STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 04/27/25 and concluded 04/30/25. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		5/28/25

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

Electronically Signed | 05/21/2025

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F 657	Continued From page 1 Based on record review, facility policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 2 of 20 sampled residents (Resident #29 and #58). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 04/28/25. This policy, revised November 2021, stated, ". . . develop a person-centered care plan . . . that reflects the actual care, condition. . . . The comprehensive care plan . . . will be reviewed and updated monthly and as needed." Review of the facility policy titled "Smoking/Tobacco Free" occurred on 04/29/25. This policy, revised January 2024, stated, ". . . maintain a policy where all buildings, grounds . . . are free of tobacco products. . . . Use of tobacco products . . . are not permitted. . . ." - Review of Resident #29's medical record occurred on all days of survey. The care plan, dated 02/24/25, stated, ". . . Will be assessed to be safe to smoke if she does engage in this activity. . . . Resident will safely use tobacco products off facility grounds and not incur any injury from smoking. . . . Resident instructed to keep cigarettes/lighter at the nurses station if she has in facility. . . . Charge nurse will give resident cigarettes and will be notified of residents leaving facility to smoke."	F 657	1. Resident #29 and Resident #58 care plans were reviewed and updated to reflect the residents current status. Current care plans remain appropriate at this time. 2. The facility has identified that all residents who are former smokers and residents who have orders for AFO use have the potential to be affected by this practice. 3. Education will be provided to all nurses on facility policy Care Plans, specifically regarding expectations on reviewing and revising resident care plans to ensure that the care plans reflect the residents current status to accurately communicate care needs and ensure continuity of care for all residents. Education has been completed on 05/20/2025 and 05/22/2025. 4. All residents who were former smokers and all residents with AFO orders care plans have been reviewed for accuracy and updated if needed. The DON or designee will audit these areas weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 5/28/2025	

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F 657	Continued From page 2 During an interview on 04/29/25 at 10:12 a.m., an administrative nurse (#1) stated, Resident #29 is a former smoker, but has not smoked since admission to the facility. During an interview on 04/30/25 at 12:23 p.m., an administrative nurse (#1) agreed staff failed to update the resident's care plan. - Review of Resident #58's medical record occurred on all days of survey and included diagnoses of hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (blood clot in the brain) affecting the right dominant side. Physician's orders included an ankle-foot orthosis (AFO) brace to the right lower leg and ankle, monitor the daily application and for possible skin breakdown. Observation on all days of survey showed Resident #58 wore an AFO to the right lower leg and ankle. The care plan failed to include an AFO to Resident #58's right lower leg and ankle. During an interview on 04/30/25 at 10:40 a.m., an administrative staff member (#1) agreed staff failed to update the care plan to include the AFO.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		5/27/25

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F 658	Continued From page 3 This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, policy review, professional reference, and staff interview, the facility failed to follow professional standards of practice for medication administration for 1 of 7 residents (Resident #19) observed during medication administration. Failure to document medications at the time of administration does not reflect the actual time of administration and may cause adverse effects for the resident. Findings include: Review of the facility policy titled "Medication - Administration and Storage" occurred on 04/30/25. This policy, dated March 2025, stated, ". . . documentation . . . immediately following administration. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 836, stated, ". . . Ten "Rights" of Medication Administration . . . Right Documentation . . . Document medication administration after giving it . . . The record [medication administration record] should . . . include the exact time of administration . . ." Observation on 04/29/25 at 4:15 p.m. showed a medication aide (MA) (#3) administered the following medications to Resident #19: * Metoprolol (blood pressure medication) scheduled at 5:00 p.m. * Seroquel (antipsychotic) scheduled at 8:00 p.m. * Metolazone (diuretic) scheduled at 5:30 p.m.	F 658	1. Resident #19 was assessed for adverse side effects. Resident #19□s medication is now being administered and documented following professional standards of practice for medication administration. Resident #58 orders were reviewed and updated to include the treatment of AFO. Resident #58□s order for AFO remains appropriate. 2. The facility has identified that all residents who receive medications or have orders for AFO use in the facility have the potential to be affected by this practice. 3. Immediate education was provided to identified CMA regarding proper medication administration and timely documentation on 05/15/2025. Education will be provided on 5/20/2025 and 5/22/2025 to the nurses and medication aides on facility Medication Administration and Storage policy, specifically regarding timely administration of medications and documentation requirements. Education will also be provided to nurses regarding order processing expectations, ensuring treatments are transcribed as ordered. 4. The Director of Nursing or designee will audit these areas weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the	

