STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gables of Boutwells Landing	13575 58th Street North Oak Park Heights, MN 55082

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, interview, and document review, the facility failed to ensure milk was not in use past the use by date, refrigerated items were labeled and dated, and maintain cleanliness of ceiling vent, refrigerator, and freezers in the main kitchen. Furthermore, the facility failed to ensure beard nets were used in food preparation and service areas. This had the potential to affect all residents who received food from the facility kitchen. Findings include: An observation on 6/8/26 at 11:19 a.m., the main kitchen was observed. A walk-in storage freezer was observed to have boxes stored on the floor and several frozen tater tots scattered across one corner of the freezer floor. A refrigerator used for some of the independent living residents contained a tray of portion cups containing tartar sauce that were undated. The bottom shelf of this refrigerator was dirty and filled with crumbs and food debris. A walk-in freezer in the main kitchen area was found to have sticky floors and several frozen sausage links scattered on the floor. A walk-in refrigerator in the main kitchen had a tray of red sauce in portion cups. The cups were not labeled or dated for when they were filled. A Ziplock bag of what appeared to be sliced meat was on the shelf with a date of 5/6. The meat appeared to have a grayish white tint to it. Another Ziplock bag containing seasoned meat was in a container with no label or date on it. Cook-A was seen wiping off counters in the food prep area. He had a short, trimmed beard that was not covered. A ceiling vent above just to the right of the main stove had brown/black dust/dirt on it. When interviewed on 6/8/26 at 11:45 a.m., the Dietary Director (DD) verified the observations of the undated/unlabeled food items, food spilled on the floor of the freezers, dirty ceiling vent and lack of beard net. DD further stated the sliced meat didn't have a good color. DD expected all food items to be labeled and dated when stored, freezers, refrigerators and vents to be cleaned, and beard nets to be worn if applicable.An observation on 6/8/26 at 12:30 p.m., the 3rd floor kitchenette was observed. The small refrigerator in the serving area by the steam table contained 2 half gallons of [NAME] skim milk. A full unopened container had a best by date of 6/7/26. An opened container with approximately 1/2 cup left had a best by date of 6/6/26. Cook-B was working on the serving side of the kitchenette where the steam table was. [NAME] had a medium length beard and was not wearing a beard net. An interview on 6/8/26 at 12:35 p.m., nursing assistant (NA)-E verified the milk in the refrigerator and stated, those should be tossed. NA-E said it was unknown how many residents drank skim milk but had not served any to their group today. NA-E further stated the cooks checked for dates on items in the fridge in the mornings. An interview on 6/8/26 at 12:43 p.m., Cook-B was the afternoon cook, and stated the morning cooks should have reviewed the items in the fridge that morning. If items are past their dates, they should be thrown out. Cook- B was not sure if he needed a beard net and further stated he was not sure where to find them.A follow up interview on 6/9/26 at 9:05 a.m., DD stated the morning cooks were expected to review items in the service refrigerators in the mornings and discard any items out of date. DD further stated beard nets were expected to be worn in the unit serving kitchens as well as the main kitchen. An interview on 6/10/26 at 11:15 a.m., the administrator stated staff were expected to ensure all food items were dated and labeled when stored and refrigerators were reviewed and items thrown out if past their dates. Staff were expected to use beard nets when (continued on next page)

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 - Many	in the kitchen and serving areas. Furthermore, refrigerators, freezers and ceiling vents should be clean. A facility policy titled Labeling and Dating Policy revised 8/2019, directed staff to label and date foods that are opened or prepared with the name of the product (if not in the original container), when opened or prepared or when must be used by. Foods that are not marked will be discarded. A facility policy titled Safe Food Storage revised 5/219, directed staff to keep all food items stored on shelves at least 6 inches from the floors and label, date and properly cover all food items upon opening.