

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Golden Acres Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1 E Main St Carrington, ND 58421	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility reported incident (FRI), policy review, and staff interview, the facility failed to ensure residents remained free from misappropriation of funds for 1 of 1 closed record (Resident #52). Failure to protect residents from misappropriation of funds may result in anxiety, mental anguish, and financial loss. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident.</p> <p>Findings include:</p> <p>Review of the facility policy, Abuse and Neglect Policy and Procedure occurred on 05/29/25. This undated policy stated, POLICY: . Residents must not be subjected to abuse by anyone, including, but not limited to facility staff . DEFINITIONS OF ABUSE: . MISAPPOPRIATION OF RESIDENT PROPERTY: Means the deliberate . exploitation or wrongful, temporary or permanent use of a resident's belongings or money without resident's consent.</p> <p>Review of Resident #52's closed medical record occurred on May 28-29, 2025. The Minimum Data Set (MDS), dated [DATE], showed severe cognitive impairment.</p> <p>Review of the FRI, dated 07/12/24, identified the family of Resident #52 contacted the facility about a significant amount of money that had been spent from the resident's checking account. The resident told family she bought an item from an employee (#16) for \$40.00 and had given the employee a signed blank check for the purchase. The family stated the employee wrote the check for \$550.00 and cashed it. The family stated the employee told the resident she had lost the initial check, and the resident then gave the employee (#16) another check for \$40.00. The check was later altered to \$340.00. The facility obtained photocopies of the checks, which appeared altered. The facility administration contacted the local police department. Facility staff interviewed Resident #52 and the resident and acknowledged buying two items from the employee. Facility staff interviewed the employee (#16) twice. During the initial interview, the employee acknowledged she had sold Resident #52 two items but could not recall what price he/she had charged. When facility staff told the employee the resident has dementia and is considered a vulnerable adult, the employee stated he/she was unaware of that. During a second interview, the employee acknowledged the transactions made with the resident and stated he/she was not 100% sure of the amount he/she received, but stated one check was around \$500.00 and another check around \$400.00 When facility staff asked about the value of the items, the employee (#16) stated he/she did not know and that he/she made the price up. The employee acknowledged the problem and apologized.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/25 at 9:30 a.m., an administrative staff member (#15) stated the facility investigated the incident and terminated the employee on 07/12/24.</p> <p>Based on the following information, non-compliance at F602 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by the following actions:</p> <ul style="list-style-type: none"> * Immediately placed the employee on suspension * Reported the incident to the ND Department of Health and Human Services * Completed an investigation following the incident * Contacted the police department *Terminated the employee after the investigation 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review, review of facility policy, and resident and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 1 of 15 sampled residents (Resident #24). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care for each resident.</p> <p>Findings include:</p> <p>Review of the facility policy titled Golden Acres Comprehensive Care Plan Policy and Procedure occurred on 5/29/25. This policy, revised January 2023 stated, . The care plan will include: Identified problems, risk factors, strengths, choices, and preferences . measurable goals . interventions to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . the care plan will be periodically reviewed and revised by a team of qualified persons . as the resident condition changes . if a condition has not resolved within approximately two weeks, or as based on clinical judgement and resident needs, further evaluation will be completed .</p> <p>-Review of Resident #24's medical record occurred on all days of survey. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms. The resident's current Minimum Data Set (MDS) indicated intact cognition.</p> <p>During an interview on 5/27/25 at 2:39 p.m., Resident #24 stated staff do not assist him regularly with urinary incontinence cares during the evening and night, and stated he voiced his concerns and asked to be assisted at least every 3-4 hours, and as needed.</p> <p>Review of Resident #24's bowel and bladder documentation for the months of March, April and May 2025, identified check and change times of 11:00 p.m., 2:00 a.m., and 4:00 a.m.</p> <p>Resident #24's current care plan stated, . toileting assistance: Extensive assist with incontinence cares upon demand . do not disturb at night . change at night upon request . The care plan failed to reflect the resident's preferences for urinary incontinence cares.</p> <p>During an interview on 5/29/25 at 9:00 am, two administrative nurses (#7 and #13) confirmed staff failed to update and individualize Resident #24's care plan.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, review of professional reference, review of manufacturer's instructions, and staff interview, the facility failed to ensure staff followed standards of practice for 2 of 9 supplemental residents (Residents #13 and #39) observed during medication administration. Failure to clarify, accurately transcribe, and reconcile new physician's orders (Resident #13) may result in residents receiving the wrong medication and failure to correctly prime an insulin pen (Resident #39) may result in residents receiving an inaccurate dose of insulin, and/or result in adverse health consequences.