STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, resident guardian and staff interviews, record review, facility policy review, and review of the facility's investigation, the facility failed to ensure three residents (Resident (R) 35, R236, and R5) out of five residents reviewed for abuse were free from abuse out of 51 total residents sampled. R236 crawled into bed with R35 and began to kiss her. In addition, R5 was verbally abused and threatened by a Resident Care Aide (RCA)1. This had the potential for R5 to suffer emotional and psychological harm (Cross Reference F607, F609, F610).Findings include: Review of a facility policy titled Abuse, Neglect and Exploitation dated 07/15/2025 indicated . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse is non-consensual sexual contact of any type with a resident. 1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024 with a diagnosis of dementia without behavioral disturbances. Review of R35's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/08/2025 located under the MDS tab indicated that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 revealed that the resident was cognitively intact. Review of R35's EMR titled Care Plan located under the Care Plan tab dated 09/06/2024 indicated that the resident had impaired cognitive function/dementia related to a stroke. The care plan failed to address that the resident fluctuated with mental status even though her cognition was identified through the BIMS score of 15. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023 with a diagnosis of delirium with known psychological disorder. Review of R236's EMR titled quarterly MDS with an ARD of 12/26/2025 located under the MDS tab indicated the resident had a BIMS score of 10 out of 15, which revealed the resident was moderately cognitively impaired. Review of R236's EMR titled Care Plan located under the Care Plan tab dated 11/17/2023 indicated the resident had impaired functional/dementia or impaired thought process related to dementia, with impaired decision making. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a document provided by the facility titled Facility Incident Report dated 01/13/2026 indicated that on 01/11/2026 R236 was found in R35's bed. R236 was observed to kiss R35 on the lips. Review of a document provided by the facility titled Abuse-Resident to Resident dated 01/20/2026 indicated that R35 had a BIMS score of 15 which revealed the resident's cognition was intact with occasional confusion. The report indicated R236 had a BIMS score of 10 which revealed that the resident had moderate cognitive impairment. The investigation indicated that staff attempted to interview R35, but she refused. Review of the facility's investigation revealed a written statement from Certified Nurse Aide (CNA) 9, dated 01/11/26, who wrote that she witnessed R236 in the bed of R35, and she asked R236 to get out of R35's bed. Before getting out of bed, R236 kissed R35 on the lips. CNA9 stated that she reported the incident to a nurse. Part of the investigation included police involvement. Per the investigation the police officer attempted to interview both residents and the officer stated they were unsuccessful in obtaining information since both residents were confused. The facility investigation included an interview with R35's roommate, R21. R21 reported that the curtain was pulled between she and R35. R21 reported that she saw R236 and could not see specifically what occurred but overheard smacking noises and stated R236 asked R35 if she wanted more and R35 laughed. The investigation determined that since both residents seemed to enjoy themselves and were not distressed from the interaction, the facility was unable to substantiate resident-to-resident sexual abuse. There was evidence that the facility moved R236 to another room away from R35 on 01/13/0226 and began 30-minute checks on the whereabouts of R236. During an interview conducted on 03/16/2026 at 3:22 PM, R35 stated she did not remember being touched or being with in bed with a male resident while being kissed and stated she felt safe. R35 did not have a resident representative. During an interview conducted on 03/18/2026 at 9:03 AM, the Legal Guardian for R236 stated that this was the first time the resident was involved in a resident-to-resident incident and stated that the resident was not able to consent since he was not capable of signing any paperwork and was not capable of making decisions. During an interview conducted on 03/17/2026 at 4:15 PM, the Administrator stated that sexual abuse did not happen between R35 and R236 but believed that the incident still needed to be reported to the State Survey Agency (SSA). The Administrator stated that neither of the residents were upset after the encounter. The Administrator stated that the room change and the 30-minute checks were implemented by facility protocol. The Administrator stated that both residents were seen by mental health providers to ensure that harm did not occur. The definition of sexual abuse did not align with the regulatory requirements. During an interview conducted on 03/18/2026 at 6:32 AM, the Assistant