STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	900 Hilligoss Boulevard Southeast Fosston, MN 56542

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to complete a significant change in status assessment (SCSA) when two or more areas of change in resident status were identified on the Minimum Data Set (MDS) for 1 of 5 residents (R2) reviewed for activities of daily living (ADLs). Findings include: R2's quarterly MDS dated [DATE], identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia and low back pain. R2's quarterly MDS dated [DATE], identified R2 had severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's Functional Abilities assessment dated [DATE], identified R2 required setup with eating and assist of one with toileting, grooming, bed mobility, toileting, transfers, and dressing. R2 was having more difficulty with ambulation, dependent with ambulation up to 10 feet and was unable to ambulate any further. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following; -6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings. -6/4/25, an order was obtained for a physical therapy evaluation and treatment for ambulation and transfers. -6/5/25, staff identified R2 needed a lot of encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop. -6/26/25, a significant weight loss was identified, as R2 had lost 8 pounds, 5 percent, in 28 days. During interview on 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 used to ambulate but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A was assisting R2 to wash and dry and put on a nightgown, NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a significant change instead of her last quarterly or documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated R2 should have had a significant change MDS completed instead of a quarterly due to the

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to revise the care plan to remove restorative nursing ambulation program from the care plan for 1 of 4 resident (R15) reviewed for restorative nurse services. Findings include:R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had severe cognitive impairment and identified R15 was dependent of staff for transfers and bed mobility and R15 did not ambulate (walk).R15's care plan dated 6/3/25 identified:R15 was to ambulate with an assist of two of the restorative aides assisting, until physical therapy (PT) provided further treatment.R15 was on a wellness ambulation program that indicated R15 would ambulate daily or as tolerated with restorative.R15's doctor's note from 11/14/24, identified R15 had declined and was no longer able to walk.R15 behavioral health note from 12/31/24, identified resident was no longer ambulating.During an interview on 7/29/25 at 2:12 p.m., family member (FM)-A stated R15 had not walked for close to a year.During interview on 7/30/25 at 8:21 a.m. , trained medication assistant (TMA)-C stated they had been working here for a couple of years and had not seen R15 walk.During interview on 7/30/25 at 9:00 a.m., TMA-A (who also work as a restorative aide) stated R15 was able to stand and transferred from bed to wheelchair. R15 had not been able to walk and was not receiving ambulation services.During interview on 7/30/25 at 12:30 p.m., registered nurse (RN)-B stated at one time R15 was able to walk but it was a long time ago. The care plan should have been updated when there was a change in R15's walking abilities.During interview on 7/30/25 at 12:37 p.m., RN-C stated R15 had not been ambulatory since they were in their current position, which was about a year. Care plans were to be reviewed every three months, or if there was a change in a resident's status. R15 was not ambulating, and the care plan should have reflected that.During interview on 7/30/25 at 12:41 p.m., the director of nursing (DON) stated it was an expectation a resident's care plan was to be reviewed every three months or sooner if there had been a change in a resident's status. R15 was not ambulatory, and the care plan should have been updated.The facility's Care Planning-Care Conferences policy dated 8/9/24, identified to reviewed and updated plan of care quarterly and with any change in resident condition or care needs.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess for a decline in activities in daily living (ADL) and ensure a referral from physical therapy for the decline in ADL's was acted upon for for 1 of 5 residents (R2) reviewed for ADL's Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia, atrial fibrillation (irregular heartbeat) and low back pain.R2's quarterly MDS dated [DATE], identified severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following;6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings. 6/4/25, an order was obtained for a physical therapy evaluation and treatment for ambulation and transfers. 6/5/25, staff identified R2 needed a lot of encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop. The medical record lacked an assessment from physical therapy and/or an assessment from nursing related to the decline in physical abilities. During interview on 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 was ambulating a few months ago but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A assisted R2 to wash and dry and put on a nightgown. NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but was unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 was becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a significant change instead of her last quarterly or documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 9:30 a.m. physical therapist (PT)-A stated he had received an order to do a physical therapy evaluation with R2 on 6/5/25. He had attempted to see R2 on a few occasions, but she had not been available each time he tried. R2 had either been in the bathroom or attending activities and so an evaluation had not been completed. It was a