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review, the facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident (R126) reviewed for self-administration of medications. Findings include: R126's admission Minimum Data Set (MDS) dated [DATE], indicated R126 was cognitively intact. R126's diagnoses included compression fracture of the spine with routine healing, epilepsy (seizures), and gastroesophageal reflux disease (GERD) (heartburn).R126's physician orders dated 5/28/26, included Calcium Carbonate (Tums) 500 milligrams (mg), two tablets by mouth every four hours as needed for heartburn or upset stomach. R126's provider orders lacked indication R126 was able to self-administer medication.R126's comprehensive nursing data collection dated 5/28/26, indicated R126 had not brought medications with upon admission. The assessment further indicated R126 did not choose to self-administer medications.R126's care plan dated 6/1/26, indicated R126 chose not to self-administer medications. Interventions directed staff to administer medications as ordered.R126's medical record lacked indication R126 had been assessed to self- administer medications. During an observation and interview on 6/8/26 at 2:17 p.m., a container of Tums was observed on R126's bedside table. R126 stated the resident's family brought the medication to the facility. R126 stated he wanted Tums available because he had not received them when requested during a previous hospitalization.During an interview on 6/8/26 at 3:50 p.m., registered nurse (RN)-B confirmed that R126 had a container of Tums on his bedside table. RN-B further confirmed no self-administration of medication assessment had been completed. (RN)-B further stated if a resident was to self administer medications, an order and assessment were to be completed. During an interview on 6/10/26 at 8:07 a.m., the Director of Nursing (DON), stated when residents wished to self-administer medications, the facility's process required physician notification, completion of a nursing assessment, physician authorization, and care plan interventions to support safe self-administration. The DON stated this process was important to promote resident autonomy while ensuring medications were managed safely.The facility's policy titled, Self-Administration of Medication Policy dated 11/2016, directed staff to assess the resident's ability to safely self-administer medications prior to allowing medications to be kept at the bedside.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure call lights were within reach for residents who were dependent on staff assistance for 3 of 4 residents (R106, R24, and R9) reviewed for call light accessibility. Findings include: R106 R106's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, no behaviors or rejection of care. two falls since prior assessment, one with major injury, and that she required partial to moderate staff assistance for toileting hygiene, lower body dressing, sit to stand ability and chair/bed to chair transfers. R106 required partial/moderate staff assistance in her manual wheelchair to propel 50 feet and make two turns. Diagnoses included blindness and anxiety. R106's care plan intervention dated 5/20/26, identified due to limited physical ability assist of one staff was required for stand and pivot transfers. The care plan did not identify wheelchair mobility. R106 care plan intervention dated 1/15/26, identified to place call light within reach and answer promptly. Two call lights were in her room for safety. R106's nursing assistant (NA) Communication Sheet dated 6/8/26, identified she was at risk for falls and was one assist for pivot transfers. The bottom of the NA Communication Sheet identified to assure call light was within reach as indicated. During an observation on 6/8/26 at 12:11 p.m., R106 was seated in her wheelchair at the dining room table in her private room and no call light was within reach. One call light was observed on her bed which was about 7 feet away, and another call light was in the bathroom out of reach. Registered nurse (RN)-A brought R106's afternoon meal to her dining room table in R106's room and left without ensuring the call light was within reach. RN-A left the room and R106 began to eat her meal alone. During an observation and interview on 6/8/26 at 12:21 p.m., family member (FM)-A entered R106's room. FM-A stated upon entering the room, R106 had already moved her wheelchair away from the dining room table and was trying to self-propel toward the other side of her room. FM-A agreed that R106's call light should have been within reach at her dining room table because she had numerous falls and declining health. A hospice consult was in progress. FM-A assisted R106 into bed and put her call light within reach. During an