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F 658	Continued From page 4 * Olanzapine (antipsychotic) scheduled at 8:00 p.m. * Polyethylene Glycol Powder (treats constipation) scheduled at 5:30 p.m. * Saccharomyces boulardii (probiotic) scheduled at 8:00 p.m. * Docusate Sodium (treats constipation) scheduled at 5:30 p.m. * Genteal Tears (artificial tears eye drops) Ophthalmic Solution scheduled at 5:30 p.m. * Potassium Chloride scheduled at 9:00 p.m. * Rivaroxaban (medication to prevent blood clots) scheduled at 9:00 p.m. Following the medication administration, the MA (#3) returned to the medication cart and only signed off the metoprolol as administered. When asked when she will sign the other medications as administered the MA stated, "When they turn yellow [indicating the correct time for the medication to be given] on the MAR [medication administration record]." During an interview on 04/30/25 at 11:35 a.m., an administrative nurse (#1) stated she expected staff to document medications at the time of administration. 2. Based on observation, record review, and staff interview, the facility failed to provide care and services for 1 of 2 sampled residents (Resident #58) with an ankle foot orthosis (AFO). Failure to place the order for an AFO brace on the treatment administration record (TAR) may result in staff not applying the AFO or monitoring its use and may delay healing of the foot and ankle. Findings include:	F 658	audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 5/27/2025	

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F 658	Continued From page 5 Observation on all days of survey showed Resident #58 wore an AFO to the right lower leg and ankle. Review of Resident #58's medical record occurred on all days of survey and included diagnoses of hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (blood clot in the brain) affecting the right dominant side. Physician's orders included an AFO brace to the right lower leg and ankle, monitor daily application of the AFO, and monitor for skin breakdown. During an interview on 04/30/25 at 10:40 a.m., an administrative staff member (#1) stated she expected staff to update Resident #58's treatment record related to the AFO.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of operator's instructions, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 4 residents (Resident #9) observed during a sit-to-stand mechanical lift transfer. Failure to	F 689	1. Resident #9 transfer status was assessed and care planned to the use of a total lift. Resident #9 use of a total lift for transfers continues to be appropriate at this time. 2. The facility has identified all residents	5/27/25

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F 689	Continued From page 6 utilize a mechanical lift properly, complete a nursing assessment, and implement a safe transfer method placed Resident #9 at risk for pain and/or injury. Findings include: Review of the "EZ Way Smart Stand [type of sit-to-stand mechanical lift] 400, 500 & 800 lb [pound] Capacities Operator's Instructions occurred on 04/30/25." The operator's instructions, revised 09/29/23, on page 2-6, stated, ". . . Patients should be able to bear some weight, have upper body strength and be able to follow simple commands. . . ." Review of the facility policy titled "Standing Lifts" occurred on 04/30/25. This policy, dated January 2024, stated ". . . Use of this lift is participatory on the part of the resident and they must be able to balance and bear-weight. . . . Have the resident hold onto the handle grips. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoarthritis, and anxiety. The quarterly Minimum Data Set (MDS), dated 03/06/25, identified substantial/maximum assistance with transfers. The care plan stated, ". . . Transfer: Assist of 1 [staff] with PAL [sit to stand mechanical lift], may use assist of 2 [staff] with behaviors/syncope episodes. . . ." A physician's order, dated 04/24/25, stated, ". . . OT [occupational therapy] starting to demonstrate increase in shoulder abduction during PAL transfer. . . ." A nursing progress note, dated 04/25/25 stated, ". . . Order for OT . . . Indication/Diagnosis: weakness with transfers. . .	F 689	that utilize a sit to stand for transfers have the potential to be affected by this practice. 3. All residents that are currently using a sit to stand lift for transfers have been assessed for appropriateness of transfer. On 5/20/2025 and 5/22/2025 all nursing staff will receive education on facility policy Standing Lifts, specifically regarding safe and proper use during transfers. Nurses will receive additional education regarding nurse assessment expectations and ensuring a safe transfer method. 4. The Director of Nursing or designee will audit these areas weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 05/27/2025.	