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure range of motion (ROM) was completed in accordance as care planned from therapy recommendations to prevent the loss of mobility for 1 of 3 residents (R17) reviewed for restorative nursing services. Findings include: R17's Therapy Screening Form dated 9/28/23, identified the physical therapist had reviewed R17's Functional Maintenance Program and ROM. R17 stated stretching felt good and staff were to continue with her current restorative program three times per week. R17's care plan dated 5/24/25, identified R17 had impaired mobility related to multiple sclerosis with a long-term goal to transfer into her wheelchair at least one time daily. Approaches included restorative nursing to assist R17 with ROM to both upper and lower extremities three times weekly. R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 had intact cognition, was dependent on staff with all activities of daily living (ADLs) and was unable to ambulate. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, anxiety, and chronic pain. R17's Point of Care History for restorative nursing identified the following:June 2025, identified R17 was offered ROM exercises two times per week and not the three times per week ordered by therapy and identified in R17's care plan. July 2025, identified R17 was offered ROM exercises one time per week for three weeks. Two times per week for one week and was not offered any exercise for one week during the month.During interview on 7/30/25, at 12:23 p.m. trained medication aide (TMA)-A stated she mainly worked in restorative nursing as an exercise technician. TMA-A did go to R17's room and offer exercises as care planned, however, R17 would frequently refuse. She thought she offered the exercises more than identified on the point of care history; however, TMA-A did not chart refused or unavailable as often as she should have. The documentation did not reflect the three times per week exercises as ordered and she felt she needed to improve her documentation. When interviewed on 7/30/25, registered nurse (RN)-A, who assisted to coordinate the restorative nursing program, stated a therapist set up the resident exercises and put the instructions in the facility restorative book for the restorative aides to follow. The restorative aide should be offering R17 exercises three times per week and document when R17 refused or was unavailable. When interviewed on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated restorative nursing should offer residents exercises as directed on their plan of care and unavailability or refusals should be documented each time it occurred. During interview on 7/30/25, at 3:13 p.m. R17 stated the staff did not ask her to do exercises very often and there were times when she was asked and refused them. She felt the staff asked her about exercises when she was in the middle of working on her computer games and then she refused. They never offered to come back at a later time, and she never asked them to come back either as they were always so busy. R17 stated staff never offered exercises very often anyway. It would be nice if they offered it daily, but they did not. The most staff came in and offered was one or two times per week. Some weeks they did not offer exercise at all. A policy for restorative nursing was requested, however, none were received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide medications as ordered for 1 of 5 residents (R11) reviewed for medication management. Findings include: R11's admission Minimum Data Set (MDS) dated [DATE], identified R11 had moderate impaired cognition and had an indwelling catheter. Diagnoses included cystitis, retention of urine., atrial fibrillation, and peripheral venous insufficiency. R11's Physician Orders dated 6/9/25, included furosemide (a diuretic to treat fluid retention) 40 milligrams (mg) to give for a 3 pound (lb.) weight gain overnight. The medication was to be given once in the morning as needed (PRN) and daily weights were to be obtained once in the mornings to give PRN furosemide, if R11 gained three pounds (lb.) in one day. R11's June 2025 Medication Administration Record (MAR) and corresponding weights were reviewed from 6/1/25 to 6/30/25 and identified the following:On 6/23/25 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/22/25 was 181.9 lbs. and was 183 lbs. on 6/23, which was a weight gain of only 1 lb. 9 oz.On 6/26/25, 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/25/25 was 183.9 lbs. and was 184.9 lbs. on 6/26/25, which was 9 oz. gain.R11's July 2025 MAR, and corresponding weights were reviewed from 7/1/25 to 7/30/25 and identified the following:On 7/9/25, 40 mg of Lasix was given for for a five percent weight gain, however, R11's weight had not been recorded the day prior, and it could not be determined if R11 had a 3 lb. weight gain. On 7/29/25, at 6:47 p.m. R11 was observed to have swelling in both lower extremities. During interview on 7/30/25, at 9:14 a.m. registered nurse (RN)-B stated R11 had an order to administer furosemide if R11 had a weight gain of 3 lbs. or more in one day. The nurse was to document the weight on the resident's MAR as well as the administration of the PRN furosemide and its effectiveness. Some of the nurses would also document the weight and administration of the PRN medication in the resident progress notes. RN-B believed the furosemide administered on 6/23/25, 6/26/25 and 7/9/25, were given in error and she would fill out medication error reports for all three of the days. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated the nurse should have clarified the PRN furosemide order before administering the medication. They had identified it was the same nurse making the medication errors and had educated her on the intent of the order and the process for obtaining and evaluating R11's weights as well when the PRN furosemide was to be administered. On 7/30/25, at 2:45 p.m. a call was attempted to R11's primary physician, however, was not returned. During telephone interview on 7/30/25, at 3:30 p.m. the facility's consultant pharmacist (CP)-C stated although R11 did receive furosemide in error on three occasions it probably was not a significant medication error, especially because R11 did not have an order to receive scheduled regularly scheduled furosemide. It would be more significant if he did receive furosemide scheduled daily and then received additional doses in error because then it could affect some of his lab values such as sodium and potassium or would worry about dehydration. Because he only received it occasionally for weight gain over 3 lbs. the three additional doses spread out throughout the two months would not be clinically significant. The facility policy Medication Management dated 8/8/24, directed nursing staff prior to administration, a medication and dosage schedule on the MAR was to be compared with the medication label. For orders with physician parameters for administration, the nurse was to verify the medication met the ordered parameters (i.e. specific range or values of weight, blood pressure, pulse blood glucose, oxygen saturations, etc.).

