STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155375	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Petersburg Care Center	309 W Pike Ave Petersburg, IN 47567

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure notification of change for 1 of 3 residents reviewed for nutrition and 1 of 1 residents reviewed for skin conditions (non-pressure ulcer related). The physician was not notified of significant weight loss and skin tears to the right wrist. (Resident 7, Resident 13)Findings include:1. On 11/18/25 at 8:59 A.M., Resident 13 was observed sitting in her room on her bed. A white bandage was observed on her right wrist, not dated. The resident indicated it had been there for a couple of days because she had hit her arm on her wheelchair. On 11/20/25 at 11:50 A.M., Resident 13 was observed lying on her bed. A non-dated white bandage was observed on her right wrist, falling off and brown colored discharge was able to be seen through the bandage. On 11/21/25 at 9:31 A.M., Certified Nurse Aide (CNA) 36 was observed to weigh the resident standing on the scale. Her weight was 93.4 lbs. On 11/19/25 at 1:16 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus type II, and anxiety. The most recent discharge MDS assessment, dated 10/23/25, indicated Resident 13 was cognitively intact and independent in decision making, had no behavior of refusals, had no skin conditions, was 63 inches tall, and weighed 94 lbs. She had no weight loss of 5% or more in the last month or loss of 10% in last 6 months, set up assistance from staff for eating and substantial to maximum assistance of staff (staff performs over half the effort) for transfers and toileting, and partial to moderate assistance of staff (staff performs less than half of the effort) for bathing. A general progress note, dated 11/15/25 at 3:34 P.M., indicated, Dried blood noted on resident's right wrist; 2 small skin tears, dry; area cleaned with wound cleanser and covered with border gauze for protection. A weekly Skin Assessment Form, dated 11/17/25, indicated, Small skin tear to top of right forearm, area covered with border gauze dressing. The resident says she scraped it on the brake of her wheelchair over the weekend. No other skin issues noted at this time. Resident 13's clinical record lacked documentation of the physician ever being notified and receiving orders for the resident's skin tears on the right wrist. The following weights were documented in Resident 13's clinical record: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/10/2025 3:45 P.M., 101.2 lbs 10/11/2025 3:11 P.M., 94.4 lbs (loss of 6.8 lbs and a 6.72% loss) 10/27/25 3:11 P.M., 96.4 lbs 11/6/25 3:13 P.M., 97.2 lbs 11/8/25 1:31 P.M., 97.5 lbs 11/15/25 11:59 A.M., 94.4 lbs (loss of 3.1 lbs) 11/18/25 11:03 A.M., 94.0 lbs (loss of 4.4 lbs) On 10/10/2025, the resident weighed 101.2 lbs. On 11/18/2025, the resident weighed 94 lbs, which was a 7.11% weight loss. The clinical record indicated a NAR note was completed on the following dates: 10/16/25 10/23/25 10/30/25 11/6/25 11/13/25 11/19/25 The clinical record lacked documentation of the physician and family being notified about the resident's continued weight loss. During an interview on 11/21/25 at 9:31 A.M., Resident 13 was observed to have a scabbed area on her right wrist without a bandage. At that time, CNA 36 indicated she had a bandage on earlier in the week, and she wasn't sure if it should still be there or not. She would notify the nurse about it. She indicated the resident was able to feed herself, did get a shake with lunch, and did refuse to drink it sometimes. She would try multiple times to get the resident to drink it before giving up, but they really didn't do anything else for weight loss that she was aware of. CNAs were supposed to weigh the residents, document it in the electronic record, and notify the nurse of big discrepancies. The nurse was to notify the MD and DON to get further orders, notify the family, and document in the electronic record. During an interview on 11/21/25 at 9:43 A.M., Licensed Practical Nurse (LPN) 24 indicated nurses should document when a resident was reweighed or when notifications were done. She indicated that no information about the bandage or skin tear on Resident 13's right wrist was reported to her. At that time, she indicated she was not sure when the bandage was last changed, but staff should document the date and initials on the bandage when it was changed. The Medical Doctor (MD) should be notified (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of new skin conditions for orders, and the family should also be notified. During an interview on 11/21/25 at 10:15 A.M., the Director of Nursing (DON) indicated she would expect nurses to notify and report any changes in condition as soon as possible to the MD and family, as well as document it in the clinical record. 