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F 689	Continued From page 7 ." Observation on 04/28/25 at 10:20 a.m. showed a certified nurse aide (CNA) (#8) transferred Resident #9 from the wheelchair to the toilet utilizing a sit-to-stand mechanical lift. The CNA placed the lift harness around the resident's waist and then physically placed the resident's hands on the handle grips of the lift. During the transfer the resident failed to hold onto the handle grips, the harness slid up the resident's back to the axilla area, the resident leaned forward with both elbows turned outward and raised above the shoulders. Facility staff failed to complete a nursing assessment to provide Resident #9 with an alternative safe transfer option before assessment by OT. During an interview on 04/30/25 at 10:34 a.m., an administrative staff member (#9) verified staff should have completed a nursing assessment to provide an alternate safe transfer method for Resident #9 until OT assessed the resident.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		5/27/25

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F 732	Continued From page 8 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 1 of 4 days of survey (April 27, 2025). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include:	F 732	1. Accurate staffing data was posted 4/28/25 and continues to be posted daily for accuracy. 2. The facility has identified that all residents and visitors have the potential to be affected. 3. Education will be provided to the DON and staff involved on facility policy	

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F 732	Continued From page 9 Review of the facility policy titled "Staffing Levels" occurred on 04/30/25. This policy, revised on February 2024, stated, ". . . the Director of Nursing is responsible for ensuring that nursing hours are posted daily . . . determines the level of nursing hours for the facility . . ." Observation on 04/27/25 at 12:02 p.m., showed a staffing report dated 04/25/25. The facility failed to update the number of licensed and unlicensed staff working the days of 04/26/25 and 04/27/25. During an interview on 04/30/25 at 12:22 p.m., an administrative staff member (#1) stated she expected the charge nurse to complete and post a daily census/staffing report.	F 732	Staffing Levels, specifically regarding the requirements for posting accurate staffing data on 5/20/2025 and 5/22/2025. 4. The Director of Nursing or designee will audit this area weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 5/27/2025.	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 5 of 7 residents (Resident #2, #19, #20, #21, and #58) observed during medication administration. Thirteen medication errors occurred during staff administration of 37 medications, resulting in a 35% error rate. Failure to properly prime insulin pens and administer medications at the correct time may result in residents receiving an ineffective and/or	F 759	1. Residents #2, #19, #20, #21, and #58, were assessed for adverse side effects. Residents #2, #19, #20, #21, and #58 and now receiving their medications timely and according to proper administration procedures. 2. The facility has identified that all residents who receive medication have the potential to be affected. In addition, all residents who receive insulin have the	5/27/25

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F 759	Continued From page 10 inaccurate dose and experience adverse reactions. Findings include: Review of the facility policy titled "Medication - Administration and Storage" occurred on 04/30/25. This policy, dated March 2025, stated, ". . . POLICY: Medications will be administered according to the following directives. . . . Medications will be considered as given at the correct time if administered one hour before or one hour after the scheduled time. . . ." Review of the facility policy titled "Insulin - Subcutaneous" occurred on 04/30/25. This policy, dated September 2024, stated, ". . . Remove cap from insulin pen . . . Prime the insulin pen . . . pointing upward . . ." - Observation on 04/29/25 at 11:18 a.m. showed a staff nurse (#2) prepared Resident #58's Humalog insulin pen for administration. The nurse primed the insulin pen holding the pen down towards the garbage can. - Observation on 04/29/25 at 11:37 a.m. showed a staff nurse (#2) prepared Resident #21's Humalog insulin pen for administration. The nurse primed the insulin pen holding the pen down towards the garbage can. - Observation on 04/29/25 at 5:01 p.m. showed a staff nurse (#4) prepared Resident #20's Humalog insulin pen for administration. The nurse primed the insulin without removing the cap.	F 759	potential to be affected by this practice. 3. Immediate education was provided to identified CMA and two identified RNs regarding timely administration of medication in addition to proper priming of insulin pens 05/16/2025. Education will be provided to all staff responsible for medication administration on facility policy Medication Administration and Storage, specifically regarding timely administration. Additional education will be provided to nurses on the facility policy Insulin Subcutaneous, specifically regarding proper priming of pens on 5/20/2025 and 5/22/2025. 4. The Director of Nursing or designee will audit these areas weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 5/27/2025.	