</p> <p>Findings include:</p> <p>Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, . Carrying Out a Physician's Order. Nurses are expected to analyze . medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Page 833, stated, There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies - it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications.</p> <p>Review of manufacturer's instructions for the NovoLog Flexpen occurred on 05/29/25. These instructions, dated 2023, stated, . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injection of air and to ensure proper dosing: E. Turn the dose selector to select 2 units F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in . A drop of insulin should appear at the needle tip.</p> <p>- Observation on 05/28/25 at 7:56 a.m. showed a nurse (#2) prepared medications for Resident #13. The nurse pulled out a medication card labeled Metoprolol Succinate ER [extended release] 50 mg [milligrams] from the medication cart. The order in the Medication Administration Record (MAR) showed Metoprolol Tartrate 50 mg. The nurse (#2) confirmed a discrepancy between the card label and MAR, did not administer the medication, and stated she would follow up on the discrepancy.</p> <p>On 05/28/25 at 9:00 a.m., the nurse (#2) stated the resident has been receiving the correct medication and dose, but confirmed nursing staff failed to clarify the order when it was written and incorrectly transcribed the metoprolol as tartrate instead of succinate on the MAR.</p> <p>- Observation on 05/27/25 at 5:30 p.m. showed a staff nurse (#2) prepared Resident #39's insulin pen for administration. The nurse (#2) held the insulin pen horizontally instead of upright when priming the pen.</p> <p>During an interview on 05/29/25 at 10:22 a.m. two administrative staff (#7 and #13), confirmed nursing staff should clarify medication orders when there is a discrepancy.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to assess residents with a history of trauma and identify known triggers for 1 of 2 sampled residents (Resident #16) reviewed for Post-Traumatic Stress Disorder (PTSD). Failure to ensure staff assess residents with PTSD upon admission, identify known triggers, and provide appropriate person-centered treatment/services may result in re-traumatization.</p> <p>Findings include:</p> <p>Review of the facility policy titled Behavioral Health Services occurred on 05/29/25. This policy, dated 10/22/18, stated, . all residents receive necessary behavioral health care and services to . reach and maintain the highest level of mental and psychosocial functioning. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes . the prevention and treatment of . trauma or post-traumatic stress disorders. This process includes: . Obtaining history . regarding mental, psychosocial, and emotional health . Care plan development and implementation .</p> <p>Review of Resident #16's medical record occurred on all days of survey. Diagnoses included PTSD. A psychiatry note, dated 11/19/24, identified a history of physical and sexual abuse, and neglect.</p> <p>The care plan identified, . Mood: Alteration in mood and behaviors related to: . anxiety, PTSD . Current indicators: feeling down, trouble sleeping, feeling tired . Observe for any changes in psychosocial/mood state and report to the physician and social worker.</p> <p>The medical record lacked documentation of an assessment of past traumas, identification of potential triggers, and a trauma care plan.</p> <p>During an interview on 05/28/25 at 4:28 p.m., an administrative nurse (#11) confirmed staff failed to assess Resident #16 for trauma, identify potential triggers, and develop a trauma care plan.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen and 1 of 1 refrigerator on a nursing unit (Prairie Unit). Failure to clean fans in areas where food is stored and prepared, failure to ensure sanitizer test strips are not expired, and failure to store resident cold packs in an area separate from food has the potential for contamination of food and may result in a foodborne illness.</p> <p>Findings Include:</p> <p>The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3 Food, Section 3-305 Preventing Contamination From the Premises, Section 3-305.11 states, A. Food shall be protected from contamination by storing the food: . 2) Where it is not exposed to . dust, or other contamination.</p> <p>Review of the facility policy Dietary Sanitation and Housekeeping Policy occurred on 05/29/25. This undated policy, stated, Goal: To provide all dietary employees with adequate training and education on sanitary requirements . and to assure that the requirements are maintained in the storage, preparation, distribution of foods . The dietary manager and assistant dietary manager are responsible to monitor sanitary conditions within the dietary department and make corrections and re-education staff as necessary. Cleaning schedules are posted and followed for routine cleaning of all equipment and work areas. Sanitizing solution concentration is periodically checked for adequate dispensing of sanitizer .</p> <p>Observation of the kitchen on 05/27/25 at 12:29 p.m. with an administrative dietary staff member (#14) showed the following:</p> <p>*Quaternary Ammonia Sanitizer test strips, used by staff to test the concentration of sanitizer solution, with an expiration date of December 2023.</p> <p>* An accumulation of dust on the hood above the oven. When asked how often the hood is cleaned, the dietary staff member (#14) stated a company cleans the hood every six months, but did not know when it was last cleaned.</p> <p>* An accumulation of dust/dirt on the grate below the front door of a reach-in refrigerator.</p> <p>* Walk in Cooler with an accumulation of black dust/dirt on a total of four fans located on two separate condenser units.</p> <p>During an interview on 05/27/25 at 10:45 a.m., the administrative dietary staff member (#4) confirmed staff should not use expired sanitizer test strips and should clean the dust/dirt from the exhaust hood, grates, and fans.</p> <p>Observation of the refrigerator/freezer on the Prairie Unit occurred on 05/27/25 at 1:00 p.m. The freezer contained two resident cold packs, used on the body, stored next to food items.