Director of Nursing (ADON) 1 stated Certified Nursing Assistant (CNA) 9 reported the resident-to-resident incident to Licensed Practical Nurse (LPN)1 immediately after witnessing the incident. ADON 1 stated that R236 was moved to another room and then the 30-minute checks began two days later. ADON1 stated that this was a one-time incident with R35 and R236 and it never happened again. ADON1 stated that he did not believe that it was abuse. ADON1 stated that R35 had days in which she was coherent and there were days that she was not. During an interview conducted on 03/19/2026 at 4:06 PM, the Administrator defined sexual abuse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included when a resident was upset and crying and not wanting to be touched. The Administrator stated both R35 and R236 were capable of making their own decisions and did not believe that sexual abuse had occurred. Also present during this interview was the Director of Nursing, Chief Compliance Officer (CCO), and National Director of Risk Management (NDRM). The Administrator stated that consent was determined if both residents were able to make their needs known. The Administrator stated after speaking with the two residents, R35 told the facility to mind your own business. The Administrator stated they interviewed R21 and the roommate reported that they were both laughing and giggling. CCO stated that both R35 and R236 were not deemed incompetent and both he and the Administrator stated that both residents had rights. The Administrator stated that the resident-to-resident was reported to the SSA out of an abundance of caution. 2. Review of R5's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, end stage renal disease, osteoarthritis, neuropathy, chronic obstructive pulmonary disease, Parkinsonism, liver cirrhosis, chronic pain, fatigue, anxiety, seizures, and bilateral leg amputation. Review of R5's admission MDS with an ARD of 04/25/2025 and located under the MDS tab of the EMR, revealed a score of 15 out of 15 on the BIMS, indicating intact cognition. He did not exhibit any behavioral symptoms. Review of R5's quarterly MDS with an ARD of 01/25/2026 and located under the MDS tab of the EMR, revealed a score of 15 out of 15 on the BIMS and no behavioral symptoms. Review of R5's Facility Incident Report Form, dated 07/06/25, and provided by the facility, revealed, During the resident smoke break, [R5] stated he asked the staff member, a RCA [Resident Care Assistant], to roll his wheelchair back towards the door and he said the staff member told him that since he rolled himself out he should roll himself back in. The resident said the staff member called him an expletive. Review of R5's Abuse – Staff to Resident Final Report, dated 07/14/2025 and provided by the Administrator, revealed RCA1 was immediately suspended pending investigation and the police department was contacted and conducted an investigation as well. Interview with R5 confirmed RCA1 refused to assist him to wheel into the building and RCA1 cussed at him and threatened him physically. Interviews with other residents who witnessed the incident confirmed a verbal altercation between R5 and RCA1 and RCA1's refusal to assist R5 with wheeling back into the building. A written statement from RCA1 revealed he confirmed he refused to assist R5 and had cussed at R5. The facility's investigation substantiated the allegation of verbal abuse and RCA1's employment was terminated. During an interview on 03/19/2026 at 10:06 AM, R5 stated about nine months ago, RCA1 refused to assist him to wheel into the facility and they got into an argument. R5 stated RCA1 threatened to pull him out of his wheelchair and stomp on him and also cussed at him. R5 stated, I was so angry, I wanted to kill him . I want him to go to hell. R5 confirmed he had not seen RCA1 since the incident and was waiting for follow-up from the police department. During an interview on 03/19/2026 at 4:30 PM, the Administrator stated R5 reported the allegation of abuse to him, and he immediately conducted an investigation. The Administrator stated he substantiated the abuse occurred due to R5's statement, witness accounts of events, and RCA1's admission of guilt.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interviews, record review, and facility policy review, the facility failed to implement their abuse policies for capacity to consent for sexual activity for two residents (Resident (R) 35 and R236), of five, out of 51 sampled residents sampled. In addition, the facility failed to implement their abuse policies by failing to immediately separate both residents and implement supervision. This had the potential for on-going sexual contact. (Refer to F600)Findings include:Review of a facility policy titled Abuse, Neglect and Exploitation dated 07/15/2025 indicated . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. The facility will have written procedures to assist staff in identifying the different types of abuse.mental, verbal abuse, sexual abuse, physical abuse.The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:A. Responding immediately to protect the alleged victim and integrity of the investigation;B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;C. Increased supervision of the alleged victim and residents;D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;E. Protection from retaliation;F. Providing emotional support1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024 with a diagnosis of dementia without behavioral disturbances.Review of R35's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/08/2025 located under the MDS tab indicated that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 revealed that the resident was cognitively intact.2. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023 with a diagnosis of delirium with known psychological disorder.Review of R236's EMR titled quarterly MDS with an ARD of 12/26/2025 located under the MDS tab indicated the resident had a BIMS score of 10 out of 15, which revealed the resident was moderately cognitively impaired.Review of a document provided by the facility titled Facility Incident Report dated 01/13/2026 indicated that on 01/11/2026, R236 was found in R35's bed. R236 was observed to kiss R35 on the lips. Included in the investigation was a document titled Abuse-Resident to Resident dated 01/20/2026, which revealed the facility moved R236 to another room on 01/13/2026 instead of on 01/11/2026 when the resident-to-resident occurred. The facility failed to implement 30-minute checks on 01/11/2026. Police were notified on 01/13/2026 instead of on 01/11/2026 when the resident-to-resident occurred. The report indicated that the police officer attempted to interview both residents and the officer stated they were unsuccessful in obtaining information since both residents were confused. There was no evidence cited in the document that the facility showed that capacity assessments were completed and consent was evaluated by a qualified professional.During an interview conducted on 03/19/2026 at 4:06 PM, the Administrator defined sexual abuse included when a resident was upset and crying and not wanting to be touched. The Administrator stated both R35 and R236 were capable of making their own decisions and did not believe that sexual abuse had occurred. The Administrator stated that both residents consented to the interaction. The facility's misunderstanding of the definition of resident-to resident sexual abuse resulted in failure to initiate capacity and protective interventions.

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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. Based on staff interviews, record review, and facility policy review, the facility failed to ensure an allegation of sexual abuse was reported timely to the Administrator and to the State Survey Agency (SSA) for two of five residents (Resident (R) 35 and R236) reviewed for abuse out of 51 sampled residents. This failure increased the risk of other vulnerable residents being abused. Findings include:Review of a facility policy titled Abuse, Neglect, and Exploitation dated 07/15/2025 indicated .Reporting of all alleged violations, regardless of residents cognitive status, to the Administrator, state agency.regardless of cognitive status.and to all other required agencies within specified timeframes.Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024.2. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023.Review of a document provided by the facility titled Facility Incident Report, dated 01/13/2026, indicated that on 01/11/2026, R236 was found in R35's bed. R236 was observed to kiss R35 on the lips.Review of a document provided by the facility titled Abuse-Resident to Resident, dated 01/20/2026, indicated that Certified Nurse Aide (CNA) 9 wrote a statement on 01/11/2026 and indicated she witnessed R236 in R35's bed and R236 kissed R35 when CNA9 directed R236 to get out of R35's bed. CNA9 stated she reported the incident to a nurse (there was no name identified in the investigation). The facility identified Licensed Practical Nurse (LPN)1 as the nurse who received the report from CNA9. There was no information on the reasons for the delay in reporting to the SSA.During an interview conducted on 03/17/2026 at 4:15 PM, the Administrator stated the Assistant Director of Nursing (ADON)1 reported the resident-to-resident incident. The Administrator stated when he was notified of the sexual incident on 01/13/2026 and that was when he reported the resident-to-resident to the SSA. The Administrator stated CNA9 reported the sexual encounter with R35 and R236 to Licensed Practical Nurse (LPN) 1. The Administrator stated that the incident between R35 and R236 was not considered sexual abuse. The Administrator stated once he learned about the resident-to-resident incident he reported the encounter to the SSA out of an abundance of caution.During an interview conducted on 03/18/2026 at 6:32 AM, ADON1 confirmed he learned about the sexual encounter which involved R35 and R236 two days after the incident. ADON1 stated the staff involved were CNA9 and LPN1 and he verbally counseled them both on timely reporting of resident-to-resident incidents. ADON1 confirmed he notified the Administrator of the resident-to-resident incident two days later. ADON1 was unable to identify how he obtained the information regarding R35 and R236 prior to reporting the allegation to the Administrator. During an interview on 03/18/2026 at 3:11 PM, LPN1 stated she was not the nurse that CNA9 reported the resident-to resident to.