observation on 6/9/26 at 8:04 a.m., R106 activated her own call light which was within reach in bed and pulled herself to a seated position at the edge of her bed. R24 R24's quarterly MDS dated [DATE], identified moderately impaired cognition, no behaviors or rejection of care, substantial/maximal staff assistance was required for toileting hygiene, lower body dressing, and chair/bed to chair to bed transfers. Partial/moderate assistance was required for sit to stand ability. R24 required partial/moderate staff assistance in her manual wheelchair to propel 50 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feet and make two turns. Diagnoses included non-traumatic brain dysfunction and arthritis. R24's care plan intervention dated 11/24/25, identified to ensure/provide a safe environment and to ensure her call light was within reach and encourage her to use it for assistance. R24's care plan intervention dated 5/26/26, identified she could transfer and ambulate with one staff assist, gait belt and rolling walker (RW). She required two staff for bed mobility. The care plan did not address wheelchair mobility. R24's NA Communication Sheet dated 6/8/26, identified she was at risk for falls, transferred with one assist and wheeled walker and to ensure the call light was within reach in the chair and bed. During an observation on 6/8/26 at 3:27 p.m., R24 was seated in her wheelchair in her room between the bed and the room door. No call light was within reach. The call light was observed on the other side of the bed and underneath the blanket. At 3:30 p.m., RN-A was asked by surveyor to assist R24 with her call light. RN-A entered R24's room took the call light and placed it within R24's reach. RN-A stated a volunteer from activities may have brought R24 to her room and not put the light in place. Even though R24 might not always use her call light but it should be within reach. During an interview together on 6/10/26 at 8:40 a.m., activities (A)-A stated after a resident is brought back to their room after an activity, facility staff and volunteers were trained to place call lights within reach. (A)-B stated they would also send a notification over the walkie-talkies to nursing staff and let them know residents were on their way back to their rooms. During an interview on 6/9/26 at 12:48 p.m., NA-C stated call lights should be placed within arm's reach of residents so they can call for help easily. During an interview on 6/10/26 at 9:28 a.m., NA-D also stated even if a resident was independent with room mobility, staff should still ensure the call light was in an easily reachable area. During an interview on 6/10/26 at 9:40 a.m., trained medication assistant (TMA)-A stated call lights should be placed within arm's length of a resident. R9 R9's annual MDS dated [DATE], indicated severely impaired cognition and diagnoses of multiple sclerosis, dementia, muscle weakness and repeated falls. It further indicated R9 was dependent on staff with toileting, transfers, and had one fall with no injury prior to admission/readmission. R9's care plan dated 11/20/23, indicated R9 was at risk for falls related to physical weakness, history of falls, MS, hypertension, renal disease, neurogenic bladder with history of urinary tract infection (UTI), depression and dementia. R9 was known to self-transfer in and out of bed. It further indicated an intervention to place the call light within reach and answer it promptly if on. I'm known not to use my call light due to cognition and impulses. During observation on 6/10/26 at 8:25 a.m., R9 was in bed sleeping and his call light was coiled up neatly hanging on the wall by the foot of his bed. R9's call light was not within reach. During observation and interview on 6/10/26 at 8:33 a.m., nursing assistant (NA)-B stated R9 sometimes used his call light and that the residents call lights should be within their reach. NA-B also (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified R9's call light was not within reach and was coiled up on the wall stating R9 must have thrown it up there. During observation and interview on 6/10/26 at 8:36 a.m., registered nurse (RN)-C stated they hadn't ever noticed R9 use his call light, but it should still be within reach. RN-C further stated the call lights should be within the resident's reach even if they had issues with their cognition and also verified R9's call light was coiled up on the wall and out of his reach. RN-C stated R9 was probably able to throw the call light, but he wouldn't have been able to put it up there so neatly. During interview on 6/10/26, at 8:40 a.m., RN-D stated call lights should be placed within reach even if the resident didn't always