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/29/25 at 10:22 a.m. an administrative nursing staff member (#7) confirmed staff should not store resident cold pack in the food freezer and identified a separate refrigerator designated for resident cold packs.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 15 sampled residents (#16, #20, #32, and #40) and 1 supplemental resident (Resident #45) observed during personal cares. Failure to practice infection control standards related to hand hygiene, glove use, and disinfecting equipment has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled Golden Acres Manor Infection Prevention and Control Program occurred on 05/29/25. This policy, revised 05/20/21, stated, . 8. Equipment Protocol: . All reusable items and equipment requiring special cleaning or disinfection shall be cleaned in accordance with our current procedures governing the cleaning and disinfecting of soiled or contaminated equipment.</p> <p>Review of the facility policy titled Golden Acres Manor Hand Hygiene occurred on 05/29/25. This policy, dated 11/28/17, stated, . All facility employees will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is indicated and will be performed . Between resident contacts . After handling contaminated objects . before applying and after removing personal protective equipment . including gloves . When, during resident care, moving from a contaminated body site to a clean body site . After assistance with personal body functions (e.g. [example] elimination .) .</p> <p>- Observation on 05/28/25 at 1:25 p.m. showed two certified nurse aides (CNAs) (#5 and #6) performed hand hygiene, applied gloves, and transferred Resident #16 to bed with a mechanical ceiling lift. One CNA (#6) removed the resident's soiled brief, and without removing her gloves, obtained a clean brief from a drawer in the bedside dresser. Both CNAs (#5 and #6) performed perineal cares, then one CNA (#6) applied the clean brief to the resident. Both CNAs (#5 and #6) removed their gloves, and without performing hand hygiene, applied new gloves, and transferred Resident #16 into the wheelchair with a mechanical ceiling lift. The CNA (#5) placed the oxygen cannula back in the resident's nose. The CNAs (#5 and #6) adjusted the resident's clothing, blanket, and lift sling. The CNAs removed their gloves, performed hand hygiene, and exited the room.</p> <p>The CNAs (#5 and #6) failed to perform hand hygiene after removing gloves and before applying new gloves, and failed to remove gloves and perform hand hygiene before touching other surfaces.</p> <p>- Review of Resident #20's medical record occurred on all days of survey. The current care plan stated, . Potential for impaired skin integrity related to: Pressure ulcer to right shoulder. History of several to sacro-coccygeal area.</p> <p>Observation on 05/28/25 at 1:36 p.m. showed two CNAs (#3 and #4) provided Resident #20's perineal cares. One CNA (#3) removed her gown/gloves and exited the room without sanitizing her hands. A few minutes later, the CNA gowned/gloved and re-entered the room with a full body mechanical lift. After the CNAs (#3 and #4) transferred Resident #20 into the wheelchair, one CNA (#3) removed her gown/gloves, exited the room without performing hand hygiene, and transported the resident to the lounge. The other CNA (#4) removed her gown/gloves, exited the room with a garbage bag and the mechanical lift, placed the lift in the hallway and the garbage in a bin in the soiled utility room, and then performed hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The CNAs (#3 and #4) failed to perform hand hygiene after removing their soiled gloves and prior to exiting the room, and failed to sanitize the mechanical lift after use.</p> <p>- Observation on 05/27/25 at 4:24 p.m. showed two CNAs (#5 and #8) performed hand hygiene, applied gloves, removed the oxygen cannula from Resident #32's nose, and transferred the resident from the recliner to the bed using a mechanical ceiling lift. One CNA (#5) performed perineal care and applied a protective skin cream. The other CNA (#8) removed the soiled brief and applied a new brief. The CNAs removed their gloves, and without performing hand hygiene applied new gloves, and transferred Resident #32 from the bed to the wheelchair using the ceiling lift. The CNAs (#5 and #8) removed their gloves. One CNA (#8) covered the resident with a blanket, tied and removed the garbage bag, performed hand hygiene, and exited the room. The other CNA (#5) placed the oxygen cannula in the resident's nose, adjusted the over the bed table, placed the call light, performed hand hygiene, and exited the room.</p> <p>The CNAs (#5 and #8) failed to perform hand hygiene after removing gloves, before applying new gloves, and prior to touching other surfaces.</p> <p>- Observation on 05/28/25 at 4:15 p.m. showed two CNAs (#11 and #12) provided Resident #40 with perineal cares, adjusted the resident's clothing, removed the heel protector boots, applied shoes, assisted to transfer from the bed to the wheelchair, and covered the resident with a lap blanket. The CNAs failed to perform hand hygiene after completing perineal cares and prior to touching the resident and other items.</p> <p>- Observation on 05/27/25 at 12:10 p.m. showed Resident #45 rested in bed. Two CNAs (#9 and #10) entered the room, performed hand hygiene, and applied gloves. One CNA (#9) provided incontinent bowel movement cares, removed the soiled gloves, applied new gloves, applied a clean brief and a protective skin cream, and placed supplies back into the bedside dresser.</p> <p>The CNA (#9) failed to perform hand hygiene after removing gloves and before applying new gloves and failed to remove soiled gloves and perform hand hygiene prior to touching other surfaces.</p> <p>During an interview on 05/29/25 at 8:38 a.m., an administrative nurse (#7) confirmed she expected staff to perform hand hygiene after removing gloves, before applying new gloves, prior to touching other surfaces, and when exiting the room. The nurse (#7) also confirmed she expected staff to sanitize the lifts prior to the lifts.</p>		