STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Holstein	505 West Second Street Holstein, IA 51025

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and policy review the facility failed to provide food at an appetizing temperature to 2 of 20 residents reviewed (Resident #21 and #51). The facility reported a census of 51 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #21 had a Brief Interview for Mental Status (BIMS) of 7 indicating severe cognitive impairment.On 4/6/26 at 3:10 PM Resident #21 stated the food was served cold at least once or twice a week. Resident #21 explained does not like cold food. 2. The MDS dated [DATE] revealed Resident #51 had a BIMS of 15 indicating no cognitive impairment.On 4/7/26 at 9:24 AM Resident #51 stated the food is frequently cool and would like it served warm. Resident #51 explained lunch and dinner were the meals that were served cold because his table was the last served. Continuous observation of lunch meal plates for the memory care unit revealed 1st tray placed in heated transport at 12:00 PM, sample plate placed on separate tray, heated transport taken back to the unit at 12:08 PM and 1st plate taken to the resident from heated transport at 12:10 PM. The temperature of food from the sample tray was: apple glazed pork loin 119 degrees, long grain and wild rice 122 degrees, and broccoli 116 degrees.Temperature obtained by Staff A, AM Shift [NAME] from the mechanical pork, on the steam table after lunch service, for the IDDSI (International Dysphagia Diet Standardization Initiative) 5 and ITSIY 6 diets was 117 degrees.On 4/8/26 at 12:50 PM the Staff B, Certified Dietary Manager (CDM) stated the pork for the IDDSI 5 and 6 should be warmer. The CDM stated the minimum temperature should be 135 degrees on the steam table. The CDM explained the food delivered to the resident on the memory care unit should also be a minimum of 135 degrees. On 4/8/26 at 3:37 PM the Administrator stated she would ask the CDM for the appropriate temperature of food on the steam table or served to residents on the memory care unit but knows the food should have been delivered to the residents above 120 degrees.Review of a policy proved by the facility reviewed 3/23/26 titled, Food Temperature Monitoring documented the proper holding temperature for hot food was greater than 135 degrees. Retake temperatures of the food on the steam table periodically throughout meal service to ensure foods are held above 135 degrees for hot food. Hot food should be served at 135 degrees or higher.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review the facility failed to prepare food in accordance with professional standards by not completing appropriate hand hygiene during meal service to prevent cross contamination, to store food in accordance with professional standards by not dating open food items or disposing of expired food items. The facility reported a census of 51 residents.Findings include: An initial kitchen observation on 4/6/26 at 10:30 AM revealed the 2 door refrigerator had a 3.5 container of cottage cheese with an open date of 4/1/26 and a best by date of 3/26/26, a large plastic container of carrots in water dated 3/31/26, an 8 oz. container of parmesan cheese with a best by date of 11/25 open without an open date, a container of parmesan cheese with a best by date of 7/16/25 open without an open date, a container of barbeque sauce outside of a store bought container with an open date of 2/19/26, a container of strawberry syrup with a best by date of 12/25 open without an open date, and a 32 oz. container of chopped garlic open without an open date. The dry storage room had a bag of crotons, a bag of [NAME] noodles, a bag of egg noodles, 2 bags of spaghetti noodles open without a date of when the item was opened. One bag of spaghetti noodles was completely open to the air without a seal of cover. The 4 door freezer had these bags of food items open without an open date: a bag of French Fries, a bag of tater tots, onion rings and potato wedges. A four slot toaster on the counter top had brown and white debris covering the top with the crumb drawer on the left full and crumb drawer on the right half full of similar brown and white debris. On 4/6/26 at 12:28 PM Staff B, Certified Dietary Manager (CDM) stated the facility's expectation was that all food items that were open would have the date the food item was opened. The CDM stated she would expect the noodles to be closed and not open to air with a clip or a twist tie. The CDM stated she expected the toaster would not have all the debris on the top and the drawer