STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 05/28/2025

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WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 5/28/25. Event ID# PUHV11. The following intake was investigated NC00230761. 1 of the 2 allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		6/13/25

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

Electronically Signed | 06/11/2025

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to maintain a resident's dignity when a resident wore a nightgown and no makeup to an outside appointment making the resident feel angry and unimportant for 1 of 1 resident (Resident # 4) reviewed for dignity and respect. Finding included: Resident #4 was admitted to the facility on 9/11/2023. The annual Minium Data Set (MDS) dated 5/19/2025 revealed Resident #4 was cognitively intact. An interview with the Transportation Driver at 2:37pm on 5/28/2025 revealed Resident #4 was unaware of her appointment on 5/27/25. He stated that he became aware of the appointment at 4:06am by text message from the Scheduler, after he learned about the appointment, he did call the facility and informed the nurse. Transport driver stated it was the nurse's job to provide verbally communicate appointments to residents.	F 550	1. Resident #4 continues to reside at the facility and has had no other scheduled appointments at this time. 2. All residents have the ability to be affected by the deficient practice. 3. Clinical staff will be reeducated on the Resident Rights Policy by the Director of Nursing or designee to ensure that residents attend appointments while maintaining dignity by being appropriately dressed, being informed of their appointment in advances and by receving appropriate ADL care prior to leavinn. To be completed by June 13, 2025. 4. The Director of Nursing or designee will interview and observe two residents weekly or two weeks and then monthly for two months that residents have their rights and attend appointments in a dignified manner. Results of these audits will be presented to the facility Quality Assurance and Performance	

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F 550	Continued From page 2	F 550		

He was aware of Resident #4 was unhappy about wearing her night gown to her doctor's appointment and he tried to console Resident #4 by provided encouragement with positive statements.

An interview with Resident #4 on 5/28/2025 at 3:25pm revealed the resident went to a doctor's appointment on 5/27/2025.Resident #4 stated that 2 aids from night shift woke her up and told her about the appointment that was scheduled. Resident #4 stated, she had to wear the night gown and the underwear that she slept in. She stated she did not have time to bathe herself with soap and water, she used wipes instead. Resident #4 revealed if she had known about her appointment that she would have taken a shower, picked out her clothes, brushed her hair piece, and picked out her perfume the night before. Resident #4 stated she would inform 2nd and 3rd shift staff that she had an appointment and to wake her up an hour before she leaves for her appointment. Resident #4 stated if she had time to do her normal morning routine for a doctor's appointment she would have picked out a pair of jogging pants and a logo t-shirt, instead of her night gown, she would also put on her makeup for the appointment. Resident #4 stated that she was angry the whole day and she did not feel important.

An interview conducted on 5/28/2025 at 2:19pm with Nurse #7 revealed, Resident #4 liked to go to her appointment with her hair and makeup done. Nurse #7 stated, normally if Resident #4 was aware of her appointments she would inform 3rd shift staff to wake Resident #4 up early.

An interview conducted on 5/28/2025 at 9:30am

Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.
5. Allegation of compliance date: June 13, 2025.

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F 550	Continued From page 3 with Vice President (VP) of Clinical Services revealed the scheduler has a personal planner that she kept all residents' appointments written down. A review of the appointment schedule revealed Resident #4 had an outside appointment on 5/27/2025 at 9:15am. An interview conducted with the Administrator and VP of Clinical Services at 4:41pm on 5/28/2025 revealed all residents have a right to choose what they want to wear when they go out of the facility.	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		6/13/25

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F 585	Continued From page 4	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 5 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain evidence of grievance investigation and decisions for 3 of 3 residents reviewed for grievances (Resident #1, Resident #2 and Resident #3). Findings included: A review of the facility's grievance policy dated April 2017 stated in part:	F 585	1. Resident #1 was interviewed on 5/28/2025 by the Administrator and had no further concerns related to dietary or nursing. Resident #2's jacket was returned to the resident. Resident #3 no longer resides at the facility. 2. All residents have the ability to be affected by the deficient practice.	