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to provide the resident's responsible party a written notice of transfer, notice of bed hold practices and complete information on the process to appeal the transfer, including appeal agency contact information for a sample of two of two residents (Resident (R)144 and R238) reviewed for hospitalizations in a total sample of 51 residents. This failure had the possibility to negatively impact residents and their responsible parties due to them not being aware of the reason for a transfer and how to appeal the transfer. Findings include:Review of the facility's policy titled, Transfer and Discharge (including AMA) reviewed 11/01/2025 indicated, .Policy Explanation and Compliance Guidelines:.2. Once admitted , the resident has the right to remain in the facility unless their transfer or discharge meets one of the following specified exemptions: a. The transfer.is necessary for the resident's welfare and the resident's needs cannot be met in the facility.The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. Specific reason of transfer.b. The effective date of transfer.The specific location .to which the resident is to be transferred.d. An explanation of the right to appeal the transfer.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. F. Information on how to obtain an appeal form.Review of the facility's policy titled, Bed Hold Notice revised 07/01/2025 indicated, Policy: It is the policy of this facility to provide written information to the resident and/or the resident's representative regarding the bed hold practices.at the time of a transfer. Policy Explanation and Compliance Guidelines: 1.at the time of a transfer to the hospital.the facility will provide the resident and/or the resident representative written information that specifies:.b. The reserve bed payment policy. C. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.2. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record.1. Review of R144 's Face Sheet located under the Profile tab of the Electronic Medical Record (EMR) revealed R144 was admitted to the facility on [DATE] with the diagnoses of non-traumatic intracerebral hemorrhage, cerebral edema, pneumonia, osteoarthritis, hemiplegia and hemiparesis affecting the right dominant side, aphasia, and seizures.Review of R144's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/25/2026 located under the MDS tab of the EMR indicated R144 was dependent for all tasks. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating R144 was severely cognitively impaired. Review of R144's EMR under the Progress Notes tab indicated a progress note, dated 02/11/2026, .Patient daughter request for patient to be transfer to the hospital. Stating that pt [patient] is getting worse.Also stating that pt having apnea when breathing and pt is not breathing well.Responsible party notified.2. Review of R238's Face Sheet located under the Profile tab of the EMR revealed R238 was admitted to the facility on [DATE] with the diagnoses of non-traumatic subacute subdural hemorrhage, seizures, cerebral infarction, atrial fibrillation, unspecified dementia, malnutrition, and type II diabetes.Review of R238's admission MDS with an ARD of 02/22/2026 located under the EMR MDS tab indicated R238 was dependent for all tasks. The MDS revealed a Brief Interview for Mental Status (BIMS) score of memory problem, severely impaired. Review of R238's EMR under the Progress Notes tab indicated a progress note, dated 02/22/2026, .change in condition.at 11:30 AM family reported resident finger nail beds became blue.his doctor communicated by phone, ordered oxygen 3 L (liters) via nasal cannula.Reason for transfer: further diagnosis and treatment.Responsible party notified. During an interview on 03/19/2026 at 12:40 PM with the National Director of Risk Management (NDRM) revealed they always call the responsible party when a resident was being discharged but we did not send (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification in writing. The NDRM explained that a bed hold notification form was sent with the resident to the hospital, but they did not retain a copy of the form in the resident's EMR. NDRM stated, In my 29 years I have never heard of this.During an interview on 03/19/2026 at 4:50 PM with the Administrator revealed he was not aware that the responsible party needed to receive a written notice of transfer and information regarding the bed hold notice upon any resident transfer to the hospital.