STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. This requirement was not met as evidenced by: Licensure Reference Number 175 NAC 12-006.12Based on record review and interview; the facility failed to obtain signed informed consents for the use of psychotropic (medication medications for Residents 1,2,12,17, and 34. The sample size was 5 and the facility census was 34. Findings are: A. Review of the facility policy Psychotropic Medication Use dated 4/14/22 revealed the following; -Psychotropic medications were considered for use only after medical, physical, functional, psychological, psychiatric, social, and environmental causes of behavioral symptoms were identified and addressed. -Residents only received psychotropic medications when necessary to treat specific conditions for which they were indicated. -Residents who were admitted receiving psychotropic medications were evaluated for appropriateness and indication for use. B. Review of the facility Psychotropic Medication Review and Gradual Dose Reduction Policy dated 1/18/19 revealed the following: -Residents and/or their families were notified quarterly of the resident's medication regimen. -Change requests made by residents and/or family were addressed through psychiatric services and/or provider review. C. Review of Resident 1's Care Plan with a revision date of 8/2/25 revealed the resident had forgetfulness, confusion, impaired decision making, and took antipsychotic, antidepressant, and antianxiety medication. Review of Resident 1's Medication Orders dated 8/12/25 revealed the following psychotropic medications; -Risperidone (antipsychotic medication) Oral Tablet 0.5 Milligrams (mg) give one tablet by mouth two times a day related to Bipolar Disorder. -Lorazepam (antianxiety medication) Oral Tablet 0.5mg Give 1 tablet by mouth in the morning for Anxiety -Sertraline (antidepressant medication) HCl Oral Tablet 25mg Give 1 tablet by mouth one time a day (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
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to Bipolar Disorder. Review of Resident 1's Medical Record revealed no evidence of signed informed consent for the use of the psychotropic medications Risperidone, Lorazepam, or Sertraline. D. Review of Resident 2's Care Plan with a revision dated 6/27/25 revealed the resident had severe cognitive impairment, a diagnosis of Alzheimer's Dementia, behavior concerns including delusions, hallucinations and inappropriate behavior. The resident took antipsychotic medication. Review of Resident 2's Medication Orders dated 8/12/25 revealed the psychotropic medication; Quetiapine Fumarate Oral Tablet 25mg Give 1 tablet by mouth at bedtime related to Alzheimer's disease with moderate psychotic disturbance. Review of Resident 2's Medical Record revealed no evidence of signed informed consent for the use of the psychotropic medication Quetiapine Fumarate. E. During an interview on 8/12/25 at 7:31 AM Registered Nurse (RN) -L revealed no awareness of any signed forms used for consent to give psychotropic medications, RN-L reported that residents/responsible parties were updated verbally or by phone for all medication changes. F. During an interview on 8/12/25 at 8:12 AM the Director of Nursing (DON) confirmed the facility had no evidence the facility had obtained resident or responsible party informed consent for the use of any or all psychotropic medications as required. G. Review of Resident 12's Care Plan with a revision date of 4/24/25 revealed the resident had a diagnosis of Non- Alzheimers Dementia, Major Depression and Anxiety Disorder, had delusions, mild cognition deficit, confused and disoriented. The resident received an antidepressant and antianxiety medications. Review of Resident 12's August 2025 Medication Administration Record (MAR) revealed the following psychotropic medications; -Escitalopram Oxalate (antidepressant medication) Oral Tablet 20mg give 1 tablet by mouth 1 time a day related to Major Depressive Disorder. -Buspirone HCl (antianxiety medication) Oral Tablet 5mg give 1 tablet by mouth 3 times a day for anxiety. -Lorazepam (antianxiety medication) Oral Tablet 0.5mg 1 tablet by mouth every 4 hours as needed for anxiety. Review of Resident 12's Medical Record revealed no evidence of signed informed consent for the use of psychotropic medication. H. Review of Resident 17's Care Plan dated 6/20/25 revealed the resident had severe cognitive impairment, was confused, forgetful and displayed sexually inappropriate language and behaviors. The resident had a diagnosis of Non-Alzheimer Dementia and Anxiety and received an antidepressant, antianxiety and antipsychotic medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 17's August 2025 MAR revealed the following psychotropic medications; -Trazadone (antidepressant medication) HCl oral tablet 50 mg 1 tablet by mouth at bedtime for insomnia. -Lorazepam (antianxiety medication) oral tablet 0.5 mg 1 tablet by mouth every 12 hours as needed for agitation. -Seroquel (antipsychotic