STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285148	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	2242 Wright Street Blair, NE 68008

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(S)Based on observation and interview; the facility staff failed to ensure privacy during care for 1 (Resident 2) of 3 sampled residents. The facility staff identified a census of 66. Findings are:A record review of Resident 2's Clinical Resident profile revealed they were admitted to the facility on [DATE].A record review of Resident 2's Minimum Data Set (MDS - a federally mandated standardized assessment tool used in Medicare and Medicaid certified nursing homes to evaluate a resident's functional capabilities, health needs and clinical status) revealed Resident 2 had a Brief Mental Status Interview (BIMS - a mandatory evaluation tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) of 5, indicating they were severely cognitively impaired.A record review of Resident 2's undated Care Plan revealed Resident had the following diagnoses: Lymphedema (a chronic condition causing fluid buildup and swelling in arm and/or legs), venous insufficiency (a long term condition where leg vein valves are damaged or weak preventing blood from flowing efficiently back to the heart), osteoarthritis (chronic degenerative joint disease causing pain in both hips, right hand), rheumatoid arthritis (a chronic systemic disease where the immune system attacks the lining of the joints causing inflammation, stiffness and potential bone deformity), open wound of left buttock, open wound of right buttock, open wound to left lower leg, open wound right lower leg, open wound left thigh, pressure ulcer of right heel, pressure ulcer of left heel, cognitive communication deficit (impaired communication due to cognitive issues relating to memory and attention), severe protein calorie malnutrition (a condition resulting from inadequate intake of protein and calories), and metabolic encephalopathy (a brain dysfunction caused by systemic illness, organ failure or chemical imbalances). A record review of Resident 2's undated Care Plan revealed Resident 2 had actual skin impairment with moisture associated skin damage (MASD) to both buttocks, unstageable pressure ulcer (a severe full-thickness wound where the base is completely hidden by necrotic tissue and the true depth cannot be assessed) to the left heel, Stage 3 pressure injury (a severe, full thickness skin loss appearing as a deep crater like wound) to right lateral foot, right middle lower leg, back left of left lower leg, Stage 1 pressure injury (localized skin injury that does not change color on pressure relief but the skin is intact) right lateral hip, Stage 3 pressure injury right root and a Stage 3 pressure injury to the right hip. A record review of Resident 2's orders summary revealed the following order: Right posterior (further back in position) hip/left posterior hip: Cleanse with saline, apply triad paste (a sterile zinc-oxide paste wound dressing paste) to wound and peri wound (around the edges of the wound), apply silver alginate (a wound dressing made from calcium alginate from seaweed and silver ions), to wound bed, cover with silicone superabsorbent dressing (a bordered foam dressing), change daily and prn (as needed) one time a day.An observation on 3/3/26 at 8:05 AM of wound care performed by Registered Nurse (RN) A for Resident 2 revealed the following. Resident 2's bed was low to the floor with a fall mat placed to the left of the bed. Resident 2 was lying on their left side. A privacy curtain was not present in the residents room. During the provision of Resident 2's wound care, Resident 2's roommate was seated at the side of their bed eating their breakfast. Resident 2 was lying on their left side with their buttocks exposed to the air. Resident 2's roommate commented (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to Resident 2 nice butt. Resident 2 and RN A laughed and RN A covered Resident 2 with a blanket.An interview on 3/3/26 at 8:20 AM with RN A confirmed Resident 2's room did not have a privacy curtain and that it had been gone for a few weeks. RN A confirmed Resident 2's roommate was able to see all personal and wound care Resident 2 received. RN A confirmed this was a breach of privacy and dignity for Resident 2.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1)Based on observation, interview and record review the facility failed to ensure two of three medical air mattresses for pressure relief (mattresses designed to prevent and treat bedsores by inflating/deflating air cells to redistribute pressure and improve circulation) were inflated in accordance with the residents' weight (Resident 2 and Resident 3). The facility had a census of 66. Findings are:A.A record review of Resident 2's Clinical Resident profile revealed they were admitted to the facility on [DATE].A record review of Resident 2's Minimum Data Set (MDS - a federally mandated standardized assessment tool used in Medicare and Medicaid certified nursing homes to evaluate a resident's functional capabilities, health needs and clinical status) revealed Resident 2 had a Brief Mental Status Interview (BIMS - a mandatory evaluation tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) of 5, indicating they were severely cognitively impaired.A record review of Resident 2's