would be empty. The CDM stated any food items with a best by date before today's date should have been thrown away and not used. An observation on 4/8/26 at 11:15 AM of Staff A, AM Shift [NAME] during lunch service revealed a piece of broccoli fell on the steam table where plates were being plated and hands were placed in-between serving the plates. Staff A picked the piece of broccoli up off the steam table with a fork and placed it back on the plate and served the plate.An observation on 4/8/26 at 12:15 PM of Staff A during the lunch service revealed Staff A obtained a hamburger bun from the bag with a paper towel in her ungloved hand, place the bun on the plate with the side the paper towel that was in her hand down on the plate, pulled the paper towel from under the bun, utilized tongs to place a hamburger on the bun, plate taken over to left side of the toaster to apply lettuce, top of bun fell onto the counter top where used utensils and other food debris was present, picked top bun up with ungloved hand, placed bun on the hamburger with lettuce and served to the resident. No hand hygiene was observed.An observation on 4/8/26 at 12:26 PM of Staff A during the lunch service revealed Staff A placed food on a residents plate with utensils in the steam table, handed the plate to staff to be served to the resident, walked from the steam table to 2 door freezer, opened the 2 door freezer with left hand, obtained a handful of French fries with right hand, placed the fries in the fryer and returned to the steam table to serve lunch. This same process was repeated 2 times with French fries and 1 time with tater tots. No hand hygiene was observed.On 4/8/26 at 12:50 PM Staff B, Certified Dietary Manager (CDM) stated hand hygiene should have been completed when the cook obtained any items from the freezer. The CDM stated she thought the deep fryer would kill all possible bacteria from cross contamination . The CDM stated tongs could have been utilized to obtain the frozen fries or tater tots. The CDM explained she would have liked to see the cook use tongs to obtain the hamburger bun as well, not a paper towel. The CDM stated the cook should not have picked the broccoli up off the steam table and placed it back on the resident plate. On 4/8/26 at 3:37 PM the Administrator stated tongs should have been used for the hamburger bun, french fries, and tater tots. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator stated the cook should not have picked the broccoli up off the steam table and placed it back on the residents plate. The Administrator stated the open bags of food items should have dates when the food item was opened. The Administrator stated the food items with best by dates before today's date should have been thrown away. Review of a policy provided by the facility reviewed on 6/6/25 titled, Hand Washing and Glove Use-Food Nutrition Services documented employees do not touch any food with bare hands- ready -to-eat or otherwise. Employees must wash hands before handling food, when switching tasks, and after performing any activity that could contaminate hands.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Records (EHR) review, resident interview, resident family interview, staff interviews and policy review the facility failed to provide dignity and respect to a resident when 2 briefs were applied for incontinency to 1 of 3 residents reviewed (Resident #21). The facility reported a census of 51 residents.Findings Include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #21 had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS documented Resident #21 required partial / moderate assistance with toilet hygiene. Review of Resident #21's EHR titled, Care Plan documented no interventions for utilization of 2 briefs for Resident #21.Review of Resident #21's EHR titled, Progress Note documented no discussions with Resident #21 or Resident #21's Daughter about the use of 2 briefs. Progress Notes documented no indications of trial or previous alternative interventions.On 4/6/26 at 3:17 PM Resident #21 explained the staff put 2 briefs on her because she is incontinent. Resident #21 stated she can tell when she has to urinate. Resident #21 stated she does not like wearing 2 briefs because it is uncomfortable and felt like the staff just did not want to clean up once she had voided. Resident #21 stated sometimes she voids and can not get to the bathroom on time and it will go through onto the chair and onto the floor. Resident #21 stated she did not think the staff were treating her with respect by applying 2 briefs. An observation on 4/7/26 