medication) oral tablet 50 mg give by mouth 2 times daily related to Dementia. Review of Resident 17's Medical Record revealed no evidence of signed informed consent for the use of psychotropic medication. I. Review of Resident 34's Care Plan with a revision date of 4/24/25 revealed the resident was restless, had delusions and was confused. The resident had a diagnosis of Anxiety Disorder, Depression, Dementia and received antidepressant and antianxiety medications. Review of Resident 34's August 2025 MAR revealed the following psychotropic medications; -Sertraline (antidepressant) HCl oral tablet 50 mg 1 tablet by mouth 1 time a day related to depression. -Alprazolam (antianxiety) oral tablet 0.25 mg 1 tablet by mouth 3 times a day for muscle spasms related to Anxiety Disorder. - Alprazolam (antianxiety) oral tablet 0.25 mg 1 tablet by mouth as needed for anxiousness related to Anxiety Disorder. Review of Resident 12's Medical Record revealed no evidence of signed informed consent for the use of psychotropic medication. J. An interview on 8/12/25 at 8:00 AM RN-L revealed of being unaware of needing a signed consent for psychotropic medications that stated the reason for the medication and side effects. RN confirmed the facility had notified the resident and families of medication changes by phone or verbally. On 8/12/25 at 8:12 AM an interview with the DON confirmed that there was no evidence the facility had obtained resident or responsible party informed consent for the use of psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** S483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in S483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.This requirement is not met as evidenced by:Licensure Reference Number 175 NAC 12-006.12Based on record review and interview; the facility failed to have a stop date for as needed (PRN) antianxiety medications for Resident's 12, 17 and 34. The facility census was 34.Findings are:A. Review of the facility policy Psychotropic Medication Use (medications that affect the mind, emotions and behavior) with a revised date of 4/14/22 revealed;-Psychotropic medications may be considered for residents only after medical, physical, functional, psychological, social and environmental causes of behavioral symptoms had been identified and addressed. Psychotropic medications would be prescribed at the lowest possible dosage for the shortest of time and are subject to gradual reduction. -Residents would not receive PRN orders for psychotropic medications beyond 14 days unless the medication was needed to treat a specific condition that was documented in the clinical record. The need to continue PRN psychotropic medications for over 14 days would need to be evaluated by the health care provider for appropriateness of medication and specific duration. Specific reasons supporting the need for the medication would be documented in the clinical record. B. Review of Resident 12's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 7/22/25 revealed the resident had delusions and mild cognition impairment. The resident had a diagnosis of Non-Alzheimer's Dementia, Anxiety and Depression and received an antianxiety medications. Review of Resident 12's Care Plan with a revision date of 4/24/25 revealed the resident had a diagnosis of Anxiety Disorder and received an antianxiety medication as needed.Review of Resident 12 August 2025 Medication Administration Record (MAR) revealed an order for:- Lorazepam (antianxiety medication) Oral Tablet 0.5 Milligrams (mg) 1 tablet by mouth every 4 hours as needed for anxiety. The resident received a dose on 8/2/25 and 8/5/25. Review of Resident 12's medical record revealed that there was no stop date for the PRN Lorazepam medication. C. Review of Resident 17's MDS dated [DATE] revealed the resident had hallucinations, delusions, behavior symptoms such as hitting, public sexual acts, screaming out and resident had severe cognition impairment. The resident had a diagnosis of Non-Alzheimer Dementia and Anxiety. Review of Resident 17's Care Plan dated 6/20/25 revealed the resident had severe cognitive impairment, was confused, forgetful and displayed sexually inappropriate language and behaviors. The resident had a diagnosis of Non-Alzheimer Dementia and Anxiety and received antianxiety medications as needed.Review of Resident 17 August 2025 MAR revealed an order for:- Lorazepam (antianxiety medication) Oral Tablet 0.5mg 1 tablet by mouth every 12 hours as needed for agitation. The resident received a dose on 8/1/25, 8/2/25, 8/3/25 and 8/5/25. Review of Resident 17's medical record revealed that there was no stop date for the PRN Lorazepam medication. D. Review of Resident 34's MDS dated [DATE] revealed the resident had delusions, verbal behaviors, rejection of cares, wandering and mild cognition impairment. The resident had a diagnosis of Non-traumatic Brain Dysfunction, Dementia, Anxiety and Depression and received anti-anxiety medications . Review of Resident 34's Care Plan with a revision date of 4/24/25 revealed that the resident was restless, had delusions and was confused. The resident had diagnosis of Anxiety Disorder, Depression and Dementia and received an antianxiety medication.Review of Resident 34 August 2025 MAR revealed an order for:- Alprazolam (antianxiety medication) 0.25 MG 1 tablet by mouth as needed for anxiousness related to Anxiety Disorder. Give daily PRN anxiousness. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident received the last dose on 7/26/25. Review of Resident 34's medical record revealed that there was no stop date for the PRN Alprazolam medication. E. On 8/7/25 at 2:15 PM an interview with the Director of Nursing (DON) confirmed that the PRN psychotropic medications for Resident's 12, 17 and 34 did not have a stop date and should have per facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02 (H)Based on record review and interview; the facility failed to report a fall with major injury within the required time frame for 1 (Resident 17) of 3 sampled residents. The facility census was 34.Findings are:A. Review of the facility policy Resident Abuse and Neglect with a revision date of 1/10/25 revealed:-All employees of the facility are responsible to protect and prevent resident abuse from occurring. -Abuse means any knowing or intentional act on the part of a caregiver which results in physical injury, psychosocial harm, unreasonable confinement, cruel punishment, sexual abuse of a vulnerable adult. -Physical abuse means damage to bodily tissue including but not limited to, fractures, bruises, lacerations and internal injuries.-Any injury resulting in possible fracture, laceration, stitches must be notified to the Administrator within 2 hours and notification to Adult Protection Services (APS). B. Review of Resident 17's medical record revealed; -On 8/11/25 at 7:20 PM Resident 17 had a fall in the dining room and received a laceration to the top of the head. Resident was transferred to the hospital per emergency services transport. -On 8/11/25 at 7:35 PM The facility Administrator was notified of Resident 17's fall with major injury and that resident was transferred to the hospital. -On 8/11/25 at 9:42 PM The facility Administrator was notified that Resident 17 would be admitted to the hospital and that resident had an acute on chronic brain bleed.-On 8/12/25 at 8:42 AM the facility Administrator notified APS of Resident 17's fall with major injury.C. An interview on 8/12/25 at 10:30 AM with the facility Administrator confirmed that APS was not notified of Resident 17's fall with major injury within 2 hours of being notified of injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Licensure Reference Number 175 NAC 12-006.09(F)(iii)Based on record review and interview; the facility failed to ensure Resident 7's Care Plan was reviewed and revised to ensure staff implemented Enhanced Barrier Precautions (EBP-infection control strategy using gowns and gloves during high contact resident care to reduce the spread of Multi-Drug Resistant Organisms (MRDO's-germ/s resistant to many antibiotics) during the provision of wound care for Resident 7. The sample size was 5 and the facility census was 34. Findings are:Review of the facility policy Care Planning with a revision date of 2013 revealed the following: -the facility interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident. -The care plan is based on resident comprehensive assessment by the interdisciplinary team-The comprehensive, person-centered care plan included measurable objectives and timetable to meet the resident's physical, psychosocial, and functional needs were developed and implemented for each resident -Described services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. -Incorporated identified problem areas and incorporated risk factors identified with associated problems. -Reflected currently recognized standards of practice for problem areas and conditions. -Areas of concern identified during resident assessment were evaluated before interventions were added to the care plan. -Assessment of residents were ongoing and care plans were revised as information about residents and the resident's condition changed. Review of the facility policy Enhanced Barrier Precautions with a revision date of August 2022 revealed the following: -Enhanced Barrier Precautions were utilized to prevent the spread of multi-drug-resistant organisms to residents. -EBP employed targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. -Gloves and gowns were applied prior to performing high contact resident care activity. -Examples of high contact care included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care (central lines, catheters, feeding tubes, tracheostomy/ventilators, and wound care. -EBP were indicated for resident/s infected or colonized with resistant organisms, and for residents with wounds, and /or indwelling medical devices regardless of their drug-resistant status. -EBP remained in place for the duration of the resident's stay or