STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115452	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Shepherd Hills	800 Patterson Rd LA Fayette, GA 30728

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on staff interviews, record review, and review of the facility policies titled, Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property and Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to protect the resident's right to be free from sexual abuse by another resident by not reporting an abuse allegation in a timely manner for two of five residents (R) (R2 and R3) reviewed for abuse. Specifically, the facility failed to ensure a final investigation report was submitted to the state survey agency within five business days. Findings include: Review of the facility's policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property dated [DATE], revealed .to comply with all applicable federal and state requirements regarding the reporting of patient abuse, neglect, exploitation, mistreatment, and misappropriation of property .Follow specific state reporting form/web portals for documenting reportable event. Unless state requirements specify otherwise, a written investigation report should be submitted to the state agency within 5 days of the incident. Review of the facility's policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property dated [DATE] revealed .to investigate allegations and occurrences of patient abuse, neglect, exploitation, mistreatment, and misappropriation of patient property .A written report of the investigation and follow-up should be submitted to the appropriate agency within five working days of the occurrence, unless otherwise indicated. Review of R2's electronic medical record (EMR) under the Profile tab revealed admission to the facility with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cervical disc degeneration, and depression. Review of R2's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated severe cognitive impairment. Further review revealed R2 used a wheelchair and was independent with mobility. R2 had no documented behaviors. Review of R3's EMR Profile tab revealed admission to the facility with diagnoses of Alzheimer's disease, dementia with mood disturbance, and depression. The resident expired on [DATE]. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's quarterly MDS under the MDS tab of the EMR, with an ARD of [DATE], revealed a BIMS score of 00 out of 15, which indicated severe cognitive impairment. Further review revealed R3 required partial/moderate assistance with mobility. R3's medical record was documented with physical behaviors directed toward others for one to three days of the assessment period. Review of Progress Notes, located under the Progress Note tab in the EMR and written by Registered Nurse (RN) 3, dated [DATE] at 7:03 pm, indicated R2 was .rubbing another resident on the leg all the way up. RN went to see and found [R2] holding the dementia females [sic] hand on his private area and rubbing. Got them apart and took the dementia female to her room. Review of the facility's Incident Report, provided by the facility, revealed an initial report was submitted [DATE] at 7:59 pm. The incident reported a suspected sexual behavior between cognitively impaired residents. Details of the incident revealed a, Nurse witnessed male resident with dementia holding female resident's with dementia hand with hand resting over the male resident's groin area. Both residents were on [sic] male resident's room. The incident reported, Residents separated. Female resident placed on 1 to 1 monitoring until room change arrangement can be made. Will 5 day follow up. [sic] An undated Follow Up Report was provided by the facility which documented, in part, that R3 . is/was simply seeking companionship not sexual behavior. She does roam the building at times and will enter other resident rooms. She will try to sit next to male residents but not with sexual activity. It appears she simply wants to have male companionship at times. There have been no other episodes of concern. During an interview on [DATE] at 10:28 am, the Administrator stated that when he submitted the follow-up report of the abuse investigation, he had done so within the required five business days. The Administrator was unable to provide documentation that the report was submitted in a timely manner and stated that the reporting system did not show the time that the follow-up report was submitted. During an interview on [DATE] at 11:58 am, the Director of Nursing (DON) stated that she was aware that the facility had five days to get the follow-up investigation report submitted to the state survey agency. The state survey agency provided the date and time of the submitted five business day follow-up investigation which revealed the facility provided the report on [DATE] at 10:14 am. The report was received by the state survey agency on the eighth business day. During an interview on [DATE] at 2:06 pm, the Administrator stated that the facility reported back to the state survey agency in five days with the follow-up investigation report. He stated that he was not aware of why the state survey agency documented a delay in the follow-up report.