2. On 11/18/25 at 1:24 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, and hypothyroidism. The most recent quarterly minimum data set (MDS), dated [DATE], indicated no cognitive impairment, no weight loss or weight gain, setup assistance from staff with eating, and a therapeutic diet. Current physician orders included, but were not limited to: Consistent carbohydrate diet, regular texture, regular (thin liquid) consistency with double protein with all meals, dated 6/24/25. Weekly weight times 4 weeks or until stable, dated 4/27/25. A current nutrition care plan, dated 5/1/25 and last revised 11/17/25, indicated to report lab work to the MD, provide diet as ordered, a Registered Dietitian to evaluate and make diet changes as needed, and weigh per MD order, all dated 5/1/25. A current congestive heart failure care plan, dated 5/20/25 and revised 11/17/25, indicated to monitor/document/report as needed any signs or symptoms of congestive heart failure, such as weight gain unrelated to intake, dated 5/20/25. A current potential fluid deficit care plan, dated 5/20/25 and revised 11/17/25, indicated to monitor/document/report as needed any signs or symptoms of dehydration, such as recent/sudden weight loss, dated 5/20/25. A current diabetes mellitus care plan, dated 5/20/25 and revised 11/17/25, indicated to monitor/document/report as needed any signs or symptoms of hyperglycemia, such as increased thirst and appetite or weight loss, dated 5/20/25. Resident 7's weights included, but were not limited to, the following: 5/16/25 223.6 pounds 6/10/25 205.8 pounds 6/19/25 204.6 pounds (8.5% loss in 1 month) 7/7/25 201.4 pounds 7/20/25 199.8 pounds 8/17/25 197.2 pounds (11.81% loss in 3 months) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/15/25 193.2 pounds 11/11/25 189.2 pounds (15.38% loss in 6 months) Interdisciplinary Team (IDT) Nutrition at Risk (NAR) meetings were held and documented on the following dates, but lacked notification to the physician for weight changes: 8/7/25 8/14/25 8/21/25 8/28/25 9/4/25 9/9/25 9/18/25 9/25/25 10/2/25 10/9/25 10/16/25 10/23/25 10/30/25 11/6/25 Progress notes lacked notification to the physician related to Resident 7's significant weight loss. On 11/19/25 at 1:31 P.M., the Director of Nursing (DON) indicated Resident 7 had been on weekly NAR meetings that included herself, the Registered Dietitian (RD), and the dietary manager related to an unexplained significant weight loss. She indicated that if anything needed to be added to the resident's orders, they would communicate with the physician for a consult. She indicated Resident 7 was still currently on weekly NAR meetings as he was having issues with edema, diabetes, and anemia. At that time, she indicated if the physician had been notified of Resident 7's significant weight loss, it was not documented. On 11/21/25 at 9:53 A.M., the Administrator provided a current non-dated Notification of Changes policy that indicated .to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there is a change requiring notification. 3.1-5(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure dependent residents, unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 1 residents reviewed for dental services. A resident's dentures were not cleaned or taken out at night as indicated. (Resident 27)Finding includes:On 11/18/25 at 10:19 A.M., Resident 27's family member indicated during visits, she had noticed Resident 27's hygiene to be poor. She indicated due to his cognition, Resident 27 would initially refuse care, and needed encouragement and often more than one attempt before he would agree to care. She indicated some staff would take the initial refusal and move on without trying further to get the care done. On 11/19/25 at 10:10 A.M., Resident 27 was observed sitting in a recliner watching television with the lights off. The resident's mouth and lips were observed with crusty debris. Dentures were not observed at that time. On 11/19/25 at 10:43 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and intellectual disabilities. The most recent quarterly minimum data set (MDS) assessment, dated 8/26/25, indicated a severe cognitive impairment, no behaviors, substantial to maximum (helper does more than half the effort) with oral hygiene, and no dental concerns. Current physician orders included, but were not limited to:May see podiatrist, dentist, audiologist, ophthalmologist, optometrist, dated 9/8/22. No salt packet (NSP) diet, mechanical soft/easy to chew texture, regular (thin liquid) consistency, dated 11/5/24. A current dental care plan, dated 12/16/24 and revised 9/15/25, indicated the resident wore upper and lower dentures. Interventions included, but were not limited to:Provide mouth care as per ADL (activities of daily living) personal hygiene, dated 12/16/24. A dental visit form, dated 1/10/25, indicated Resident 27 had been seen for dental services on 1/9/25. The Registered Dental Hygienist (RDH) indicated on the form, Denture has generalized extremely heavy orange thick mature plaque, heavy