until wound resolution or discontinuation of the indwelling medical device. During an observation on 8/6/25 at 9:30 AM there was a sign on the room door of Resident 7 indicating the resident was on EBP. During an observation of wound care for Resident 7 on 8/7/25 at 9:10 AM Licensed Practical Nurse-(LPN)-B entered Resident 7's room, while the resident was lying in bed and without putting on a gown or gloves, proceeded to remove the heel boot from the resident right foot and then put on a pair of disposable gloves. LPN-B then removed and disposed of a foam dressing from the resident's heel exposing a golf ball sized area of blackened skin on the resident heel. The area did not appear to be open or draining. LPN-B then cleaned the wound with a wound cleanser, changed gloves and painted the area with a liquid betadine (anti-infective agent) swab. LPN-B then replaced the heel boot on the resident, removed gloves and sanitized hands with Alcohol Based Hand Sanitizer (ABHR). LPN-B confirmed the area being treated was a facility acquired pressure ulcer. During an interview on 8/7/25 at 9:20 AM LPN-B revealed being unaware Resident 7 was on EBP and acknowledged that all residents on EBP require the use of gown and gloves during the provision of wound care. She confirmed she did not follow proper procedure caring for Resident 7's heel wound.During an interview on 8/7/25 at 11:36 AM Nurse Aide (NA)-E revealed being aware Resident 7 was on EBP and a gown and gloves were required during the provision of care, such as toileting, dressing, and assisting with transfers. During an interview on 8/11/25 at 3:22 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM the MDS/Care Plan Registered Nurse (RN-K) confirmed Resident 7's Care Plan was not updated to reflect the use of EBP during high contact care activities such as wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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** Licensure Reference Number 175 NAC 12-006.09 Based on interview and record review; the facility failed to complete neurological assessments (assessment of motor and sensory skills, hearing, speech, vision, coordination, and balance to determine a potential injury or change in status) after unwitnessed falls for 1 (Resident 24) of 4 sampled residents. The facility identified a census of 34. Findings are: A. Review of the Neurological Assessment Policy with a revision date of 10/2010 revealed the purpose of the policy was to provide guidelines for a neurological assessment. Assessments were to be completed: 1) upon physician order; 2) when following an unwitnessed fall; 3) after a fall with a suspected head injury; or 4) when indicated by a resident's condition. Steps in the procedure:-perform neurologic checks with the frequency as ordered or per falls protocol.-determine the resident's orientation to time, place, and person.-observe the resident's speech pattern and clarity of speech.-check the pupil's reaction. -determine motor ability.-determine sensation in extremities.-have the resident smile to determine if there is any facial drooping. Documentation:-the date and time the procedure was performed. -the name and title of the staff performing the procedure.-all assessment data obtained.-how the resident tolerated the procedure.-if the resident refuses, the reason for the refusal and interventions taken. B. Review of Resident 24's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 7/22/25 revealed the resident was admitted on [DATE] with diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, and depression. The following was assessed regarding the resident:-cognition was moderately impaired.-frequently incontinent of urine.-one fall with injury (except major) since the previous assessment.-used a wander/elopement alarm daily. Review of an Occurrence Report dated 9/17/24 at 7:25 PM revealed Resident 24 was found on the floor. The resident reported trying to go after a spider and lost balance. In addition, the resident reported hitting their head on the floor and complained of pain to the resident's head. Review of a Neurological Check Record revealed neurological checks were to be completed every hour for 2 hours, every 4 hours x2, then every 8 hours x1. Review of the record completed after Resident 24's fall on 9/17/24 revealed documentation assessments were completed on 9/17/24 at 9:00 PM and at 11:00 PM. An assessment was completed on 9/18/24 at 1:00 AM but at 5:00 AM, the staff failed to assess and/or document the residents skin condition, hand grasps, pupil reaction, level of orientation, speech, motor response and level of consciousness. There was no indication the resident had refused the assessment. Review of an Occurrence Report dated 4/7/25 at 6:00 AM revealed the resident had rolled out of bed and was on the floor. The report identified the resident was only orientated to person (know who you are, your name, age, and other personal details) and to time (a sense of what day, month, or year it is, and even approximate time like