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on record review, staff interviews, document review, and review of the facility policy titled, Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to protect the residents' right to be free from sexual abuse by another resident by failing to conduct a thorough investigation for an incident of potential sexual abuse behavior for two of five residents (R) (R2 and R3) reviewed for abuse. Findings include: Review of the facility's policy titled, Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, dated [DATE], revealed .to investigate allegations and occurrences of patient abuse, neglect, exploitation, mistreatment, and misappropriation of patient property .Documentation of the investigation should include, but not be limited to, the following: names of accused and any witnesses . details of the alleged incident and injury .signed statements from pertinent parties .information gathered from the investigation .any other police or ombudsman reports or other documentation related to the investigation . Interviews should be conducted of all individuals who have relevant information, utilizing open-ended questions. Review of R2's electronic medical record (EMR) Profile tab, revealed admission to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cervical disc degeneration, and depression. Review of R2's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated severe cognitive impairment. Further review revealed R2 used a wheelchair and was independent with mobility. R2 had no documented behaviors. Review of R3's electronic medical record (EMR) Profile tab, revealed admission to the facility with diagnoses of Alzheimer's disease, dementia with mood disturbance, and depression. The resident expired on [DATE]. Review of R3's quarterly MDS under the MDS tab of the EMR, with an ARD of [DATE], revealed a BIMS score of 00 out of 15 which indicated severe cognitive impairment. Further review revealed R3 required partial/moderate assistance with mobility. R3 was documented with physical behaviors directed toward others for one to three days of the assessment period. Review of Progress Notes, located under the Progress Note tab in the EMR for R2, and written by Registered Nurse (RN) 3, dated [DATE] at 7:03 pm, indicated Another resident came to the nurse's station and reported R2 was .rubbing another resident on the leg all the way up. RN3 went to see and found [R2] holding the dementia females (sic) hand on his private area and rubbing. Got them apart and took the dementia female to her room. The resident who came to RN3 was not interviewed for the investigation. RN3 was also not documented with an interview in the investigation report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes, located under the Progress Note tab in the EMR for R3 and written by Licensed Practical Nurse (LPN) 5, dated [DATE] at 1:11 am, documented Resident at this time on one-on-one for incident earlier in this shift where a male resident place (sic) her hand on his crotch. LPN5 was not documented with an interview in the investigation report. Review of the facility's Incident Report, provided by the facility, revealed an initial report was submitted [DATE] at 7:59 pm. The incident reported a suspected sexual behavior between cognitively impaired residents. Details of the incident revealed a, Nurse witnessed male resident with dementia holding female resident's, with dementia, hand with hand resting over male resident's groin area. Both residents were on [sic] male resident's room. The incident reported stated, Residents separated. Female resident placed on 1 to 1 monitoring until room change arrangement can be made. Will 5 day follow up. (sic) There were no statements by any residents or staff in the investigation report. An undated Follow Up Report was provided by the facility, which documented, in part, that R3 . is/was simply seeking companionship not sexual behavior. She does roam the building at times and will enter other resident rooms. She will try to sit next to male residents but not with sexual activity. It appears she simply wants to have male companionship at times. There have been no other episodes of concern. No additional documentation was provided with the investigation follow-up report to indicate a thorough investigation was completed, to include any record reviews, staff and resident interviews, or other pertinent information used in the conclusion of the report. During an interview on [DATE] at 3:50 pm, the Administrator stated that the nurse documented the observation of the two residents holding hands with the hands resting along the upper thigh of R2. He stated the incident was documented on the facility 24-hour report, but it might not have been a reportable event. He stated that both residents had dementia, and there was no intent for anything inappropriate. The Administrator stated he was not aware of whether they interviewed any staff members who saw the incident, and did not think they interviewed the residents, because they were confused. During an interview on [DATE] at 11:08 am, the Director of Nursing (DON) stated that the incident happened at nurse shift change. She stated the nurse that saw the incident was RN3, who charted the incident in the progress notes for R2. She stated that LPN5 charted the situation in R3's chart. The DON confirmed that there were no documented interviews from staff or residents about the incident, just what was in the progress notes. During an interview on [DATE] at 11:37 am, LPN2 stated that R2 and R3 both had dementia. LPN2 stated that after any potential abuse, the staff had two hours to alert the Director of Nursing and the Administrator, and then do the reportable [sic]. She stated it was important to gather statements, witness statements, and to paint a picture of what happened. LPN2 stated the staff would let the physician and the family know. During an interview on [DATE] at 2:30 pm, RN3 stated that another resident was going down the hallway and came up to her and told her that R2 had his hand on the leg of R3. RN3 stated she went down to the room and R3 was sitting on R2's bed. She stated her hand was on his groin, and his hand was resting on top of her hand. RN3 stated R2 was rubbing his hand on top of hers, not forcefully or against him. RN3 stated there was no nudity or other activity going on, but R2 should not have had his hand on R3's leg. She stated R2 was sitting in his wheelchair. She stated she had not seen this behavior before from either of them. RN3 stated she had interviewed both R2 and R3, but neither really said anything. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed no documentation of resident interview attempts in the investigation. During an interview on [DATE] at 11:58 am, the DON stated that during an investigation she would ask for statements from those who witnessed the incident. She stated she would look at the assessments to see if the resident's BIMS scores indicated they were interviewable, then she would interview them. She stated that usually after an incident, she would talk to residents and families and get observers' statements. If unclear, she stated she would ask more in-depth questions to better understand the incident. During an interview on [DATE] at 1:02 pm, LPN5 stated that she had documented the incident in the resident record only. She stated that the full investigation would be completed by the DON and Administrator. During an interview on [DATE] at 2:06 pm, the Administrator stated that he was the Abuse Coordinator. He stated that he would receive the reporting documentation and would put in the initial basic information into the State Survey Agency portal. He stated that the staff would discuss the incident in the morning meeting if there had been a reportable, and ask the team if they had any additional information that they could provide. The Administrator stated that they would process the information gathered about the situation. He stated that for a thorough investigation he would determine if there were direct witnesses or if anyone heard anything. He stated he would not want to rely on secondary information. He stated that would include talking to residents, or others as needed. He stated that they usually tried to have statements from residents if they were reliable or interviewable, and have the interview dictated and have them sign it if they could.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 09262 Based on observation, interview, record review, and review of the facility policies titled, Procedure: Perineal Care and Procedure: Catheter Care, the facility failed to clean the perineal area of bowel movement during incontinence care for one of two residents (R) (R12) reviewed for ADL (activities of daily living) care for dependent residents. The deficient practice had the potential to cause infection for R12. Findings include: Review of the facility policy titled Procedure: Perineal Care dated 2019 revealed .11. If heavy soiling is present, wear gloves and use tissues or wipes to remove soiling prior to perineal care .Remove and discard gloves and wash hands .13. Wash hands and put on clean gloves for perineal care. 14. Gently wash, rinse, and dry the perineal area, wiping from the clean urethral area toward the dirty rectal area to avoid contaminating urethral area .15. If indwelling urinary catheter is present: Hold catheter tubing .while washing perineum. 16. turn resident on their side .17. Gently wash, rinse, and dry the rectal area and buttocks wiping from the labia downward over rectal area until area is clean .19. Perform hand hygiene Review of the facility policy titled Procedure: Catheter Care dated 2019 revealed 2. Separate inner labia with nondominant hand. Wash down the center, wiping downward from front to back and stopping at the base of the labia .3. Rinse and dry the urethral and perineal area, .until entire area is clean, soap free and dry. 4. Hold catheter tubing .while washing perineum .5. When washing, rinsing, and drying the urethral area: a. Gently wash, rinse and dry around the juncture of the catheter and meatus. b. Wash the catheter from the meatus down the tube about 3 inches .12. Perform hand hygiene . Review of R12's electronic medical record (EMR) Profile tab, indicated R12 was admitted to the facility with diagnoses of sepsis, urinary tract infection, paraplegia, morbid obesity, bed confinement status, and diarrhea. Review of R12's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/30/2024 in the EMR under the RAI tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact. The MDS indicated resident was dependent on staff for hygiene, resident was incontinent of bowel, and resident had an indwelling urinary catheter. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Training Nurse Aide (TNA) 2, TNA3 and Certified Nurse Aide (CNA) 3 on 4/18/2024 at 11:10 am, revealed TNA2, TNA3, and CNA3 entered R12's room and applied gloves. When the top sheet was lowered, a large amount of bowel movement was observed on the pad between R12's legs and R12's indwelling foley catheter tube was underneath R12's left leg. R12 was turned to her right side. TNA2 removed the bowel movement from R12's right buttocks and folded the pad covering the bowel movement underneath R12. TNA3, TNA2, and CNA3 turned R12 to her left side and TNA3 wiped R12's left buttocks of bowel movement and with a wipe, picked up the bowel movement that was on the pad. R12's indwelling foley catheter tubing was underneath R12's leg. R12 was turned back onto her back and the indwelling urinary catheter tubing was underneath R12's left leg. While wearing the same gloves, TNA3 was observed cleaning the catheter tubing while holding the catheter tubing close to the perineum (groin) and cleaned the actual indwelling foley catheter. TNA3 did not clean R12's perineal area. TNA2, wearing the same gloves, used the resident's bed control and raised the head of the bed. R12 requested to have her the Continuous Positive Airway Pressure (CPAP) device placed on her chest. TNA2, wearing the same gloves, opened the bottle of water and filled the CPAP humidifier and then picked up the CPAP mask and placed it on R12's chest. TNA3 removed her gloves, performed hand hygiene, exited the room, and returned with clean bed linen. TNA2, TNA3, and CNA3 removed all soiled bed linen, applied clean linen, and covered R12 with the top sheet. R12's indwelling urinary foley catheter tubing remained underneath R12's left leg. During an observation and interview on 4/18/2024 at 12:10 pm, Licensed Practical Nurse (LPN) 1 was asked about the positioning of R12's indwelling urinary catheter tubing. LPN3 stated that R12's indwelling urinary catheter tubing was positioned underneath R12's left leg and it should not be under her leg. LPN3 moved the catheter tubing so that it was not under the leg. During an interview on 4/18/2024 at 12:52 pm, TNA2 was asked about R12's incontinence observation and that TNA2 touched the bed control and the CPAP device without changing her gloves after they were contaminated with bowel movement. TNA2 confirmed that she did not change her gloves and did not perform hand hygiene prior to touching the bed control, the CPAP humidifier, and placing the CPAP mask on R12's chest. TNA2 stated that she was trained to change her gloves, perform hand hygiene, and apply clean gloves before touching these items. TNA2 confirmed that R12's catheter tubing was under R12's leg and that the tubing should be over the leg, which TNA2 confirmed during the incontinence care, and also they did not clean the perineal area and they should have cleaned this area. During an interview on 4/18/2024 at 1:08 pm, TNA3 confirmed the indwelling urinary catheter tubing was under R12's leg and that it was supposed to be over her leg. TNA3 confirmed that she did not clean R12's perineal area after she cleaned the catheter tubing.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 09262 Based on facility document review and staff interview, the facility failed to provide eight hours of consecutive Registered Nurse (RN) coverage for three of 14 days on the nursing schedule. Findings include: Review of the Staffing Sheets provided by the Director of Nursing (DON), dated 4/7/2024 through 4/20/2024, indicated that there was no RN coverage for 4/10/2024, 4/17/2024, and 4/18/2024. During an interview on 4/19/2024 at 9:30 am, the DON confirmed that there was no RN coverage for 4/10/2024, 4/17/2024, and 4/18/2024. The DON stated she thought her hours working as the DON would count as the RN eight hours of consecutive coverage when there was not an RN providing direct resident care on the unit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 09262 Based on observations, staff interview, record review, and review of the facility policy titled, State Minimum Staffing for Healthcare Centers, the facility failed to ensure that posted staffing information was accurate and current on the daily nurse staffing document and accurately reflected Registered Nurses (RN) on the unit directly responsible for resident care per shift. The deficient practice presented staffing levels higher than the actual staffing levels to residents and visitors reviewing posted staffing documents. Findings include: Review of the facility policy titled State Minimum Staffing for Healthcare Centers dated 7/15/2016 revealed . 1. Each facility will complete the Daily Nursing Hours for Healthcare Centers Form Information on the form . d. The total number of each category directly responsible for resident care per shift Registered Nurse .The total number of hours worked for each category per shift . Observations on 4/17/2024 at 10:00 am, on 4/18/2024 at 9:00 am, and on 4/19/2024 at 8:30 am revealed the daily nurse staff posting document was taped to the glass information board on the North hallway. The document identified the date, the facility's name, the facility's census, the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. The document indicated on the day shift for 4/17/2024, three RNs working eight hours each, with the census of 105; on the day shift for 4/18/2024, three RNs were working eight hours each, with the census of 104; and on the day shift for 4/19/2024, two RNs were working eight hours each, with the census of 104. Review of the Nursing Schedule provided by the Director of Nursing (DON), dated 4/17/2024 through 4/19/2024, revealed that an RN was not scheduled on the day shift for these days. During an interview on 4/18/2024 at 1:28 pm, the DON stated that the three RNs on the day shift for 4/17/2024 and 4/18/2024 were the Infection Preventionist (IP), the Clinical Care Competency (CCC) person, and herself. During an interview on 4/19/2024 at 9:30 am, the DON stated that the Administrator called the Corporate Office and was told that the DON could not count her hours on the daily nurse staff posting document. The DON stated that was why 4/19/2024 indicated two RNs on the day shift working eight hours. The DON confirmed after reviewing the nursing schedule for 4/17/2024 to 4/19/2024, that there were no RNs scheduled on the day shift to provide direct resident care for these days.

