STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 survey started on 05/19/25 and concluded 05/21/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		6/20/25

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

Electronically Signed | 06/16/2025

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of the North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, review of facility policy, and staff interview, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity for 2 of 14 sampled residents (Resident #5 and #222). Failure to treat residents with dignity, speak respectfully, and provide privacy during toileting has the potential to affect the residents' psychosocial wellbeing and does not enhance the residents' quality of life. Findings include: The North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, updated 03/21/23, stated, ". . . The facility must treat you courteously, fairly and with dignity. . . ." Review of the facility policy titled "Standards of Care" occurred on 05/21/25. This policy, dated August 2024, stated, ". . . Dignity . . . door to be closed anytime cares are being completed. . . ." - Observation on 05/19/25 at 1:23 p.m. showed a certified nurse aide (CNA) (#9) attempted to transfer Resident #5 from the wheelchair to the	F 550	1. Resident # 5 and Resident # 222 were assessed following the incidents to ensure psychosocial wellbeing. Education provided 5/28/2025 to staff involved on facility policy Standards of Care, specifically regarding expectations for treating residents with dignity, speaking respectfully, and providing privacy during toileting. Facility will care for residents in a manner which preserves and improves the residents dignity and respect. 2. All residents of the facility have the potential to be affected. 3. Education with be provided to all nursing staff on facility policy Standards of Care, specifically regarding expectations for treating residents with dignity, speaking respectfully, and providing privacy during all cares by June 19th, 2025. 4. QA monitoring will be implemented following completion of mandatory education on 6/18/2025. The Director of Nursing (DON) or designee will be responsible for monitoring that staff consistently speak to residents with dignity and respect, and that doors and	

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F 550	Continued From page 2 bed. The resident had difficulty standing up and the CNA stated, "She usually gets up herself, but she's my drama queen." - Observation on 05/20/25 at 10:13 a.m. showed a CNA (#9) and a nurse (#12) entered Resident #222's room and left the door open. Observation from the hall showed the resident seated on the commode. At 10:24 a.m., the nurse (#12) exited Resident #222's room and left the door open. Observation showed the resident on the bed with only a shirt on. During an interview on 05/21/25 at 1:08 p.m., an administrative staff member (#1) stated she expected staff to treat residents with respect, dignity, and privacy.	F 550	privacy curtains are closed at all times when providing cares weekly for one month, monthly for three months, and least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 641		6/20/25

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F 641	Continued From page 3 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 18 sampled residents (Resident #1 and #55). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2024, page A-32, stated, ". . . Complete if A0310A = 01 . . . Annual assessment . . . Coding Instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." Review of Resident #1's medical record occurred on all days of survey. The medical record	F 641	1. Resident #1 MDS for section A1500 was reviewed and modified to ensure accurate coding. All residents considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition MDS section A1500 were reviewed and modified if needed to ensure they were accurately coded. Resident #55□s MDS for section H0100A was reviewed and modified to ensure accurate coding. In addition, all residents who have an indwelling catheter, MDS section H0100A, were reviewed and modified if needed to ensure they were accurately coded. 2. All residents with a serious mental illness or an indwelling catheter have the potential to be affected. 3. Education was provided to the MDS Coordinator by DON or designee regarding accurate coding of the MDS utilizing the RAI manual on 6/5/25. 4. The DON or designee will audit MDS section A and Section H weekly for one month, monthly for three months,	

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F 641	Continued From page 4 included the diagnosis of schizophrenia, neurocognitive disorder, bipolar, and dementia. The facility failed to code the serious mental illness on the annual MDS, dated 12/12/24. During an interview on 05/21/25 at 10:40 a.m., an administrative staff member (#13) confirmed staff failed to code Resident #1's MDS for a serious mental health illness. SECTION H: BOWEL AND BLADDER The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-2, states, ". . . Check next to each appliance that was used at any time in the past 7 days. . . . H0100A, indwelling catheter . . ." - Review of Resident #55's medical record occurred on all days of survey. A physician's order, dated 02/04/25, identified an indwelling catheter. A quarterly MDS, dated 03/04/25, Section H0100A, lacked documentation to indicate the presence of an indwelling catheter. During an interview on 05/21/25 at 10:26 a.m., an administrative staff member (#13) confirmed staff failed to code Resident #55's MDS for the presence of an indwelling catheter.	F 641	quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		6/20/25