morning, afternoon, or night) and the fall was unwitnessed. There was no evidence neurological checks were completed to assess the resident for potential injury. Review of an Occurrence Report dated 4/15/25 at 11:32 AM revealed the resident was found sitting on the floor. The fall was unwitnessed. The report indicated the resident was only orientated to person. Further review of the report revealed no evidence neurological assessments were completed after the resident's unwitnessed fall. During an interview on 8/11/25 at 9:37 AM, Registered Nurse (RN)-I confirmed if a resident had an unwitnessed fall and was not orientated to person, place, time and situation, the staff should initiate and complete neurological assessments to evaluate for a potential head injury. An interview on 8/11/25 at 10:35 AM with the Director of Nursing (DON) verified neurological assessments were not completed or were not thoroughly completed after the resident's falls on 9/17/24 at 7:25 PM, 4/7/25 at 0600 and 4/15/25 at 11:32 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)Based on observation, record review, and interview; the facility failed to implement new measures to prevent pressure ulcer development for Resident 7 following a significant condition change. The sample size was 3 and the facility census was 34. Findings are: Review of the facility Pressure Ulcer Policy and Procedure date 1/8/2016 revealed the following: -The purpose of the procedure was to provide guidelines for the structured assessment and identification of residents at risk for developing new pressure injuries or worsening of existing pressure injuries. -Licensed nursing staff examined an individual's skin condition upon admission to the facility. This included the initial admission and readmission following hospitalizations.-The purpose of pressure injury assessment was to identify all risk factors and to determine which factors could be modified.-Once the assessment was completed the facility completed a resident centered care plan to address and modify risk for pressure injury. -Development of the care plan was based on risk factors and the resident's overall condition, and interventions were modified as the resident's condition changed, or if the interventions were deemed inadequate. Review of Resident 7's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/27/25 revealed the resident was dependent on staff assistance for bed mobility, transfers, and hygiene. In addition, the resident had functional limitations to both lower extremities. The resident had a surgical wound but no pressure ulcers. Review of Resident 7's Progress Notes revealed the following;-on 6/24/25 at 12:26 PM the resident returned to the facility from the hospital. -on 7/7/25 at 5:17 PM the resident had a fluid filled blister on the heel, approximately 4 centimeters (cm) x 4cm, secondary to left lower extremity weakness related to a left hip fracture. The facility requested an order to treat the area with betadine (liquid anti-infective agent) swabs twice daily and to have the resident wear a protective boot to keep the heel free from any pressure continuously until healed.Review of Resident 7's Care Plan with a revision date of 7/1/25 revealed the following;-The resident was at risk of falling and sustained a hip fracture from falling at the facility on 6/18/25 and underwent surgical repair on 6/19/25.-Physical and Occupation Therapy evaluation and treatment were ordered on 6/27/25 following readmission from the hip fracture. -Self-care deficit approaches were updated on 7/1/25 including increased assistance needs with hygiene, dressing, toileting, bed mobility, and ambulation. -On 4/30/24 the resident was noted to be at risk for skin impairment and staff were to monitor document, and treat any skin impairment and a pressure relief mattress was on the resident's bed , however no change in the approaches/interventions related to the skin integrity risk were added to the care plan following the resident's hip fracture until 7/8/25 (after the blister area/pressure sore developed on the residents heel) for the use of a protective heel boot. During an observation of wound care for Resident 7 on 8/7/25 at 9:10 AM Licensed Practical Nurse (LPN)-B entered the resident's room and informed the resident of the dressing change to the left foot. LPN-B then removed a heel protection boot and a foam dressing from the resident's heel exposing a golf ball sized area of blackened skin on the resident's left heel. The area did not appear to be open or draining. LPN-B then cleaned the wound with a wound cleanser and painted the area with liquid betadine (anti-infective agent) and replaced the heel boot. LPN-B confirmed the area being treated was a facility acquired pressure ulcer. During an interview on 8/11/25 at 11:15 AM the Director of Nursing confirmed the facility implemented professional therapy and increased assistance with cares (dressing, hygiene, toileting, bed mobility, and ambulation) however the facility did not address items such as