at 3:36 PM of personal care provided to Resident #21 by Staff E, Certified Nurse Assistant (CNA) and Staff F, CNA revealed Resident #21 ambulated to the bathroom on her own with the use of a walker, hand hygiene completed by both Staff E and Staff F, gloves applied by both CNA's, Staff E removed the first yellow colored brief, the second pull up style brief remained, Staff E provided personal care from the peri cloths resting on the bowl of the sink, Staff E pulled the yellow brief through the legs to the front, Staff E removed gloves, Staff E assisted in pulling up sweat pants, Staff E completed hand hygiene, Staff F removed gloves and completed hand hygiene. On 4/7/26 at 3:45 PM Staff F, CNA stated Resident #21 took herself to the bathroom and she turns on her call light if she needs a new brief. Staff F stated she will turn the call light on and go to the bathroom. Staff F explained if they are not quick enough to respond to the call light Resident #21 will go back to her chair and wait to have her pants pulled up. Staff F stated the staff recently started double briefing her because she voids very heavily and started double briefing her because it will get on her dressings. Staff F explained that she knew that Resident #21 required a double brief because there was a note hanging on the wall in the CNA room.On 4/7/26 at 3:50 PM an observation in the CNA room revealed a note on the wall that had written Resident #21 was to have 2 briefs and pad (brief first then pull-up).On 4/8/26 at 2:52 PM the Director of Nursing (DON) stated they do not use 2 briefs on any resident besides Resident #21. The DON explained the 2 briefs was Resident #21's preference lately. The DON stated Resident #21 would be incontinent at meals, there would be a large puddle and it would embarrass her. The DON stated she was made aware of the preference yesterday by the CNA after the surveyor observation. On 4/8/26 at 3:07 PM the Assistant Director of Nursing (ADON) stated the first day Resident #21 wanted to try the double brief she spoke with Resident #21's Daughter about it. The ADON explained she had spoken with the staff and put on the communication board that they were trialing the double brief. The ADON stated they had not put the double brief intervention on the care plan yet. The ADON explained Resident #21 stated she was fine with using 2 briefs. The ADON said she had talked to Resident #21 a couple of times and she thought that 2 briefs continued to be a good idea. The ADON acknowledged she had not made any documentation in Resident #21's EHR about the use of 2 briefs for Resident #21 or discussion with Resident #21 or Resident #21's Daughter. On 4/9/26 at 9:26 AM Resident #21's Daughter/POA stated the facility called her yesterday on 4/8/26 and told her they started to use 2 briefs for her mother's incontinence. Resident #21's Daughter explained yesterday was the first call (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had received. Resident #21's Daughter stated the facility explained they had been working with the incontinent situation and that was the best option. Resident #21's Daughter stated she seen Resident #21 4/4/26 and Resident #21 did not have the 2nd brief at that time. On 4/9/26 at 11:58 AM Resident #21 stated she does not want to wear 2 briefs. Resident #21 stated it irritates her because she knows they do not want to care for her urinary needs appropriately. Resident #21 explained she would like somebody to pay a little bit of attention and the facility would like her to handle it herself. Resident #21 stated she did not feel the facility was providing her with dignity or respect by using 2 briefs. Resident #21 stated nobody at the facility had spoke to her about if she wanted to use 2 briefs or if she was okay with trialing 2 briefs.On 4/9/26 at 2:09 PM the ADON stated the facility had tried other alternatives for Resident #21 such as just pull ups and just the velcro brief style and she acknowledged they were not on the care plan or documented in the progress notes as they were just trials. The ADON stated it was placed on the CNA board and only talked to them during huddles. The ADON stated she should have entered the information of trials in Resident #21's EHR. The ADON explained the facility typically would call the first day of the trial to get the okay. The ADON explained that it was not applied to the care plan because they were trialing the 2 briefs but was now on the care plan. The ADON explained that there was a late entry that she had entered today that reflected the conversation with Resident #21 and Resident #21's family.Review of a policy provided by the facility with review date of 12/1/25 titled, Care Plan documented the care plan will be modified to reflect the care currently required/provided for the resident. The Resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, document review, Electronic Health Record (EHR) review, family interviews, staff interviews and policy review.The facility failed to protect a resident from the use of a physical restraint that the resident could not consistently remove on their own for 1 of 2 residents reviewed (Resident # 9). The facility reported a census of 51 residents.Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment . The MDS reported Resident #9 utilized a trunk restraint in the wheelchair. The MDS also documented Resident #9 had diagnoses of anxiety disorder, bipolar disorder, impulse disorder and unspecified intellectual disability. Review of a document provided by the facility on 4/6/26 titled, CMS 802 (Resident Matrix) documented use of a restraint for Resident #9. Review of Resident #9's EHR titled, Care Plan documented the resident utilized a seatbelt for physical restraints related to fall risk with an initiation date of 3/12/26. Resident #9 will remain free of complications related to restraint use, including contractures, skin breakdown, altered mental status, isolation or withdrawal. Provide restraint free time during activities when possible to supervise closely and apply the seat belt when up in the wheelchair. Review of Resident #9 EHR titled, Progress Notes, Assessments, Care Plan, Tasks, MAR/TAR (Medication Administration Record and Treatment Administration Record) reported no documentation of monitoring for any complications related to the restraint, no documentation of restraint free time, the length of time the restraint is anticipated to be used, who may apply the restraint, how to apply the restraint, the time and frequency the restraint should be released, specific direct monitoring and supervision provided during the use of the restraint, on going re evaluation for the need for the restraint and interventions to prevent and address any risks related to the use of the restraint. Review of Resident #9's Physician Order dated 3/12/26 at 3:56 PM documented to fasten seat belt when up in wheelchair.Observations completed on 4/6/26 at 11:25 AM, 1:15 PM, 2:20 PM, revealed Resident #9 sitting in the common area in a wheelchair with the seatbelt present and fastened across the lap and sitting in front of the TV.Observations completed on 4/7/26 at 9:00 AM and 10:15 AM, revealed Resident #9 sitting in the common area in a wheelchair with the seatbelt present and fastened in front of the TV. Observations completed on 4/8/26 at 9:09 AM, 9:30 AM and 10:15 AM, revealed Resident #9 sitting in the common area in a wheelchair with the seatbelt present and fastened in front of the TV playing with her socks.On 4/8/26 at 9:37 AM Staff C, Certified Nurse Assistant (CNA) stated during care that Resident #9 will attempt to get out of the chair and that is why the resident has to have a seatbelt. On 4/8/26 at 10:14 AM Staff D, CNA stated she worked with Resident #9 frequently. Staff D acknowledged Resident #9 does not mess with her seat buckle and could not buckle or unbuckle the seat belt. Staff D stated the seat belt was in the wheelchair one day, so she just applied it. Staff D said she had not provided restraint free time when working with Resident #9 besides bathing or when repositioned to the bed. Staff D, denies knowing of any documentation that is the CNA's responsibility in regards to the seatbelt nor of any documentation that she is aware of that tells her that resident is to be wearing the seatbelt. Staff D, explained she just knows the resident is supposed to wear the seatbelt when up in her wheelchair.On 4/8/26 at 10:34 AM Staff G, Registered Nurse (RN) stated she did not know if the wheelchair was provided by the facility. Staff G said she had not seen Resident #9 manipulate the seat belt, buckle or unbuckle the seat belt. Staff G explained Resident #9 always has the seat belt on when in the wheelchair. Staff G explained it could be hard to get Resident #9 to reposition to the bed because she attempts to climb out of the bed. An observation on 4/9/26 at 12:13 PM revealed The DON (Director Of Nursing) asking resident #9 to remove the seatbelt that was over her lap in the wheelchair. Resident #9 was unable to follow commands to remove the seat belt and she repeatedly stated I can't I can't. On 4/9/26 at 12:30 PM Resident #9's Mother stated she did not recall being (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified about consent for the seat belt. She explained that she first witnessed the seat belt in place when she visited the facility a few days after Resident #9 was admitted . Mother acknowledged that she thought Resident #9 would benefit from using the seat belt if the facility thought it was needed because Resident #9 could fall out of the wheelchair when being energetic. Mother stated that she has not witnessed Resident #9 removing the seat belt on her own. Review of Resident #9's document dated 3/12/26, titled, Restraint Consent documented a telephone consent from Resident #9's daughter on 3/12/26. Document also signed by DON and Assistant Director of Nursing (ADON). On 4/9/26 at 12:13 PM DON stated Resident #9 is inconsistent with being able to remove the seatbelt herself. On 4/9/26 at 1:32 PM the DON stated Resident #9's ability to unbuckle her seat belt is inconsistent. The DON explained Resident #9 would tell the staff that the belt is unbuckled and then buckle the seat belt herself. The DON stated on the first day Resident #9 was a concern for falling out of the chair and that was the reason for the use of the restraint. The DON and ADON said that they had contacted Resident #9's Mother over the phone for consent to use restraint with explanation of the pros and cons for use. The DON stated the mother was at the facility the day Resident #9 entered the facility and then returned about a week later since then she has been at the facility about twice a week. The DON stated the care plan should have length of time and when the seat belt was released. The DON explained when Resident #9 first came to the facility she would lunge forward in the wheelchair. DON stated that she would expect more documentation to be in place related to use of a restraint then what the facility currently had. The DON acknowledged that she had added tasks on 4/9/26 and added more detail to the care plan for example when to remove the restraints. The DON stated there were not any less restrictive measures put into place prior to using the seatbelt. DON and ADON denied doing an assessment for restraints prior to using the seatbelt or having an assessment since the seat belt had been in place. Review of Policy provided by the facility with review date of 3/30/26 titled, Physical Restraints/Psychotropic Medications Alternatives documented to provide non-pharmacological alternatives to the use of a physical restraint or psychotropic medications.

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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 observation, Electronic Health Records (EHR) review, policy review and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube, that was on Enhanced Barrier Precautions (EBP) for 1 of 1 reviewed (Resident #9) and with missed opportunities for hand hygiene when personal cares were completed for 1 of 3 reviewed (Resident #21). The facility reported a census of 51 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS documented Resident #9 had a feeding tube in place.Review of Resident #9's EHR titled, Order Summary Report documented a physician's order to flush PEG tube with 200cc of tap water daily to maintain patency. Review of Resident #9's EHR titled, Care Plan documented Resident #9 required EBP related to peg tube placement with an initiation date of 3/12/26. The intervention for EBP on Resident #9's Care Plan documented to don a gown and gloves when performing high contact care activities including dressing, transferring, providing hygiene, repositioning, checking and changing. Observation on 4/8/26 at 9:30 AM of EBP sign outside of Resident #9's room that required the use of gown and gloves during high contact resident care activities such as dressing, transferring, providing hygiene, changing briefs, assisting with toileting and device care for feeding tubes.An observation on 4/8/26 at 9:38 AM of Staff C, Certified Nurse Assistant (CNA) and Staff D, CNA completed a transfer to the toilet and personal cares on Resident #9. Observation revealed Resident #9 was in bed lying down, Staff C and Staff D applied gloves, neither staff applied a gown, removed Resident #9's pants, removed Resident #9's brief, lift cloth applied, mechanical full body lift driven by Staff D, and Staff C guided Resident #9 to the commode, Staff D removed gloves, Staff C removed gloves, hand hygiene completed by both staff, gloves applied by both staff, Staff D applied socks, removed gloves, completed hand hygiene, returned to the lift, Staff D did not apply any gloves, Resident #9 sat on the commode until ready to transfer back to bed