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F 677	Continued From page 5 Based on observation, record review, review of facility policy, and staff interview the facility failed to ensure residents received the necessary services to maintain personal and oral hygiene for 2 of 8 sampled residents (#5 and #52) dependent on staff for personal hygiene. Failure to provide assistance with oral care and personal hygiene may result in poor hygiene, and decreased self-esteem and quality of life. Findings include: Review of the facility policy titled "Standards of Care" occurred on 05/21/25. This policy, dated December 2023, stated, ". . . Oral cares are provided a minimum of AM [morning] and PM [evening](teeth/dentures cleansed and mouth rinsed or swabbed). . . . Peri-cares are provided after each toileting or brief change . . ." - Review of Resident #5's medical record occurred on all days of survey. The care plan stated, ". . . Self-care deficit . . . Bathing: assist of 1 . . . Grooming: assist of 1 . . . Toileting: Check and change . . . Assist of 1 . . ." Observation on 05/19/25 at 1:20 p.m., showed Resident #5 sat in the wheelchair in her room, with her pants half off, disheveled hair, and faced towards the door. A certified nurse aide (CNA) (#9) knocked, entered the resident's room and turned to leave until the surveyor informed the CNA the resident needed assistance. Observation on 05/20/25 at 8:04 a.m., showed two CNAs (#9 and #11) assisted Resident #5 with morning cares (dressing and toilet use). After the resident voided, the CNA (#9) wiped the	F 677	1. Staff involved were educated on standards of care specifically regarding expectations on providing assistance with oral care and personal hygiene for Resident #5 and Resident #52 on 5/28/2025. 2. All residents have the potential to be affected. 3. Education will be provided to all nursing staff by June 19th, 2025, on facility policy Standards of Care, specifically regarding expectations on providing assistance with oral care and personal hygiene. 4. The DON or designee will audit the provision of proper AM cares with oral cares and personal hygiene weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025	

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F 677	Continued From page 6 resident's perineal area with toilet paper. The CNAs assisted Resident #5 back to the wheelchair and transported him/her to the dining room for breakfast. The CNAs failed to assist Resident #5 with oral cares and cleansing the perineal area. - Review of Resident #52's medical record occurred on all days of survey. The care plan stated, ". . . Self -care deficit . . . Grooming: assist of 1 . . . Toileting: Assist X [of] 2 w/Medi-stand [sit to stand mechanical lift] q3 [every three] hours and PRN [as needed] . . ." Observation on 05/19/25 at 12:33 p.m., showed two CNAs (#6 and #7) assisted Resident #52 with toileting. The CNA (#6) assisted the resident with lowering pants and removed the wet brief. When the resident finished toileting the CNA (#6) used the mechanical lift to assist the resident to a standing position, and the CNA (#6) applied a clean brief and the other CNA (#7) assisted the resident to dress. The CNAs failed to complete perineal cares. During an interview on 05/21/25 at 1:08 p.m., an administrative nurse (#1) stated she expected staff to provide dependent residents with ADLs.	F 677		
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	F 689		6/20/25

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F 689	Continued From page 7 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 professional reference, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents for 2 of 9 sampled residents (Resident #5 and #49) observed during transfers. Failure to utilize and/or properly use gait belts and lock wheelchair brakes during transfers placed the residents at risk of injury and/or pain. Findings include: Review of the policy titled "Standards of Care" occurred on 05/21/25. This policy, dated August 2024, stated, ". . . A gait belt will be used for all assisted transfers . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th edition, eText 2021, Pearson Education, Inc., New Jersey, page 1106, stated, ". . . Positioning a client in good body alignment . . . are essential aspects of nursing practice . . ." Page 1117, stated, "Wheelchair Safety: Always lock the brakes on both wheels of the wheelchair when the client transfers in or out of it. . . . Ensure the client is positioned well back in the seat of the wheelchair. . . ." -Review of Resident #5's medical record occurred on all days of survey. Diagnosis included a history of falls. The care plan stated, "Unsteadiness on feet . . . Weakness . . . Transfers: Assist X [of] 1 [staff] . . ."	F 689	1. Staff involved in observation educated on resident #5 and #49□s proper transfers of residents including facility policy Standards of Care, specifically regarding proper use of gait belts and expectations of locking wheelchair brakes during transfers to prevent accidents proper application of gait belt on 5/27/2025. 2. All residents requiring assistance with transfers/ambulation have the potential to be affected. 3. Education will be provided to all nursing staff on facility policy Standards of Care, specifically regarding proper use of gait belts and expectations of locking wheelchair brakes during transfers to prevent accidents by June 19th, 2025. 4. The DON or designee will audit proper placement of gait belts and proper use of wheelchair brakes during transfers weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025.	