keeping the resident's heels off the bed following a hip fracture. Further interview confirmed the resident did develop a pressure sore to the left heel first reported on 7/7/25. During an interview on 8/11/25 at 3:22 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the MDS/Care Plan Registered Nurse (RN-K) confirmed Resident 7's Care Plan was not updated to include support surface changes or ways to protect the resident's heels due to loss of mobility until after a pressure area developed on the resident's heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(I)(i)Based on record review and interview; the facility failed to develop and/or revise interventions for the prevention of ongoing falls for 1 (Residents 24) of 4 sampled residents. The facility census was 34. Findings are:A. Review of the facility Falls and Fall Risk Management policy with a revision date of 2/16/21 revealed that based on previous evaluations and current data the staff were to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try and minimize complications of falling. Fall risk factors included; environmental factors, conditions which may contribute to falls, and medical factors. Staff with the input of the fall risk management team, safety committee and the provider were to implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff were to implement additional interventions or different interventions or indicate why the current approach remained relevant. Monitoring Subsequent Falls and Fall Risk: -staff were to monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. -if the resident continued to fall, the staff/fall risk management team were to re-evaluate the situation and whether it was appropriate to continue or change interventions. As needed, the attending physician would help the staff reconsider potential causes that may not previously have been identified. B. Review of Resident 24's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 7/22/25 revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, and depression. The following was assessed regarding the resident:-cognition was moderately impaired.-frequently incontinent of urine.-one fall with injury (except major) since the previous assessment. -used a wander/elopement alarm daily. Review of an Occurrence Report dated 9/17/24 at 7:25 AM revealed the resident had an unwitnessed fall. The resident reported going after a spider and lost balance. The resident was assessed as orientated to person (know who you are, your name, age, and other personal details), to time (a sense of what day, month, or year it is, and even approximate time like morning, afternoon, or night) and to situation (what is happening around them). In addition, the resident was assessed as having impaired memory and balance. An intervention was identified to provide education to the resident to call the staff for assistance when needed and for a Physical Therapy (PT) evaluation. Review of a Progress Note by the PT dated 10/17/24 (1 month after the resident's fall) revealed no new recommendations were made related to fall prevention. Review of an Occurrence Report dated 12/31/24 at 12:00 PM revealed the resident was found on the floor of the bathroom. The resident's blood pressure at the time of the fall was 67/39 (normal blood pressure for an adult is 120/60) and the resident was difficult to arouse. The resident's medications were reviewed, and a new order was received to discontinue a blood pressure medication. Review of an Occurrence Report dated 4/7/25 at 6:00 AM revealed the resident had rolled out of bed and onto the floor. A new intervention was developed to place an assist bar (a safety device which assists residents with repositioning and getting into/and out of bed) on the resident's bed. Review of an Occurrence Report dated 4/15/25 at 11:32 AM revealed the staff heard the resident calling out and found the resident on the floor next to the bed. The resident indicated trying to find something under the bed. The report identified the resident had been assessed as orientated to person only. An intervention for education to the resident was listed. No further interventions were identified. During an interview on 8/7/25 at 8:45 AM, Nursing Assistant (NA)-A reported the resident had a history of falls and remained a fall risk. The resident did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walk independently with the walker and the resident roomed with the spouse. The resident was not always compliant and frequently did not remember to call for staff assistance if the resident was dizzy or needed assistance. An interview on 8/11/25 at 9:37 AM with Registered Nurse (RN)-I indicated if a resident was not orientated x4 or was identified on the Occurrence Report as having impaired memory then listing an intervention for re-education of the resident was not an effective intervention to prevent further falls. Resident 24 had a history of exit seeking and of an elopement and did not always make good decisions. Interview on 8/11/2025 at 