to get dressed. To the resident, both Staff C and Staff D applied lift cloth to full body mechanical lift, Staff C with gloves gave Staff D with no gloves the lift remote, Staff C assisted resident with lift cloth and assisting with directions, Staff D directed the full body lift, Staff C completed hand hygiene, applied gloves, Staff C pulled lift straps down between legs, Staff C obtained peri wash and peri wipes, Staff C utilized one wipe one swipe with care, Staff C removed gloves, Staff D applied brief, Staff C with no gloves fastened right side of the brief, Staff D fastened the left side of brief. Staff D removed gloves completed hand hygiene, both staff assisted Resident #9 with pulling pants up with no gloves on. Both Staff C and Staff D assisted in placing lift cloth into position. Staff C completed hand hygiene, Staff C applied gloves, Staff D without gloves applied the lift cloth to the lift, Staff D ran lift remote with no gloves. Staff C moved the wheelchair into position, Staff C assisted Resident #9 with positioning in the sling, Staff D ran the lift remote, moved the lift into place, Staff C assisted Resident# 9 into the wheelchair, both staff placed foot rests in place. Staff C removed gloves, Staff C applied gloves, completed the cleansing process with sanitizing wipes on the full body mechanical lift. Staff D completed hand hygiene and wheeled resident down to the therapy room.On 4/8/26 at 3:26 PM the Director of Nursing (DON) stated there could have been more hand hygiene and more applications of gloves during Resident #9's cares. The DON stated Resident #9 had a PEG tube in place. The DON explained Resident #9 required EBP when personal care was completed. The DON stated the staff should have worn gowns when completing cares on Resident #9. 2. The Minimum Data Set (MDS) dated [DATE] revealed Resident #21 had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS documented Resident #21 required partial / moderate assistance with toilet hygiene. An observation on 4/7/26 at 3:36 PM of personal care provided to Resident #21 by Staff E, Certified Nurse Assistant (CNA) and Staff F, CNA. Resident #21 ambulated to the bathroom on her own with the use of a walker, (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	hand hygiene completed by both Staff E and Staff F, gloves applied by both CNA's, wet wipes placed on the sink spread out by Staff E. Staff E removed the first yellow colored brief, the second pull up style brief remained, Staff E continued to wear the same gloves, provided personal care from the peri cloths resting on the bowl of the sink. Staff E pulled the yellow brief through the legs to the front, Staff E removed gloves, Staff E assisted in pulling up sweat pants, Staff E completed hand hygiene, Staff F removed gloves and completed hand hygiene. On 4/8/26 at 2:52 PM the Director of Nursing (DON) stated she would have expected hand hygiene with any change of gloves and after removal of Resident #21's brief. The DON stated after the personal care she would expect hand hygiene, with new gloves and when Resident #9's pants were pulled up. The DON stated they do not use 2 briefs on residents but it has been Resident #9's preference lately. Review of a policy provided by the facility reviewed 11/13/25 titled, Hand Hygiene documented the purpose of the policy was to guide compliance for hand hygiene with the Centers for Disease Control and Prevention (CDC) and the World Health Organization's Moments of Hand Hygiene recommendations. All employees in patient care areas will adhere to the 4 moments of hand hygiene and 2 zones of hand hygiene: Entering room, before clean task, after bodily fluid/glove removal, exiting room, and zones are patient zone and health-care zones. Staff will complete hand sanitization when entering the patient room, after removing gloves regardless of task completed, after contact with secretions, when moving from contaminated body site to a clean body site during patient care, when entering supply drawers and when exiting patient room.Review of a policy provided by the facility reviewed 7/7/25 titled, Standard Enhanced Barrier, and Transmission-based Precautions documented Enhanced Barrier Precautions (EBP) expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDRO) to staff hands and clothing. EBP are also used for residents with chronic wounds and residents with indwelling medical devices such as feeding tubes. The procedure indicated to post clear signage indicating the type of precautions and required PPE gown and gloves during high-contact resident activities required the use of gown and gloves.