use it or had issues with their cognition. During interview on 6/10/26 at 8:42 a.m., RN-F stated all call lights should be within reach even if the resident had issues with their cognition or they didn't use the call light on a regular basis. During interview on 6/10/26 at 10:47 a.m., the director of nursing (DON), stated before nursing staff exited a resident's room, they should ensure their call light was within reach. If the resident moved independently after they placed the call light next to them, they can't help that, but they would put the call light within reach again when they were rounding. The DON further stated if a resident was unable to use the call light due to cognition, the call light should be removed as an intervention on their care plan. The facility policy regarding call lights dated November of 2022, indicated the following procedure for call light use: 1. All facility personnel must be aware of call lights at all times.2. Answer all call lights promptly whether or not you are assigned to the resident.3. See manufacturer's instructions for turning off the call light and managing the call light system.4. Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as possible.5. Position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light when needed.a. Ensure the call light is accessible to the resident while in their bed or other sleeping accommodation in their room (e.g., recliner).b. Ensure the call light is accessible to the resident if they were lying on the floor near the toilet, bath or shower.6. Orient all new residents to the call light as appropriate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide setup meal assistance for 1 of 2 residents (R28) reviewed for activities of daily living (ADLs). Findings include:R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 had severe cognitive impairment, required setup or clean up assistance with eating, and substantial/maximal assistance with mobility. R28's diagnoses included non-traumatic brain dysfunction (an alteration in brain function caused by internal factors such as illness, oxygen deprivation, or toxic exposure), dementia, and Alzheimer's disease. R28's care plan last reviewed 4/2/26, indicated R28 had ADL self-care performance deficit related to her diagnoses and that she was independent with eating after setup. During interview on 6/8/26 at 12:22 p.m., family member (FM)-A stated R28 required assistance with meals and needed to have her silverware placed out, otherwise she would eat with her fingers. During observation on 6/9/26 at 8:56 a.m., nursing assistant (NA)-A entered R28's room and assisted her to a sitting position on the edge of her bed. NA-A explained she was going to assist with a transfer to her chair. R28 refused to transfer. NA-A explained it was time for breakfast and left to retrieve R28's breakfast tray. During observation on 6/9/26 at 9:20 a.m., R28 was still sitting on the side of her bed with the bedside table approximately three feet away and at a 45 degree angle from R28. All items on the tray were covered and the silverware still rolled up in the napkin. During continuous observation between 9:20 a.m. and 9:39 a.m., NA-A walked past R28's room several times, looked in the room but did not enter, and did not offer to set up R28's meal. During observation on 6/9/26 at 9:39 a.m., housekeeper (H)-A walked by and stopped at R28's doorway. H-A entered and pushed the tray table over and positioned it in front of R28 who was still sitting on the edge of her bed. H-A uncovered her food and beverage, heated up the plate in the microwave, and unrolled the silverware. R28 immediately picked up the juice and began drinking and then proceeded to eat her breakfast independently. During interview on 6/9/26 at 9:41 a.m., H-A stated she had noticed R28's tray table and breakfast were not within her reach and had not been set up for her. H-A stated she heated up R28's meal and opened everything up for her. During observation on 6/9/26 at 10:04 a.m., R28 was done with breakfast and she had eaten approximately 75% of the eggs and 90% of what appeared to be French toast. R28 had not touched the bowl of fruit, but drank approximately 25% of both the milk and juice. During interview on 6/9/26 at 10:28 a.m., NA-A stated R28 could eat independently after everything was set up for her. NA-A stated if the lids were not removed from the food and beverages, she often would not know what to do and would not eat. During interview on 6/9/26 at 11:35 a.m., registered nurse (RN)-A stated would expect R28 to have her meal set up for her with lids removed and the tray table in front of her and within reach when the meal was delivered. RN-A stated this was the responsibility of nursing, and not housekeeping to ensure the resident was set up appropriately for a meal. RN-A stated R28 should be seated in a wheelchair or recliner for her meals when she was eating in her room, but she often refused. During interview on 6/10/26 at 11:14 a.m., director of nursing (DON) stated would expect a resident who required meal setup assistance would have their tray set up appropriately and within reach. Facility policy Meal Tray Delivery Policy - Care Center dated 7/2020, indicated, Assistance with tray set up and uncovering food items will be provided as needed.and Items will be placed so they are convenient for the individual and neatly arranged.