10:35 AM with the Director of Nursing (DON) confirmed the following:-9/17/24 at 7:25 PM the resident had a fall in the resident's room when trying to get a spider. The resident was educated to call staff if another bug was found and then staff would address. The resident was evaluated by PT on 10/15/24 as part of a quarterly assessment and no new recommendations were made. -4/15/25 at 11:32 AM the resident had a fall in the resident's room as the resident was looking for something underneath of the bed. The only intervention was to educate the resident to seek staff assistance. -Resident 24's cognition was moderately impaired, and the resident did not always make good choices. Providing the resident education was not an effective intervention to prevent further falls for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This REQUIREMENT is not met as evidenced by Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to long term use of an antibiotic medication for Resident 23. The antibiotic did not specify a duration and had no supporting documentation for clinical use based on laboratory results. The sample size was 7 and the facility census was 34. Findings are: A. Review of the facility Antibiotic Stewardship Program with a revision date of 1/16/20 revealed the following:-the purpose of the program was to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events. -the overall goal was to prevent undesirable outcomes related to misuse by optimizing the selection of drug, dose, route, and duration of therapy. -the leadership team was to regularly review the appropriateness of antibiotic courses and make recommendations for adjustment where necessary, establish new or revised protocols for appropriate antibiotic prescribing, monitor antibiotic use, and provide education on responsible use of antibiotics to residents, families, and healthcare workers. -all nurses were to be educated regarding proper assessment for infection prior to calling a physician. -the facility was to ensure the pharmacy reviewed all antibiotic usage for appropriateness. -the facility would monitor for any adverse reactions/outcomes related to use of antibiotics. B. Review of Resident 23's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/23/25 revealed the resident was admitted [DATE] with diagnosis of obstructive uropathy (condition affecting the urinary tract where urine flow is blocked) and diabetes. Review of Resident 23's admission Order Summary Report dated 7/14/24 revealed an order for Macrobid (antibiotic used to treat urinary tract infections)100 milligrams (mg) one capsule daily. Further review of the physician orders revealed no stop date was indicated for the Macrobid. Review of Nursing Progress Notes revealed the following:11/19/24 at 1:35 PM the staff obtained a urine specimen from the resident's suprapubic catheter. 11/22/24 at 5:30 PM the resident was started on Cipro (antibiotic used to treat bacterial infections) 500 mg twice a day for 10 days to treat a urinary tract infection. Review of Resident 23's current Care Plan with a revision date of 2/11/25 revealed the resident had a suprapubic catheter (flexible tube inserted into the abdomen and directly into the bladder to remove urine) due to diagnosis of prostate catheter and obstructive uropathy. The care plan also identified the resident was taking Macrobid as a prophylactic (medication used to prevent disease). Review of Health Status Progress Notes dated 1/14/25 at 3:22 PM, 2/14/25 at 4:23 PM, 3/25/25 at 4:41 PM and 6/27/25 at 9:05 AM revealed the resident's Primary Care Provider (PCP) reviewed the resident's documentation in the medical record and medication use. Further review revealed no evidence the PCP addressed the continued use of the Macrobid 100 mg daily given as a prophylactic for potential urinary tract infections. Review of a Urology Visit Note dated 5/6/25 revealed the resident was seen by the urologist but the urologist failed to assess the continued use of the Macrobid. Review of the resident's Order Recap Report dated 8/12/25 revealed Resident 23 continued to receive the Macrobid 100 mg given once daily. Interview with the Infection Preventionist on 8/11/2025 at 12:02 PM verified the following regarding Resident 23:-had an order for Macrobid 100 mg daily for prevention of UTI which was ordered with the resident's admission on [DATE].-was treated for a urinary tract infection on 11/22/24 despite the ongoing use of the Macrobid as a prophylactic. -no evidence the resident's urologist and/or PCP had addressed the need for a stop date or an indication for continued use of the antibiotic.