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F 585	Continued From page 6 4. The investigation and report would include: f.) employee account of the alleged incident and h.) recommendations for corrective action. a.) Resident # 1 was admitted to the facility on 7/5/23. A review of the grievance filed by Resident #1 on 1/3/25 revealed she was concerned that third shift Nurse Aides (NA) did not come in and check on her or answer her call bell. Resident #1 was further concerned that she received dry and burnt food from the kitchen. The grievance was not completed, as there was no documentation regarding an investigation, outcome or recommendation for corrective action. b.) Resident #2 was admitted to the facility on 10/22/24. A review of the grievance filed by Resident #2 on 12/19/24 indicated she was missing a plaid varsity jacket and had last seen it about 3 weeks before. The grievance was incomplete as it did not include documentation of an investigation, outcome or recommendations for corrective action. c.) Resident #3 was admitted to the facility on 9/25/24. Review of the grievance filed by Resident #3 on 12/11/24 revealed he was concerned that the NA assigned to him on 12/10/24 did not assist him with toileting. The grievance was incomplete as it did not include documentation of an investigation, outcome or recommendations for corrective action.	F 585	3. The Administrator was reeducated by the Vice President of Clinical Services on 5/28/2025 to ensure that the facility maintains evidence of grievances and investigation completion. 4. The Administrator or designee will ensure that there is evidence of investigation of grievances weekly for two weeks and then monthly fortwo months. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthy for three months for review, and if warranted, further action. 5. Allegation of Compliance date: June 13, 2025.	

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F 585	Continued From page 7 An interview was conducted with the Social Worker (SW) on 5/28/25 at 2:10 PM. The SW stated she helped residents fill out the initial information on the grievance form that included the date, time, their name, room number, the department the grievance will go to and their concern. She then gave the grievance form to the pertinent department head, and they did the investigation. After the grievance was investigated, it was given to the Administrator to review and sign, then it came back to her to be filed. The SW was unsure how grievance forms that were not completed ended up filed in her office. In an interview with the Administrator on 5/28/25 at 2:12 PM she stated she was the "last stop" for grievances. The Administrator revealed she gets the completed form from the responsible department head then checks in with the complainant to ensure the grievance had been resolved.After this she gives the grievance to the SW to be filed. The Administrator was not sure how incomplete grievances ended up going to the SW to be filed.	F 585		
F 880 SS=F	Infection Prevention & Control 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.	F 880		6/13/25

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F 880	Continued From page 8 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. (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	F 880		

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F 880	Continued From page 9 (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, record review and staff interview, the facility failed to: a.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when Nurse #1 and Nurse Aide (NA) #1 provided wound care without wearing gowns for 2 of 2 staff observed for infection control (Nurse #1 and NA #1) and b.) to implement their policy for EPB for the current 41 of 61 residents that required the precautions due to chronic wounds or indwelling medical devices. The findings included: The facility policy titled Isolation-Categories of Transmission Based Precautions dated October 2018 stated in part: 1. EBP requires the use of gown and gloves only for high contact resident care activities (unless otherwise indicated as part of Standard	F 880	1. Resident #5 was placed on enhanced barrier precautions on 2/28/2025. 2. All residents have the ability to be affected by the deficient practice. An audit was completed on 5/8/2025 of all residents that require enhanced barrier precautions. Signage was placed over the residents' beds as well as gloves and disposable gowns inside of each room for residents who require enhanced barrier precautions by the Director of Nurses. 3. Clinical staff were reeducated on the Infection Control Policy including the enhanced barrier precautions by the Director of Nurses or designee on 5/28/2025. The Director of Nurses or designee will ensure that all newly hired persons receive education prior to directly working with residents.	