undated Care Plan revealed Resident had the following diagnoses: Lymphedema (a chronic condition causing fluid buildup and swelling in arm and/or legs), venous insufficiency (a long term condition where leg vein valves are damaged or weak preventing blood from flowing efficiently back to the heart), osteoarthritis (chronic degenerative joint disease causing pain in both hips, right hand), rheumatoid arthritis (a chronic systemic disease where the immune system attacks the lining of the joints causing inflammation, stiffness and potential bone deformity), open wound of left buttock, open wound of right buttock, open wound to left lower leg, open wound right lower leg, open wound left thigh, pressure ulcer of right heel, pressure ulcer of left heel, cognitive communication deficit (impaired communication due to cognitive issues relating to memory and attention), severe protein calorie malnutrition (a condition resulting from inadequate intake of protein and calories), and metabolic encephalopathy(a brain dysfunction caused by systemic illness, organ failure or chemical imbalances). A record review of Resident 2's undated Care Plan revealed Resident 2 had actual skin impairment with moisture associated skin damage (MASD) to both buttocks, unstageable pressure ulcer (a severe full-thickness wound where the base is completely hidden by necrotic tissue and the true depth cannot be assessed) to the left heel, Stage 3 pressure injury (a severe, full thickness skin loss appearing as a deep crater like wound) to right lateral foot, right middle lower leg, back left of left lower leg, Stage 1 pressure injury (localized skin injury that does not change color on pressure relief but the skin is intact) right lateral hip, Stage 3 pressure injury right root and a Stage 3 pressure injury to the right hip. A record review of the undated care plan include the following intervention (actions taken to improve a situation): Air mattress: Ensure mattress is inflated and functioning properly.A record review of Resident 2's order summary revealed the following order dated 11/04/2025:Air mattress. Ensure mattress is inflated and functioning properly, two times a day for Monitoring A record review of Resident 2's weight record on 3/3/2026 revealed Resident 2 weighed 154.3lbs An observation on 3/3/2026 at 8:00 AM of Resident 2's bed revealed Resident 2 had an air pressure relieving mattress set at 180lbs.An interview on 3/3/2026 at 8:20 AM with Registered Nurse A (RN) RN A confirmed the pressure on the air mattress was set at 180lbs. RN A confirmed a pressure relieving air mattress should be calibrated in accordance with the individuals weight. RN A confirmed Resident 2 weighed was154.3lbs and the air pressure mattress was set at the incorrect pressure for Resident 2's weight. RN A confirmed an incorrectly set mattress could contribute to skin breakdown for Resident 2.B.A record review of Resident 3's Clinical Resident Profile sheet revealed Resident 3 was admitted to the facility on [DATE].A record review of Resident 3's weights revealed Resident 3's weighed 196.9lbs. A record review of Resident 3's Minimum Data Set, dated [DATE] (MDS - a federally mandated standardized assessment tool used in Medicare and Medicaid certified nursing homes to evaluate a resident's functional capabilities, health needs and clinical status) revealed Resident had a Brief Interview for Mental Status (BIMS - a mandated evaluation tool used to screen (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and identify the cognitive condition of residents upon admission into a long term care facility) of 11 indicating Resident 3 was moderately cognitively impaired (the resident may need assistance with daily activities, experience or memory but is not considered severely impaired). A record review of Resident 3's undated care plan revealed Resident 3 has the following diagnoses: Type 2 diabetes, previous fracture of the shaft of the right tibia, spinal stenosis (a narrowing of the spinal canal), polyneuritis (inflammation and damage of multiple peripheral nerves causing widespread numbness, burning pain and weakness), arthropathy (any disease affecting the joints causing pain, inflammation, swelling and reduced range of motion), osteoarthritis (a chronic degenerative joint disease caused y the breakdown of protective cartilage.A record review of Resident 3's care plan revealed Resident 3 had a Stage 3 Pressure Injury (a severe, full-thickness skin loss causing a deep, crater like wound) to the right buttock.A record review of Resident 3's skin observation notes by the Assistant Director of Nursing (ADON) and dated 01/05/2026, revealed the following: right buttock 3.3cm x 3cm x 0.2cm (measurement) no s/s(signs or symptoms) of infection tx(treatment) in place Type of impairment: pressure injury. A record review of Resident 3's care plan revealed the following intervention: Air Mattress dated 01/28/2025.An observation on 3/3/26 at 10:55 AM revealed Resident 3 had a pressure relieving air mattress which was set at Maximum inflation of 380lbs. An interview on 3/3/26 at 10:55 AM with RN A confirmed Resident 3's pressure relieving air mattress was set at the maximum inflation setting of 380lbs and should have been set according to Resident 3's weight. RN A confirmed the incorrect inflation of the mattress could contribute to skin breakdown for Resident 3.