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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. 09262 Based on observations, staff interviews, record review, and review of the facility policies titled, Procedure: Perineal Care and Glove Use, the facility failed to follow standard and transmission-based precautions to prevent the spread of infection for one of two residents (R) (R12) who was dependent on nursing staff to provide incontinence care. Specifically, facility staff failed to perform hand hygiene, apply clean gloves during incontinence care, after contamination of bowel movement, before cleaning the indwelling foley urinary catheter, before touching the bed control, and before touching the Continuous Positive Airway Pressure (CPAP) humidifier and mask. The deficient practice had the potential to spread infection. Findings include: Review of the facility's policy titled, Procedure: Perineal Care dated 2019 revealed .11. If heavy soiling is present, wear gloves and use tissues or wipes to remove soiling prior to perineal care .Remove and discard gloves and wash hands .13. Wash hands and put on clean gloves for perineal care. 14. Gently wash, rinse, and dry the perineal area .15. If indwelling urinary catheter is present: Hold catheter tubing .19. Perform hand hygiene Review of the facility's policy titled Glove Use dated 11/20/2020 revealed .6. Anytime a contaminated surface is touch [sic], the glove mush [sic] be changed .7. Wash hands when removing and or changing gloves. Review of R12's electronic medical record (EMR) Profile tab, indicated R12 was admitted to the facility with diagnoses of sepsis, urinary tract infection, paraplegia, morbid obesity, bed confinement status, and diarrhea. Review of R12's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/30/2024 in the EMR under the RAI (Resident Assessment Instrument) tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact. The MDS indicated resident was dependent on staff for hygiene, resident was incontinent of bowel, and resident had an indwelling urinary catheter. Observation of Training Nurse Aide (TNA) 2, TNA3 and Certified Nurse Aide (CNA) 3 on 4/18/2024 at 11:10 am revealed TNA2, TNA3, and CNA3 entered R12's room and applied gloves. When the top sheet was lowered a large amount of bowel movement was observed between R12's legs on the pad. R12 was turned to her right side. TNA2 removed the bowel movement from R12's right buttocks. TNA3, TNA2, and CNA3 turned R12 to her left side and TNA3 wiped R12's left buttock of bowel movement, and with a wipe picked up the bowel movement that was on the pad. R12 was turned back onto her back. While wearing the same gloves, TNA3 was observed cleaning the catheter tubing while holding the catheter tubing close to the perineal area. While wearing the same gloves, TNA2 used the resident's bed control to raise the head of the bed. R12 requested to have her CPAP mask placed on her chest. Still wearing the same gloves, TNA2 opened the bottle of water, filled the CPAP humidifier, and then placed the CPAP mask on R12's chest. (continued on next page)

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	115452	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Shepherd Hills	800 Patterson Rd LA Fayette, GA 30728

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	During an interview on 4/18/2024 at 12:52 pm, TNA2 was asked about R12's incontinence observation and informed that TNA2 touched the bed control and the CPAP mask without changing her gloves after they were contaminated with bowel movement. TNA2 confirmed that she did not change her gloves and did not perform hand hygiene prior to touching the bed control, the CPAP humidifier, and placing the CPAP mask on R12's chest. TNA2 stated that she was trained to change her gloves, perform hand hygiene, and apply clean gloves before touching these items. During an interview on 4/18/2024 at 1:08 pm, TNA3 confirmed that she did not change her gloves, perform hand hygiene, and apply clean gloves prior to cleaning R12's catheter tubing.