thick yellow calculus, and heavy brown staining. Spent 20 minutes cleaning dentures . Denture hygiene is extremely poor . Patient/Staff instructions for Dentures: Remove dentures nightly, soak in water/denture cleaning tablet. Brush with denture brush in a.m. Patient was cooperative. A dental visit form, dated 2/25/25, indicated Resident 27 had been seen for dental services on 2/25/25. The RDH indicated on the form, Denture has heavy plaque present . Pt [patient] states wears all the time and never removes. stressed the importance of cleaning nightly and soaking in water to help with plaque control. A dental visit form, dated 8/19/25, indicated Resident 27 had been seen for dental services the same day. The form indicated poor oral health with heavy plaque and debris. The form also indicated the resident would benefit from staff assistance to remove, clean, and soak dentures every night. On 11/20/25 at 6:39 A.M., Certified Nurse Aide (CNA) 5 indicated that when she assisted Resident 27 to get up that morning, his dentures were in the denture cup, soaking. However, she indicated that it was not always the case, as many times, he still had the dentures in his mouth in the mornings. She indicated that sometimes the dentures were still pretty slimy and covered in debris coming out of the denture cup, so staff should be brushing and/or wiping them with a cloth. On 11/21/25 at 9:53 A.M., the Administrator provided a current non-dated Activities of Daily Living (ADLs) policy that indicated The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care . 3.1-38(a)(3)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was underweight received the appropriate services to maintain weight for 1 of 2 residents reviewed for nutrition. Notifications of significant weight loss were not completed, the dietitian's recommendations of house shakes were not implemented until 15 days later, and additional interventions were not attempted after the underweight resident continued to lose weight. (Resident 13)Finding includes:On 11/21/25 at 9:31 A.M., Resident 13 was observed being weighed by Certified Nurse Aide (CNA) 36. Her weight, standing on the scale, was 93.4 pounds (lbs).On 11/19/25 at 1:16 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus type II, and anxiety. The resident was readmitted to the facility on [DATE] after being out of the facility on leave of absence, falling, and fracturing her hip.The most recent discharge Minimum Data Set (MDS) assessment, dated 10/23/25, indicated Resident 13 was cognitively intact and independent in decision making, no behaviors or refusals, 63 inches tall, weight of 94 lbs with no weight loss of 5% or more in the last month or loss of 10% in last 6 months, set up assistance from staff for eating and substantial to maximum assistance of staff (staff performs over half the effort) for transfers and toileting, and partial to moderate assistance of staff (staff performs less than half of the effort) for bathing.Current physician's orders included, but were not limited to, the following:house shake one time a day, daily with lunch as a supplement, ordered 10/31/25 weekly weight times 4 weeks or until stable every day shift every Saturday, 10/25/25 regular diet, regular texture, regular (thin liquid) consistency diet, 10/24/25 A current Nutrition Care Plan, last revised 10/14/25, included, but was not limited to, interventions to explain and reinforce to the resident the importance of maintaining the diet ordered.Encourage the resident to comply, explain consequences of refusal, obesity/malnutrition risk factors, and Registered Dietitian (RD) evaluate and recommend diet changes as needed, initiated 5/29/25. The following weights were documented in the resident's clinical record:10/10/2025 3:45 P.M., 101.2 lbs10/11/2025 3:11 P.M., 94.4 lbs (loss of 6.8 lbs and a 6.72% loss) 10/27/25 3:11 P.M., 96.4 lbs 11/6/25 3:13 P.M., 97.2 lbs11/8/25 1:31 P.M., 97.5 lbs11/15/25 11:59 A.M., 94.4 lbs (loss of 3.1 lbs)11/18/25 11:03 A.M., 94.0 lbs (loss of 4.4 lbs)On 10/10/2025, the resident weighed 101.2 lbs. On 11/18/2025, the resident weighed 94 lbs, which was a 7.11% weight loss.On 10/16/25, a Nutrition Assessment Review (NAR) note indicated the following:The resident's most recent weight was 94.4 lb on 10/11/2,5, standing on the scale. Returned from hospital 10/9/25, recent left hip surgical repair from fracture. Triggering for significant weight loss in the past month. Weight of 94 lb on 10/11/25 and 100 lb on 10/01/25. 