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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** Licensure Reference Number 175 NAC 12-006.18Based on observation and interview, the facility failed to ensure that wound care was being provided to residents in a manner that would prevent cross contamination of the wounds for 3 of 3 residents surveyed (Residents 2, 3 and 4). The facility had a census of 66. Findings are:A. A record review of the facilities Infection Control Guidelines for all Nursing Procedures, revised April 2013, revealed the following: Employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:After handling items potentially contaminated with blood, body fluids or secretions In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, used an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations:Before and after direct contact with residents;A record review of the facility's undated Handwashing policy revealed the following guidelines:After handling used dressings, specimen containers, contaminated linens, etc. After contact with blood, oral secretions, mucous membranes, broken skin, etc.After handling items or work surfaces potentially contaminated with blood, excretions or secretions. B. A record review of Resident 2's Clinical Resident profile revealed they were admitted to the facility on [DATE].A record review of Resident 2's Minimum Data Set (MDS - a federally mandated standardized assessment tool used in Medicare and Medicaid certified nursing homes to evaluate a resident's functional capabilities, health needs and clinical status) revealed Resident 2 had a Brief Mental Status Interview (BIMS - a mandatory evaluation tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) of 5, indicating they were severely cognitively impaired.A record review of Resident 2's undated Care Plan revealed Resident had the following diagnoses: Lymphedema (a chronic condition causing fluid buildup and swelling in arm and/or legs), venous insufficiency (a long term condition where leg vein valves are damaged or weak preventing blood from flowing efficiently back to the heart), osteoarthritis (chronic degenerative joint disease causing pain in both hips, right hand), rheumatoid arthritis (a chronic systemic disease where the immune system attacks the lining of the joints causing inflammation, stiffness and potential bone deformity), open wound of left buttock, open wound of right buttock, open wound to left lower leg, open wound right lower leg, open wound left thigh, pressure ulcer of right heel, pressure ulcer of left heel, cognitive communication deficit (impaired communication due to cognitive issues relating to memory and attention), severe protein calorie malnutrition (a condition resulting from inadequate intake of protein and calories), and metabolic encephalopathy (a brain dysfunction caused by systemic illness, organ failure or chemical imbalances). A record review of Resident 2's undated Care Plan revealed Resident 2 had actual skin impairment with moisture associated skin damage (MASD) to both buttocks, unstageable pressure ulcer (a severe full-thickness wound where the base is completely hidden by necrotic tissue and the true depth cannot be assessed) to the left heel, Stage 3 pressure injury (a severe, full thickness skin loss appearing as a deep crater like wound) to right lateral (to the side) foot, right middle lower leg, back left of left lower leg, Stage 1 pressure injury (localized skin injury that does not change color on pressure relief but the skin is intact) right lateral hip, Stage 3 pressure injury right root and a Stage 3 pressure injury to the right hip. A record review of Resident 2's orders summary revealed the following order: A record review a physician order dated 2/27/26 revealed the following information: Right posterior (further back in position) hip/left posterior hip: Cleanse with saline, apply triad paste (a sterile zinc-oxide paste wound dressing paste) to wound and peri wound (around the edges of the wound), apply silver alginate (a wound dressing made from calcium alginate from seaweed and silver ions), to wound bed, cover with silicone superabsorbent dressing (a bordered foam dressing), change daily and prn (as needed) one time a day.A record review of a skin/wound note dated 2/27/26 by the Assistant Director of Nursing revealed the following:Location: Right posterior (further back in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position) hip. Etiology (cause): Stage 3 PI (Pressure Injury) Measurements: 3.5cm x 2.9cm x 0.2cmWound Status: NewNew treatment orders received for right posterior and lateral (side) hip and right medial (medium) foot. Left posterior hip, right lateral foot, left heel, and right. heel treatments changed this week. Continue current treatments as ordered to all other areas. PCP (primary care provider) and POA (power of attorney) notified of status of areas and new orders.Author: Assistant Director of Nursing [e-SIGNED]An observation on 3/3/26 at 8:05 AM of wound care performed by Registered Nurse (RN) A for Resident 2 revealed RN A reviewed Resident 2's wound care orders and gathered the supplies needed for the treatment. RN A knocked on Resident 2's door and informed (gender) it was time for a dressing change. Resident 2 agreed and RN 2 placed paper towels on Resident 2's bedside table and placed the supplies on the towels. Resident 2's bed was low to