-there was no evidence that the facility had provided education to the providers regarding use of the Macrobid. -the resident continued to receive the Macrobid 100 mg once daily without a stop date or documentation related to clinical (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use based on symptoms or laboratory results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(vi)Based on observation, record review, and interview; the facility failed to label open insulin contains (vials/pens) with dates indicating when they were opened for Resident's 2, 13, and 14, to ensure the medication was not used beyond recommended use by dates. The sample size was 3 and the facility census was 34. Findings are: Review of the facility policy Storage of Medications with a revision date of November 2020 revealed the following;-The facility stored all drugs and biologicals in a safe, secure, and orderly manner. -Drugs and biologicals used in the facility were stored in locked compartments, under proper temperatures, light, and humidity controls.-Discontinued, outdated, or deteriorated drugs or biologicals were returned to the dispensing pharmacy or destroyed. Review of the facility policy Insulin Administration with a revision date of [DATE] revealed no evidence the facility policy addressed dating insulin once opened, based on practice standards to avoid the potential of using insulin beyond it's effectiveness.During a tour on 8/12/25 starting at 9:32 AM of the facility medication carts 4 out of 5 opened insulins vials/pens were not dated when opened. The following undated insulins were identified;Resident 2's;-Lantus 30 units every night, and -Humalog 5 units 3 times daily and per sliding scale (dose based on blood glucose level results), -Resident 13's Basaglar 22 units in the morning and 12 units in the evening, and-Resident 14's Lantus 45 units every night. During an interview on 8/12/25 at 9:35 AM Registered Nurse-L confirmed the above insulin vials/pens were not dated when opened. In addition, the facility expected insulin pens to be dated when opened to avoid using them past the recommended effective dates. During an Interview on 8/12/25 at 11:29 AM the Director of Nursing confirmed all insulin once opened, required a date to alert staff of how long opened insulin could be safely used once it was opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observation, record review, and interview; the facility failed to implement Enhanced Barrier Precautions (EBP-infection control strategy using gowns and gloves during high contact resident care to reduce the spread of Multi-Drug-Resistant Organisms (MRDO's-germ/s resistant to many antibiotics) during the provision of wound care for Resident 7. The sample size was 5 and the facility census was 34.Findings are: Review of the facility policy Enhanced Barrier Precautions with a revision date of August 2022 revealed the following: -Enhanced Barrier Precautions were utilized to prevent the spread of multi-drug-resistant organisms to residents. -EBP employed targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. -Gloves and gowns were applied prior to performing high contact resident care activity. -Examples of high contact care included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care (central lines, catheters, feeding tubes, tracheostomy/ventilators, and wound care. -EBP were indicated for residents infected or colonized with resistant organisms, and for residents with wounds, and/or indwelling medical devices regardless of their drug-resistant status. -EBP remained in place for the duration of the resident's stay or until wound resolution or discontinuation of the indwelling medical device. On 8/6/25 at 9:30 AM a sign on the door of Resident 7's indicated the resident was on Enhanced Barrier precautions. During an observation of the provision of wound care for Resident 7 on 8/7/2025 at 9:10 AM Licensed Practical Nurse (LPN)-B entered the resident room, instructed the resident that the LPN-B was going to change the foot dressing. Without putting on a gown or gloves, LPN-B proceeded to remove the resident's left heel boot and then put on a pair of disposable gloves. LPN- B then removed and disposed of a foam dressing from the resident's left heel, exposing a golf ball sized area of blackened skin on the resident heel. The was not open or draining. LPN-B then cleaned the wound with a wound cleanser, changed gloves and painted the area with liquid betadine (anti-infective agent). LPN-B [NAME] then placed the heel boot back on the resident, removed the gloves and sanitized hands with Alcohol Based Hand Sanitizer (ABHR). LPN-B completed the entire wound care task while not wearing a gown. In addition, LPN-B confirmed the area being treated was a facility acquired pressure ulcer.During an interview on 8/7/25 at 9:20 AM LPN-B reported being unaware Resident 7 was on EBP and acknowledged that all residents on EBP require the use of a gown and gloves during the provision of wound care. She confirmed she did not follow proper procedure caring for Resident 7's heel wound.During an interview on 8/11/25 at 3:22 PM the Care plan Registered Nurse (RN-K) confirmed Resident 7's Care Plan was not updated to reflect the use of EBP during high contact care.During an interview on 8/11/25 at 3:30 PM the Director of Nursing confirmed that EBP including the use of gowns and gloves was required during wound care for Resident 7.