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to adhere to infection control practices and policies during incontinence care for two of three residents (Resident (R) 172 and R181) observed for incontinence care in the sample of 51 residents. The deficient practice had the potential to place R172 and R181 at risk of cross-contamination and infection.Findings include: Review of the facility's policy titled Perineal Care with a revision date of 01/01/26 provided by the facility indicated that: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Review of the facility's policy titled Handwashing/Hand Hygiene with a revision date of August 2019 provided by the facility indicated that: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations; h. Before moving from a contaminated body site to a clean body site during resident care, and j. After contact with blood or bodily fluids. Review of the facility's policy titled, Enhanced Barrier Precautions, revised 03/01/25, provided by the facility indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and gloves use during high contact resident care activities. Initiation of Enhanced Barrier Precautions. for residents with any of the following: wounds.even if the resident is not known to be infected or colonized with MDRO. Implementation of Enhanced Barrier Precautions: . PPE [Personal Protective Equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact care activities include: . Changing linens, changing briefs, . and Wound care. Review of the facility's policy titled, Hand Hygiene, revised 03/01/25, provided by the facility, indicated, 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. 1. Review of R172's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R172 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, need for assistance with personal care, and a fall from a non-moving wheelchair. Review of the admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/16/26 showed documentation R172 completed a Brief Interview for Mental Status (BIMS) with a score of 11 out of 15, which indicated R172 was moderately cognitively impaired. Review of R172's Care Plan located under the Care Plan tab in the EMR revealed R172 was on enhanced barrier precautions for potential infection related to wounds. During an observation on 03/18/26 at 6:44 AM, Certified Nurse Aide (CNA) 8 entered R172's room to (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform incontinence care. An EBP sign was posted on R172's bedroom door that indicated, Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities.changing linens, providing hygiene, changing briefs, . wound care. CNA8 performed hand hygiene, donned gloves, and performed incontinence care. CNA8 did not wear a gown while performing incontinence care. Midway through care, the Regional Risk Consultant (RRC) instructed CNA8 to put on a gown. CNA8 did not perform hand hygiene during glove changes. CNA8 left the room while wearing the gown and obtained a clean sheet from the linen cart that was outside the room, and deposited R172's soiled brief and linens into the trash bin and linen hamper outside the room without bagging the soiled linens or brief. During an interview on 03/18/26 at 7:24 AM, CNA8 stated, I changed gloves going from soiled to clean. I did not sanitize my hands between glove changes. I should sanitize my hands when I remove gloves. I did not wear a gown in the beginning. During an interview on 03/18/26 at 7:29 AM, the RCC stated, We need to make sure we have everything in the room to start with. We should sanitize our hands anytime we take gloves off. During an interview on 03/19/26 at 12:31 PM, the Assistant Director of Nursing (ADON) 3 stated, For residents with EBP precautions, staff are to put on a gown and gloves. I encourage staff to wash their hands every time they remove or change gloves, before and after providing care. If needing to leave the room, they are to remove the gown. They should have all of their supplies in the room before going in, or ask another staff member to bring the needed supplies, so they don't have to de-gown. Only take what is needed off the linen cart. It is not appropriate to have the linen cart outside the room and grab things off the linen cart while gowned. During an interview on 03/19/26 at 2:00 PM, the Director of Nursing (DON) stated, It was not appropriate for staff to go in and out of the room wearing a gown. Staff should have all of their supplies before going into the room. There is a risk of cross-contamination. The expectation is that staff perform hand hygiene with each glove change. 2. Review of R181's admission Record found under the Profile tab of the EMR indicated an admission date of 05/30/22 with diagnoses cerebrovascular insufficiency, hemiplegia, and hemiparesis affecting the right side, vascular dementia, and major depressive disorder. Review of R181's MDS with an ARD of 12/27/25 found under the MDS tab of the EMR indicated R181 was always incontinent of bowel and bladder. During an observation on 03/17/26 at 1:34 PM of R181's incontinent care, CNA5 donned gloves and provided incontinent care using the same pair of gloves throughout the process. CNA5 wrapped up the urine-soiled brief, applied barrier cream to the perineal area, and put on a new brief without changing dirty gloves and performing hand sanitization. In an interview on 03/17/26 at 1:44 PM, CNA5 stated she did not change gloves, and that handwashing and gloves were put on before she entered the room to provide care.