the floor with a fall mat placed to the left of the bed. Resident 2 was lying on their left side. RN A used hand sanitizer and donned gloves. RN A pulled Resident 2's brief down on the right hip to expose a dressing. RN A removed the dressing and discarded it in the trash. RN A stated it needed a larger dressing, pulled Resident 2's brief up to cover the undressed and open wound and removed their gloves. RN A returned to the treatment cart and obtained a larger bordered foam dressing and returned to the room. RN A used hand sanitizer, donned clean gloves, and pulled Resident 2's brief down again to uncover the open area. RN A opened the 4x4 gauze packets and poured sterile water over them. RN A pushed the brief back from where it was touching the open wound with their right hand and wiped the wound with the wet gauze held in their right hand without using hand sanitizer or changing gloves. RN A discarded the gauze in the trash and realized they needed a cotton tipped applicator to apply the cream. Resident 2's roommate was seated at the side of their bed eating their breakfast. Resident 2's roommate commented to Resident 2 nice butt. RN A and Resident 2 laughed. RN 2 pulled Resident 2's blanket up to cover residents buttocks. Resident 2's blanket was touching Resident 2's undressed wound. RN 2 exited the room and reentered wearing gloves and carrying a cotton tipped applicator. RN A approached Resident 2's bed, pulled down their blanket, exposed Resident 2's buttocks again and used the cotton tipped applicator to apply the triad cream to the wound without removing their gloves, using hand sanitizer, or cleaning the wound again. RN A discarded their gloves, used hand sanitizer, donned clean gloves, and opened a packet of silver alginate dressing and applied it to the wound and then applied the large, bordered foam dressing. RN A dated and signed the dressing and pulled the resident brief up. RN A discarded their gloves and remaining supplies in the trash, used hand sanitizer, and exited the room.An interview on 3/3/26 at 8:20 AM with RN A confirmed they should not have entered the residents room wearing gloves and provided wound care while wearing those gloves. RN A confirmed they should have cleaned the wound again after Resident 2's blanket touched the uncovered wound. RN A confirmed they should not have touched the residents briefs and then cleaned the wound wearing the same gloves. RN A confirmed they should have used hand sanitizer and changed gloves when moving from a dirty area to a clean area. RN A confirmed Resident 2's brief should not have touched the open and undressed wound and Resident 2's blanket should not have touched the open wound and undressed wound. RN A confirmed these separate actions provided opportunities for cross contamination of the wound. C.A record review of Resident 3's Clinical Resident Profile sheet revealed Resident 3 was admitted to the facility on [DATE].A record review of Resident 3's Minimum Data Set, dated [DATE] (MDS - a federally mandated standardized assessment tool used in Medicare and Medicaid certified nursing homes to evaluate a resident's functional capabilities, health needs and clinical status) revealed Resident had a Brief Interview for Mental Status (BIMS - a mandated evaluation tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) of 11 indicating Resident 3 was moderately cognitively impaired (the resident may need assistance with daily activities, experience or memory but is not considered severely impaired).A record review of Resident 3's undated care plan revealed Resident 3 has the following diagnoses: Type 2 diabetes, previous fracture of the shaft of the right tibia, spinal stenosis (a narrowing of the spinal canal), polyneuritis (inflammation and damage of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple peripheral nerves causing widespread numbness, burning pain and weakness), arthropathy (any disease affecting the joints causing pain, inflammation, swelling and reduced range of motion), osteoarthritis (a chronic degenerative joint disease caused by the breakdown of protective cartilage.A record review of Resident 3's care plan revealed Resident 3 had a Stage 3 Pressure Injury (a severe, full-thickness skin loss causing a deep, crater like wound) to the right buttock.A record review of Resident 3's skin observation notes by the Assistant Director of Nursing (ADON) dated 0105/2026 revealed the following: right buttock 3.3cm x 3cm x 0.2cm (measurement) no s/s (signs or symptoms) of infection tx(treatment) in place Type of impairment: pressure injury. A record review of Residents physician orders dated 2/13/2026 revealed the following orders:Right buttock: Cleanse with saline, apply triad paste, cover with silicone supra sorbent dressing, change daily and prn (as needed). One time a day for wound care and as needed for soiling. An observation on 3/3/26 at 10:45 AM of wound care provided to Resident 3 by Registered Nurse (RN) A revealed the following: RN A donned a clean mask and entered Resident 3's room with the required supplies for Resident 3 treatment. RN A placed paper towels on the bedside table and placed the supplies on the paper towels. RN A used hand sanitizer and donned a gown and gloves. RN A assisted Resident 3 to turn onto their left side and untied the residents brief to expose Resident 3's right buttock. RN A removed their gloves, used hand sanitizer, and donned