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F 759	Continued From page 11 - Observation on 04/29/25 at 4:15 p.m. showed a Medication Aide (MA) (#3) administered the following medications to Resident #19: * Seroquel (antipsychotic) scheduled at 8:00 p.m. * Metolazone (diuretic) scheduled at 5:30 p.m. * Olanzapine (antipsychotic) scheduled at 8:00 p.m. * Polyethylene Glycol Powder (treats constipation) scheduled at 5:30 p.m. * Saccharomyces boulardii (probiotic) scheduled at 8:00 p.m. * Docusate Sodium (treats constipation) scheduled at 5:30 p.m. * Genteal Tears (artificial tears eye drops) Ophthalmic Solution scheduled at 5:30 p.m. * Potassium Chloride scheduled at 9:00 p.m. * Rivaroxaban (medication to prevent blood clots) scheduled at 9:00 p.m. When the MA (#3) prepared Resident #19's medications she stated, "He likes all his meds [medications] at this time. I've gotten to know how he likes things and I realize that is not how they are set up." Record review showed the MA (#3) failed to administer the medications at the scheduled times or within one hour before or after. Observation on 04/29/25 at 4:32 p.m. showed a MA (#3) administered Cymbalta (antidepressant) to Resident #2, scheduled to be administered at 3:00 p.m. Record review showed the MA (#3) failed to administer the medication at the scheduled time or within one hour before or after.	F 759		

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	355069	A. BUILDING _____ B. WING _____	C 04/30/2025

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F 759	Continued From page 12 During an interview on 04/30/25 at 11:35 a.m., an administrative nurse (#1) stated she expected staff to prime insulin pens with the cap off and with the needle pointed upright. The nurse also stated, "It is unacceptable for staff to administer medications at anytime other than an hour before or an hour after the scheduled medication time."	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/27/25

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F 880	Continued From page 13 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 880		

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F 880	Continued From page 14 by: Based on observation, record review, and review of facility policy, the facility failed to follow standards of infection control and prevention for 3 of 14 sampled residents (Resident #19, #25 and #46) observed during cares. Failure to practice infection control standards related to hand hygiene and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Infection Control - Enhanced Barrier Precautions" occurred on 04/30/25. This policy, revised December 2024, stated, ". . . Enhanced barrier precautions are used to limit or prevent the spread of resistant organisms during high-contact resident care activities. These may be indicated for residents with . . . chronic wounds that include pressure ulcers . . . venous ulcers . . . gown and gloves must be worn during high-contact resident care activities such as . . . wound care for chronic wounds requiring a dressing . . ." Review of the facility policy titled "Hand Hygiene" occurred on 04/30/25. This policy, dated November 2024, stated ". . . Hand hygiene will be done: a. Before and after resident contact (before you leave the room) b. Before every clean procedure c. After every dirty procedure . . ." - Review of Resident #19's medical record occurred on all days of survey. The current care plan stated, ". . . is on Enhanced Barrier Precautions for presence of RLE [right lower extremity] venous ulcer . . . increased risk for	F 880	1. Residents #19, #25, and #46 were monitored for signs and symptoms of infection. Staff are now providing cares to resident #19, #25, and #46 following proper infection control standards related to hand hygiene and enhanced barrier precautions. 2. The facility has identified that all residents have the potential to be affected. 3. Education will be provided to all staff regarding facility policy Hand Hygiene and Infection Control- Enhanced Barrier Precautions to ensure infection control standards are met on 5/20/2025 and 5/22/2025. 4. The Director of Nursing or designee will audit this area weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implements and the results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on 5/27/2025.	

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F 880	Continued From page 15 infections . . ." Observation on 04/27/25 at 1:03 p.m. showed a nurse (#5) entered Resident #19's room, applied gloves, and provided wound care. The nurse (#5) failed to follow EBP and apply a gown during high contact wound care. - Review of Resident #46's medical record occurred on all days of survey. A quarterly MDS, dated 03/06/25, identified an indwelling foley catheter. The current care plan stated, ". . . is at increased risk of infections related to foley catheter . . . on Enhanced Barrier Precautions . . ." Observation on 04/27/25 at 1:51 p.m. showed a certified nurse aide (CNA) (#6) entered Resident #46's room, donned gloves, and provided catheter care. The CNA (#6) failed to follow EBP and don a gown during high contact catheter care. - Observation on 04/27/25 at 3:45 p.m. showed a CNA (#7) assisted Resident #25 with perineal care. The CNA (#7) applied gloves, performed perineal care, applied a clean brief, assisted the resident off the toilet, collected the garbage, exited the room, threw away the garbage, and removed the soiled gloves. Without performing hand hygiene, the CNA reentered the room and assisted the resident to the commons area in the wheelchair. The CNA (#7) failed to remove the soiled gloves after providing perineal care and failed to perform hand hygiene. During an interview on 04/30/25 at 11:45 a.m. and 12:29 p.m., an administrative nurse, (#1)	F 880		

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F 880	Continued From page 16 stated she expected facility staff to follow appropriate hand hygiene and EBP.	F 880		