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F 880	Continued From page 10 Precautions). a.) High contact resident care activities: in the resident room to include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. 2. Residents are not restricted to their rooms and do not require placement in a private room. EBP is intended to be in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 3. Enhanced Barrier Precautions (EBP) are recommended for residents with indwelling medical devices and wounds who do not otherwise meet the criteria for Contact Precautions, even if they have no history MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring an MDRO and many residents colonized with an MDRO are asymptomatic or not presently known to be colonized. a.) An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples include but are not limited to, central vascular lines including hemodialysis catheters, indwelling urinary catheters, feeding tubes and tracheostomy tubes.	F 880	4. The Director of Nurses or designee will review two residents weekly for two weeks and then two residents monthly for two months to ensure appropriate enhanced barrier precautions are in place. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted further action. 5. Allegation of Compliance Date: June 13, 2025	

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b.) A wound is defined as the care of any skin opening requiring a dressing. However, the intent of EBP is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds such as skin breaks or skin tears covered with a Band Aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers.

The policy further stated that for EBP, appropriate notification was placed above the resident's bed so personnel and visitors are aware of the need for EBP and the signage informs staff of instructions for PPE use while providing high contact resident care activities.

a.) An observation of Nurse #1 and NA #1 providing wound care to Resident #5 was conducted on 5/28/25 at 11:55 AM. There was no signage indicating Resident #5 required EBP for high contact care observed inside or outside of the room. NA #1 was present to assist with repositioning Resident #5. Nurse #1 and NA #1 were observed performing hand hygiene and donning gloves before repositioning Resident #5 and starting wound care. Neither Nurse #1 nor NA #1 donned a gown before providing high contact care to Resident #5.

An interview was conducted with Nurse #1 on 5/28/25 at 12:30 PM. Nurse #1 indicated she was the facility's Wound Care Nurse, and she had no residents on her wound care list that required EBP. She indicated that Resident #5 had chronic

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wounds that she treated daily. Nurse #1 further stated she had not received education about EBP at any time since she was hired in February 2025 and was under the impression EBP was for residents with an infectious disease such as influenza.

In an interview with NA #1 on 5/28/25 at 12:35 PM she stated she had not been trained on EBP since she was hired and did not have any residents on EBP. NA #1 was not aware of indications for a resident to be on EBP.

b.) Observations of resident rooms in all halls on 5/28/25 revealed no signage indicating any resident required EBP, nor any Personal Protective Equipment (PPE) used for EBP readily available.

An interview was conducted with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM. The ADON indicated she was also the Infection Preventionist for the facility. She stated that there were no residents in the facility that required EBP, that she knew it was a "new thing for residents with intravenous lines" but hadn't looked into it yet as she just started in February 2025. The ADON revealed she was also responsible for training staff on infection prevention and control but had yet to start a training program. The ADON stated she was unaware that residents with chronic wounds and indwelling medical devices would require EBP with high contact care.

In an interview with the Director of Nursing (DON) on 5/28/25 at 12:31 PM she stated the facility had no residents on EBP. She was aware EBP was to be used for residents with chronic wounds and

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	345339	A. BUILDING _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 indwelling medical devices and was able to give examples of such. She indicated that Nurse #1 and NA #1 should have been wearing gowns while completing wound care for Resident #5. The DON further stated she was unsure why EBP was not implemented in the facility as she had just started there 4 weeks ago. An interview was conducted with the Administrator on 5/28/25 at 1:38 PM. The Administrator was unable to say why EBP was not implemented in the facility or why Nurse #1 and NA #1 were not wearing gowns while proving high contact care for Resident #5. She was unsure if staff received training on EBP at any time and did not know the regulation. A list of 41 residents that had chronic wounds or indwelling medical devices and required EBP was provided by the Administrator on 5/28/25 at 2:10 PM which included resident's names and the reasons they should have been on EBP prior to 5/28/25.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882		6/13/25