clean gloves and then used their left gloved hand to push and reposition Resident 3' s right buttock to expose the open wound. RN A used their right hand to place the cotton applicator into the triad paste and apply it to the wound. RN A had to remove their left hand from Resident 3's right buttock and use both hands to peel back the adhesive portion of the bordered foam dressing. This allowed the wound and triad paste to come into contact with Resident 3's brief. RN A repositioned Resident 3's buttock with their left hand, placed the dressing on the wound with their right hand and refastened Resident 3's brief. RN A removed their gown and gloves, used hand sanitizer, and exited the room. An interview on 3/3/26 at 10:55 AM with RN A confirmed Resident 3's wound paste and brief touched provided an opportunity for cross contamination of the wound. RN A confirmed they should have used hand sanitizer and changed gloves before opening the foam dressing and applying it to the wound. RN A confirmed touching the clean dressing with their contaminated left glove provided an opportunity for cross contamination of the wound. D.A record review of Resident 4's Clinical Resident Profile revealed Resident 4 was admitted on [DATE]. A record review of Resident 4's Minimum Data Set, dated [DATE] revealed Resident 4 had a BIMS of 6 indicating the resident was severely cognitively impaired.A record review of Resident 4's undated care plan revealed the resident had the following diagnoses: Dementia (a decline in mental ability, including reason, memory and behavior -severe enough to interfere with daily life), age related osteoarthritis (a degenerative joint disease), anxiety disorder (persistent, excessive worry), sarcopenia (age related loss of muscle mass, strength and function) and erythema intertrigo (a chronic skin rash occurring in body folds where skin rubs against skin causing moisture, heat and frictionA record review of Resident 4's skin/wound note dated 2/26/26 by the Assistant Director of Nursing revealed the following:Location: Clarification: left buttock. Etiology: Pressure Injury Stage 3Measurement: 1.5cm x 1.9cm x 1.1cm, undermining (where the tissues under the wound edge detach forming a hidden pocket beneath the skin) from 12 o'clock to 12 o'clock, deepest at 5 o'clock measuring 3cm.Wound Status: Not healed. Treatment changed this week. Primary Care Provider and Power Of Attorney notified of status of area and new orderAuthor: Assistant Director of Nursing .A record review of Resident 4's wound care orders dated 2/26/26 revealed the following information: Left buttock: cleanse with saline, apply triad paste to peri wound, apply Gentelle blue or equivalent to wound bed and undermining, cover with silicone foam dressing, change 3 times weekly and prn (as needed). One time a day for pressure injury and as needed for soiling. An observation on 3/3/26 at 10:25 AM of wound care provided to Resident 4 by Licensed Practical Nurse (LPN) B. LPN B entered the Resident 4's room wearing a face mask and carrying 2 small tubes of saline solution, a cotton tipped applicator, triad paste, Gentelle Blue foam dressing (a foam dressing containing 3 antimicrobial agents) and a bordered foam dressing. LPN B (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed a paper towel on Resident B's bed and placed the dressing supplies on the towel. LPN B then used hand sanitizer and donned a gown and gloves. LPN B assisted Resident 4 to roll on their left side and hold the positioning bar. LPN B removed the Resident 4's blankets, unfastened their brief on the right side and uncovered their buttocks. LPN B then place a clean chux pad (a highly absorbent waterproof sheet designed to protect mattresses from incontinence, spills, or bodily fluids) underneath Resident 4's buttocks. LPN B removed their gloves, used hand sanitizer, and donned clean gloves. LPN B used their left hand to lift Resident 4's right buttock and used their right hand to wash the wound with saline solution. Without handwashing and changing the soiled gloves, LPN B patted the area dry with their right hand and a 4inch (in) x4 in gauze pad. LPN B used a cotton tipped applicator to apply triad paste around the wound and then removed their left hand from the resident's buttock, which allowed Resident 4's buttocks to come together and touch the residents brief. LPN B separated Resident 4's buttocks using their left hand and used their right hand to place the Gentelle blue foam into the wound as far as it would go as the wound had undermining. LPN B released Resident 4's buttocks again, allowing them to close over the Gentelle Blue. LPN B used both hands to peel off the adhesive cover on the silicone dressing and apply it to the wound. LPN B refastened Resident 4's brief, gathered and discarded the trash and covered the resident with blankets before they removed their gown and gloves, used hand sanitizer, and exited the room.An interview on 3/3/25 at 10:40 AM with LPN B confirmed allowing Resident 4's buttocks to touch the residents brief and then close over the blue dressing provided two opportunities for cross contamination of Resident 4's wound. LPN B confirmed they should have changed their gloves after they had cleaned the resident wound and before they had applied the paste to the residents wound and confirmed failure to do so provided further opportunity for cross contamination of Resident 4's wound.