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure 2 of 2 residents (R7, R9) with perimeter mattresses were assessed for safety. Findings include: R7R7's significant change Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia, reduced mobility and muscle weakness. It further indicated R7 required partial assistance with bed mobility (roll left and right), substantial assistance with lying to sitting on the edge of the bed, sitting to standing, and transfers.R7's care plan dated 2/13/24, indicated R7 had limited physical mobility related to dementia with mood disturbance and anxiety, [NAME] disease (genetic muscle disorder), spinal stenosis, and osteoarthritis. It further indicated an intervention of a perimeter mattress to assist R9 in finding the edges of her bed for bed mobility. R7's Mobility, Physical Device, and Fall Risk assessment dated [DATE], lacked documentation of an assessment for a perimeter/defined edge mattress. R9 R9's annual MDS 4/21/26 indicated severely impaired cognition and diagnoses of dementia, multiple sclerosis (MS), and repeated falls. It further indicated partial to moderate assistance with bed mobility and one fall with no injury prior to admission/readmission. R9's care plan dated 11/20/23, indicated R9 had limited physical mobility related to physical weakness, history of falls, incontinence, hypertension, renal disease, dementia, MS, depression and delusional disorder. It further indicated an intervention to use a bariatric sized bed with a perimeter mattress to define the edges of the bed. R9's Mobility Physical Device and Fall Risk assessment dated [DATE], lacked documentation of an assessment for a perimeter/defined edge mattress. During observation on 6/10/26 at 8:25 a.m., R9 was in bed asleep and had a perimeter mattress.During interview on 6/10/26 at 7:35 a.m., registered nurse (RN)-C stated they were unsure if a resident needed a physician's order or an assessment in order to have a perimeter mattress. During interview on 6/10/26 at 7:48 a.m., RN-D stated in order for a resident to use a perimeter mattress, they would need a doctor's order and an assessment. During interview on 6/10/26 at 8:47 a.m., RN-A stated they typically don't give out perimeter mattresses to residents, but one of the main reason's was so they can feel the edges of the bed, so they don't fall. They are never used to keep a resident in bed. Before a resident was permitted to use a perimeter mattress, the interdisciplinary team (IDT) would review the situation (Ex: fall), and engineering would check to make sure the resident was the appropriate size for the mattress. The nurse was also required to fill out a safety assessment. During an interview on 6/10/26 at 8:15 a.m. RN-F stated in order for a resident to be able to use a perimeter mattress, IDT would need to decide if it was appropriate (in order to ensure it wasn't used as a restraint), and maintenance would need to do an assessment for the entrapment zone which should also be done yearly. During a follow up interview at 8:42 a.m., RN-F stated the engineering department fills out the assessments. During interview on 6/10/26 at 9:54 a.m. the director of nursing (DON) stated in order for a resident to be able to use a a perimeter mattress, IDT would meet to discuss the situation and if they felt the resident needed it, they would put a TELS request (work order) in for the engineering department. The engineer ensures the perimeter mattress meets all the requirements. Then a clinical manager would be responsible for completing a Mobility Physical Device and Fall Risk Assessment to ensure it meets the resident's needs and is safe to use. These assessments are tracked on quarterly basis and through MDS assessments. The DON verified R7's last assessment was completed on 4/11/24 and R9's was on 4/23/24 and that both lacked documentation of an assessment for a perimeter/defined edge mattress. The facility policy titled Physical Device Assessment Policy dated November of 2022, indicated upon admission, with significant change, annually or the implementation of a new device, the resident will be assessed for physical devices. The assessment will be reviewed quarterly. The assessment includes but is not limited to an assessment of symptoms, ability to use the device, and potential risk and benefit.