6 lb weight loss in the past couple of weeks/month; 6% (significant). Current Diet orders: regular diet, regular texture. Current meal consumption ranges from 26-100%. Intakes have declined since the recent hospitalization. Recommendation: house shakes or fortified food given weight loss, poor/varied oral intakes, and recent surgery; the dietary service manager will discuss options with the resident. See the residents' care plan for a list of all focuses, goals, and interventions. The resident will continue to be evaluated for any weight changes, and the plan of care will be updated as appropriate. (The house shakes were not put in as an order for 15 additional days) On 10/23/25, a NAR note indicated the following:The resident's most recent weight was 94.4 lbs on 10/11/25, standing on the scale. Pending updated weight this week. Consuming variable intakes of 26-100% of meals. Likes/tried the chocolate house shakes. Current diet orders: regular diet, regular texture. Current Interventions: On a regular diet, regular texture, and consuming 26-100% of meals; intakes have declined since the recent hospitalization. See the residents' care plan for a list of all focuses, goals, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and interventions. The resident will continue to be evaluated for any weight changes, and the plan of care will be updated as appropriate On 10/30/25, a NAR note indicated the following:The resident's most recent weight was 96.4 lbs on 10/27/25 on the scale in her wheelchair. She was up 2 lbs in the past two weeks. Consuming 26-100% of meals. Will place an order for house shakes daily with lunch. Recommendations: house shake daily with lunch; the resident prefers the chocolate flavor. See the residents' care plan for a list of all focuses, goals, and interventions.The resident will continue to be evaluated for any weight changes, and the plan of care will be updated as appropriate. On 11/6/25, a NAR note indicated the following:The resident's most recent weight was 96.4 lbs on 10/27/25 on the scale in her wheelchair. Pending updated weight this week. Consuming 51-100% of meals. Consuming 75% of the house shake daily at lunch. Current Interventions: house shake daily with lunch; the resident prefers the chocolate flavor. See the residents' care plan for a list of all focuses, goals, and interventions.The resident will continue to be evaluated for any weight changes, and the plan of care will be updated as appropriate. On 11/13/25, a NAR note indicated the following:The resident's most recent weight was 97.5 lbs on 11/8/25, standing on the scale. Weight of 98 lb on 11/08/25; up 2 lb in the past 2 weeks. Consuming 26-100% of meals; receiving house shake daily at lunch. Current Interventions: house shake daily with lunch; the resident prefers the chocolate flavor. See the residents' care plan for a list of all focuses, goals, and interventions. The resident will continue to be evaluated for any weight changes, and the plan of care will be updated as appropriate. On 11/19/25, a NAR note indicated the following:WEIGHT WARNING: Value: 94.0 Vital Date: 11/18/25 MDS: -10.0% change over 180 day(s) [12.1% , 13.0]Resident triggering for significant weight loss in the past 6 months; will continue to monitor weekly at NAR. The most recent 30-day follow-up physician's note, dated 11/11/25, lacked documentation of the resident's fluctuating weight, weight loss, and any documentation of education given to the resident or staff about her nutrition. The clinical record lacked notification of the physician and family about the resident's weight loss, education given to the resident about weight loss and nutrition risks, and any alternative interventions tried since the resident was continuing to lose weight on the current interventions. During an interview on 11/21/25 at 9:31 A.M., Certified Nurse Aide (CNA) 36 indicated Resident 13 was able to feed herself, did get a house shake with lunch, did refuse to drink it sometimes, and was sometimes weaker than others and needed more assistance with mobility. CNA 36 indicated she would try multiple times to get the resident to drink it before giving up, but they really didn't do anything else for weight loss that she was aware of. CNAs were supposed to weigh the residents, document it in the electronic record, and notify the nurse of big discrepancies. The nurse was to notify the MD and DON to get further orders, notify the family, and document in the electronic record. During an interview on 11/21/25 at 9:43 A.M., Licensed Practical Nurse (LPN) 24 indicated nurses should document when a resident was reweighed or when notifications were done. She indicated the Medical Doctor (MD) should be notified of significant weight loss, and the family should also be notified. During an interview on 11/21/25 at 10:15 A.M., the Director of Nursing (DON) indicated she would expect nurses to notify and report any changes in condition as soon as possible to the MD and family, as well as document it in the clinical record. They have discussed Resident 13 weekly in NAR meetings, but the dietitian had not recommended any alternative interventions besides the shake. She indicated she was not aware of other interventions tried on Resident 13 for her weight loss. On 11/21/25 at 10:02 A.M., a current non-dated Weight Monitoring Policy was provided by the Administrator and indicated, . the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range . The facility will utilize a systemic approach to optimize a resident's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary . Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss. Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed. d. If the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietitian, Dietary Manager, or the nursing department may initiate this process. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate. The interdisciplinary plan of care communicates care instructions to staff . 3.1-46(a)(1)

