nursing is responsible for implementing this plan of correction by 6/30/25	
F0880 SS = D	Infection Prevention & Control	F0880	It is the facility's policy to maintain an infection	06/30/2025

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F0880 SS = D	Continued from page 9 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880	Continued from page 9 prevention and control program that includes proper implementation of enhanced barrier precautions for residents with wounds, catheters, and other qualifying conditions per CDC guidelines. Corrective Action for Affected Residents: On 5/16/25, the Director of Nurses assessed Resident #14 to ensure proper wound care was being provided with appropriate PPE usage. The Infection Preventionist reviewed Resident #14's care plan to verify enhanced barrier precautions were clearly documented. MA-C #1 was immediately re-educated on proper enhanced barrier precaution protocols including the requirement to wear both gloves and gowns during wound care. Identifying other Residents having the Potential to be Affected: On 5/16/25, the Infection Preventionist conducted a facility-wide audit of residents with wounds, catheters, and other qualifying conditions to identify those requiring enhanced barrier precautions. Care plans were reviewed to ensure enhanced barrier precautions were properly documented where indicated. Measures put into place or Systemic Changes: 1. The Infection Preventionist/Designee will conduct mandatory in-service education for all nursing staff by 6/29/25 regarding: " Enhanced barrier precaution protocols " Proper PPE selection and use during wound care " Documentation requirements for enhanced barrier precautions 2. Enhanced barrier precaution signage has been updated and placed outside rooms of qualifying residents 3. PPE supply stations have been reviewed and restocked to ensure adequate availability of gowns and other necessary PPE 4. The facility's Enhanced Barrier Precautions policy has been reviewed and updated to include specific requirements for wound care Plan to Monitor Performance: 1. The Admission nurse/designee will conduct direct observation that enhanced barrier precautions are being	

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F0880 SS = D	Continued from page 10 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure enhanced barrier precautions were implemented for 1 of 2 sample residents (#14) during wound care. The findings were: 1. Observation on 5/16/25 at 10:38 AM showed MA-C #1 entered the room of resident #14. The MA-C performed hand hygiene and donned gloves and performed wound care for the resident. Observation showed the resident had wound care performed to an open wound on his/her left shin and an open area to one of his/her left toes. Observation showed a plastic container which contained personal protective equipment, including gowns, was located near the resident's bed. Further observation showed the MA-C did not wear a gown during the wound care. 2. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed enhanced barrier precautions should be used for all residents with wounds, catheters, and dialysis or other types of ports. Further interview revealed gloves and gowns should be worn for enhanced barrier precautions	F0880	Continued from page 10 used during wound care rounds 3 times per week for 4 weeks, then weekly for 8 weeks to ensure proper implementation of enhanced barrier precautions 2. The Infection Preventionist will review 100% of new admissions and residents with new wounds weekly for 12 weeks to ensure appropriate enhanced barrier precaution orders are in place 3. Results of these audits will be tracked and trended 4. Any identified deficiencies will result in immediate re-education and additional monitoring The Director of Nursing will report monitoring results to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months and quarterly thereafter. The QAPI committee will assess the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained.	

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F0880 SS = D	Continued from page 11 during wound care and she confirmed resident #14 was on enhanced barrier precautions. 3. Review of the policy titled "Enhanced Barrier Precautions" provided by the infection preventionist/staff development coordinator on 5/16/25 showed "...2...b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcer) ...even if the resident is not known to be infected or colonized with MDRO [multi-drug resistant organism] ..."	F0880		