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper infection control practices involving hand hygiene and glove use during incontinent care for 1 of 1 resident (R8) observed during cares. Findings include:R8's annual Minimum Data Set (MDS) dated [DATE], indicated R8 had moderately impaired cognition, had an indwelling urinary catheter, was frequently incontinent of bowel, required a feeding tube, and was dependent on staff for all personal care. R8's diagnoses included benign neoplasm of meninges (tumors in the protective membranes of the brain and spinal cord), chronic kidney disease, dysplasia (difficulty swallowing), aphasia (condition affecting speech), dependance on supplemental oxygen, and history of nontraumatic intracerebral hemorrhage (brain bleed not due to injury). R8's care plan dated 4/2/26, indicated R8 had a suprapubic catheter (tube directly through the skin into the bladder for draining), was incontinent of bowel, had a G/J (gastrojejunostomy) tube to receive nutrition, received supplemental support via nasal cannula, was at risk of infections, and required enhanced barrier precautions in addition to standard precautions during high-contact resident care activities. During observation and interview on 6/9/26 at 10:54 a.m., nursing assistant (NA)-B and NA-A entered R8's room to perform incontinent care. Both NAs performed hand hygiene, donned gloves and a gown prior to entering room. NA-B removed R8's brief and cleaned front peri area with premoistened wipes. R8 was then positioned on left side facing NA-A while NA-B wiped his bottom and removed the dirty brief. NA-A called for the nurse for a skin check and medication application to bottom. While waiting for the nurse, R8 was repositioned on his back and covered up. At 11:04 a.m., registered nurse (RN)-A entered with appropriate PPE (personal protective equipment). No glove change had been completed by either NA. R8 was repositioned on left side, NA-B used same gloved hands to reposition while touching R8's bare skin. R8 continued to have active soft bowel movement (BM). RN-A used wipes to clean the BM. NA-B took over incontinent care and cleaned the large amount of BM that continued to ooze out. NA-B removed all the soiled wipes, under pad, and draw sheet and placed soiled items in bags. NA-B did not change gloves and picked up the package of wipes to set aside, grabbed a new brief and opened a new package of chux (under pad) and grabbed several while RN-A applied ointment to R8's bottom. Again, R8 was repositioned with assistance from NA-B using same gloved hands touching R8's exposed legs and back bare skin. NA-B used same gloved hands to rip a slit in the new brief to fit around the suprapubic catheter insertion site just over the dressing. NA-B then situated R8. NA-B handled the catheter tubing, touched and pulled at sheet on all sides of the sheet, adjusted the oxygen tubing and the feeding tube tubing. At 11:20 a.m., NA-B removed his gloves and donned new ones, without performing hand hygiene and then retrieved a graduate cylinder. NA-B emptied R8's catheter bag. When asked, NA-B stated that was the first time during all of R8's cares that he had changed his gloves and confirmed he did not perform any hand hygiene in between glove change. NA-B further stated he had used the same gloves to reposition and touch other items after cleaning the BM from R8. NA-B stated he should have changed his glove and performed hand hygiene after incontinent care and prior to touching any other items. During interview on 6/9/26 at 11:25 a.m., registered nurse (RN)-A stated NA-B should have changed gloves after incontinent care and hand hygiene should have been performed and new gloves donned. During interview on 6/10/26 at 11:14 a.m. director of nursing (DON) stated expectation for staff to change gloves and perform hand hygiene when working from soiled to clean areas during incontinent care. Facility policy Infection Control Standard Precautions dated 2020, indicated, Appropriate hand hygiene is essential in preventing transmission of infectious agents. Hand Hygiene includes hand washing with soap and water and hand hygiene with alcohol-based hand rub (ABHR).Hand hygiene continues to be the primary means of preventing the transmission of infections. The policy further indicated, Hand Hygiene should be performed.Before donning [PPE] and After removing [PPE].