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills set to carry out the functions of the food and nutrition service for 1 of 1 kitchen observed. The Dietary Manager was not certified. (Dietary Manager)Finding includes:On 11/17/25 at 10:13 A.M., the Dietary Manager was asked to provide her certification certificate. During an interview on 11/21/25 at 11:10 A.M., the Administrator indicated the Dietary Manager failed the test, but she is registered to take the test again. The new test date was unknown. There was another dietary staff member certified until hers expired September 2025.On 11/21/25 at 11:10 A.M., a non dated current Dietary Services Policy was provided by the Administrator and indicated, The facility employs sufficient staff with the appropriate competencies and skill sets to cany out the functions of the Food and Nutrition Services . 3.1-20(a)

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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. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment to help prevent the development and transmission of infections for 1 of 3 residents observed for care. During a dressing change, a wound care Nurse Practitioner (NP) did not remove or change gloves after touching several items and did not wash hands according to policy. (Resident 46)Finding includes: On 11/19/25 at 1:55 P.M., a wound care NP was observed to change a dressing on Resident 46's leg. The NP entered the room along with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) 3. She put on a gown and gloves without washing or sanitizing her hands first. The NP assisted the DON and LPN 3 with rolling the resident to the right side by removing the blanket from the resident and pushing her, touching the back of her gown as well as her skin. The NP then touched the side rail, the curtain, and removed her mobile phone from her pocket, touching the screen. Without removing the gloves, the NP removed the dressings, touching the wound beds with the same gloved hand/finger that was used to touch the other items. The NP continued to touch the screen of her phone in between removing dressings from the wound beds. Once the dressings were all removed, the NP removed her gloves and washed her hands for 3 seconds. She then put on a pair of clean gloves. The NP then assisted in rolling the resident again, touching the sheet and the visibly soiled incontinence pad. She then grabbed the trash can and moved it closer to the bed. She removed her gloves and put on a clean pair without washing or sanitizing her hands, then applied dressings to the wounds. The resident was then rolled back onto her backside on top of the visibly soiled incontinence pad observed with brown, yellow, and red substances. The NP then removed her gloves and washed her hands with a 4-second soap lather. Neither the DON nor LPN 3, who were present for the duration of the care, addressed the actions of the NP during or after the wound care. At that time, the NP indicated she was not the normal NP that was in the facility, and it was her first day there. The NP that was normally there was from the wound care service contracted by the facility and was currently on vacation. She explained she was a travel NP and was filling in that week. She indicated that hand washing should probably last about 20 seconds. She further indicated she needed to view pictures on her phone during the dressing change to view previous assessments of the wounds in order to compare. The NP was responsible for wound care for at least two other residents in the facility who received care from the wound care service.On 10/21/25 at 10:00 A.M., the Infection Preventionist (IP) indicated handwashing should last 40-60 seconds, with hand scrubbing no less than 20 seconds. She indicated that if any items, such as the bed or a phone, were touched with gloves on, staff should change gloves before touching the resident, and staff should never lay a resident on a soiled incontinence pad. She indicated that anytime staff soiled their gloves, they should wash their hands or sanitize them after removing them and before putting on a clean pair. On 11/21/25 at 9:53 A.M., the Administrator provided a current non-dated Hand Hygiene policy that indicated All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . Hand hygiene technique when using soap and water: . Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. 3.1-18(b)3.1-18(l)