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) recommendations during personal care for 1 of 1 residents (R11) reviewed who had a catheter. Findings include:A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.R11's admission Minimum Data Set (MDS) dated [DATE], identified R11 had moderate impaired cognition and required moderate to maximum assistance with dressing, and grooming and supervision with bed mobility, transfers. R2 had an indwelling catheter. Diagnoses included cystitis and retention of urine. R11's care plan dated 7/22/25, identified R11 had an indwelling catheter due to urinary retention and required enhanced barrier precautions (EBP) during high contact cares. On 7/29/25, at 1:27 p.m. R11's room was observed from the hallway which had an orange-colored sign posted on the door which read Enhanced Barrier Precautions . Providers and staff must also: Wear gloves and gown for the following high contact resident care activities . dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assistance with toileting .the signage was provided from the CDC. Inside the room, a hard plastic cart with drawers with gowns and other PPE supplies was located inside R11's bathroom. During observation on 7/29/25, at 6:47 p. m. nursing assistant (NA)-B was assisting R11 to prepare for bed. R11 was lying on his bed and NA-B was at R11's bedside. NA-B was not wearing a disposable gown. NA-B obtained a wash basin with warm water and washcloth from R11's bathroom and donned disposable gloves, NA-B did not put on a disposable gown. NA-B opened R11's brief and preceded to wash R11's groin and peri area. NA-B leaned over the bedside while washing and NA-B's uniform touched R11's bed and upper thigh, while washing the groin area. NA-B finished washing and drying R11's peri area, removed his gloves and called for the nurse on his walkie. Registered nurse (RN)-D entered R11's room and put on gloves. RN-D did not put on a disposable gown. RN-D manipulated R11's catheter near the tip of the penis, pulled R11's foreskin back and instructed NA-B to continue to try to wash the cream off of R11's groin, stating R11 had a lot of cream build up in the area. RN-D removed her gloves, applied alcohol-based hand sanitizer (ABHR) to her hands and exited the room. NA-B donned disposable gloves and without gowning, continued to wash and then dry R11's groin and peri are. NA-B, after removing their gloves called for the nurse on the walkie. RN-D entered R11's room, donned disposable gloves, but did not don a disposable gown, and applied the prescription cream to R11's groin and penis. RN-D removed her gloves, applied ABHR to her hands and exited the room. After cleaning up the bedside, NA-B washed his hands, put on a disposable gown and donned gloves. NA-B stated he was donning the disposable gown because he planned to drain R11's catheter. NA-B emptied R11's catheter, rinsed and put away the urinal and removed his PPE.During interview on 7/29/25, at 7:38 p.m. NA-B stated he had not been instructed to wear PPE when assisting R11 with personal care, only when working with R11's catheter. NA-B reviewed the EBP signage located on R11's door, NA-B verified the sign instructed staff to wear gown and gloves when assisting the resident with bath, transfers, cares, dressing, grooming and personal care. NA-B stated he should have been wearing a gown and gloves when he assisted R11 to prepare for bed and that was his mistake, he had screwed up. When interviewed on 7/29/25, at 7:39 p.m. RN-D verified she had manipulated R11's catheter near his penis and put on prescribed cream without donning a disposable gown. RN-D stated R11 was on EBP and she should have had a gown on when she assisted with R11's care. It was important to wear a gown and gloves when providing personal care when a resident was under EBP to prevent staff from bringing the germs out into the facility and to protect the other residents. She had not realized NA-B was not wearing a gown when providing care to R11 either and he should have been wearing one as well. During interview on 7/30/25, at 9:21 a.m. RN-E stated she was in