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F 882	Continued From page 14 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to designate a qualified Infection Preventionist who was certified in infection prevention and control, to be responsible for the facility's Infection Control and Prevention Program. This had the potential to affect 72 of 72 residents in the facility. The findings included: During an interview with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM the ADON indicated she was also the facility's Infection Preventionist (IP) and stated she was responsible for oversight of infection control duties. The ADON further stated she had worked at the facility since late February 2025 and had completed 13 of the 20 modules needed to obtain IP certification through the Centers for Disease Control and Prevention (CDC) IP program. The ADON was not aware she had to have IP certification to hold the position of IP. In an interview with the Director of Nursing (DON) on 5/28/25 at 1:38 PM she stated she was aware the ADON did not yet have an IP certification and the ADON was working on it through the CDC IP program. The DON further stated she had been encouraging the ADON to complete her certification as soon as possible. The DON was not aware the ADON needed to hold an IP	F 882	1. The Assistant Director of Nurses completed her Infection Preventionist training on 5/31/2025. From 5/28 until 5/31 the Director of Nurses was the acting Infection Preventionist. She completed her certification on 8/29/2024. 2. All residents have the ability to be affected by the deficient practice. 3. Education was completed with the Director of Nurses by the Administrator on 5/28/2025 to ensure that the designated person for the infection preventionist is a has received the necessary traininig. 4. The Director of Nurses or designee will review monthly for two months to ensure that the infection preventionist is a qualified. Results of these audits will be presented to the facility Quality Assurance and Performance Improvements (QAPI) Committee monthly for three months forrev iew and, if warranted, further action. 5. Allegation of Completion of date: June 13, 2025	

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F 882	Continued From page 15 certification to be the facility IP. She thought it was adequate that the ADON was working toward her certification. An interview was conducted with the Administrator on 5/28/25 at 2:14 PM. The Administrator stated she was aware the ADON was also the facility's IP but was unaware the ADON did not yet have her IP certification.	F 882		
F 945 SS=E	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to have an effective system in place to train nurses and nurse aides (NAs) and verify their competency with infection control policies for Enhanced Barrier Precautions (EBP). The Assistant Director of Nursing (ADON)/Infection Preventionist (IP) who was responsible for training staff on infection control practices and procedures was unaware that residents with chronic wounds and indwelling medical devices required EBP with high contact care. Nurse #1 and NA #1 failed to follow the infection control policy by providing wound care for a resident with chronic wounds without wearing gowns. The facility had 41 residents that required EBP due to chronic wounds or indwelling medical devices. This deficient practice was identified for 3 of 3 staff (ADON/IP, Nurse #1, and	F 945	1. Clinical staff was reeducated on Infection Control Policy including the enhanced barrier precautions by the Director of Nurses or designee on 5/28/2025. 2. All residents have the ability to be affected by the deficient practice. 3. Clinical staff was reeducated on the Infection Control Policy including the enhanced barrier precautions by the Director of Nursing or designee completed on 5/28/2025. The Director of Nursing or designee will be the person who will ensure all newly hired clinical staff will be educated prior to directly working with staff.	6/13/25

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F 945	Continued From page 16 NA #1) reviewed for competency and had the potential to affect other facility residents. Findings included: This tag is cross-referenced to: F880: Based on observation, record review and staff interview, the facility failed to: a.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when Nurse #1 and Nurse Aide (NA) #1 provided wound care without wearing gowns for 2 of 2 staff observed for infection control (Nurse #1 and NA #1) and b.) to implement their policy for EPB for the 41 residents that required the precautions due to chronic wounds or indwelling medical devices. An interview was conducted with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM. The ADON revealed she was responsible for training staff on infection prevention but had yet to start a training program. In an interview with the Director of Nursing (DON) on 5/28/25 at 12:31 PM. She indicated she was unaware staff were not trained or competent in the use of EBP. An interview was conducted with the Administrator on 5/28/25 at 1:38 PM. She stated she was unsure if staff received training on EBP at any time.	F 945	4. The Director of Nursing or designee will review two residents weekly for two weeks and then two residents monthly for two months to ensure staff are educated on the infection control policy to include enhanced barrier precautions. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Allegation of completion date: June 13, 2025.	