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F 689	Continued From page 8 Observation on 05/19/25 at 1:23 p.m. showed Resident #5 seated in a wheelchair in her room. A certified nurse aide (CNA) (#9) attempted to transfer Resident #5 from the wheelchair to the bed by placing her arms under both of the resident's armpits and the resident stated, "Ow." The CNA (#9) reseated the resident and left the room to get additional staff assistance. Two CNAs (#9 and #10) entered the resident's room and attempted to assist the resident to stand. The CNA (#10) stated, "We need to use the gait belt" and applied a gait belt. Both CNAs (#9 and #10) placed one hand on the gait belt, placed their opposite arm under the resident's armpits, and transferred the resident to the bed. Observation on 05/20/25 at 8:04 a.m., showed two CNAs (#9 and #11) placed a gait belt around Resident #5's waist. The CNAs assisted the resident to stand and transferred the resident to the toilet. As they walked, the gait belt slid up under the resident's armpits. The CNAs failed to properly apply/secure the gait belt prior to the transfer. -Review of Resident #49's medical record occurred on all days of survey. The care plan stated, "High Risk for injury . . . Ambulation: Non-Ambulatory Gait: wc [wheelchair] with assist . . . Transfers: Assist X [of] 1 with Medi stand [sit-to-stand mechanical lift]." Observation on 05/20/25 at 8:24 a.m. showed two CNAs (#4 and #5) transferred Resident #49 from the bed, to the toilet, and from the toilet to the wheelchair utilizing a sit-to-stand mechanical lift. The CNAs failed to lock the brakes on the	F 689		

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F 689	Continued From page 9 wheelchair, and the wheelchair rolled away. One of the CNAs noticed and locked one of the brakes. As the CNAs (#4 and #5) lowered the resident into the wheelchair, the chair pivoted away from the lift, and the back wheels of the chair lifted off the ground. The CNAs lowered the resident into the wheelchair and told her to "scoot" back while still in the lift harness. Resident #49 tried to scoot back but failed. The CNAs (#4 and #5) removed the lift harness and pushed on the resident's chest causing the resident to lean back, hips still forward, and slouching in the wheelchair. The CNAs (#4 and #5) reclined the wheelchair back. The CNAs (#4 and #5) failed to lock the wheels on the wheelchair, and place Resident #49 in a comfortable seating position in the wheelchair. During interviews on the afternoon of 05/21/25, three administrative staff members (#1, #2, and #3) stated they expect staff to lock all wheelchair brakes prior to transfers and staff member (#1) stated she expected staff to properly utilize gait belts for all assisted transfers.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		6/20/25

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F 695	Continued From page 10 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide respiratory care for 1 of 1 sampled resident (Resident #5) with an order for oxygen. Failure to administer oxygen according to physician orders may result in complications and compromise the residents' respiratory status. Findings include: Review of the facility policy titled "Oxygen use and Storage" occurred on 5/21/25. This policy, dated July 2023, stated, ". . . Oxygen will be administered per practitioner orders . . ." Review of Resident #5's medical record occurred on all days of survey and identified a physician's order, dated 05/14/25, stated, oxygen at 2 liters per minute per nasal cannula. Observation on all days of survey showed Resident #5 without oxygen. During an interview on 05/21/25 at 1:08 p.m., an administrative staff member (#1) stated she expected staff to administer oxygen as ordered.	F 695	1. Resident #5 s respiratory status was assessed, and order was updated as prescribed. Staff were educated on the use of supplemental oxygen for resident #5 on 5/21/22. 2. All residents who use supplemental oxygen have the potential to be affected. 3. The facility will educate all nursing staff on facility policy Oxygen Use and Storage, specifically regarding administering oxygen according to physician orders. Staff education will be provided by June 19th, 2025. 4. The DON or designee will audit the use of supplemental oxygen for all residents on oxygen, as ordered weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025.	
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	F 880		6/20/25

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(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
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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 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

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	355078	A. BUILDING _____ B. WING _____	05/21/2025

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F 880	Continued From page 12 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 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 14 sampled residents (Resident #43, #49, and #52) and one supplemental resident (Resident #272) observed during cares. Failure to practice infection control standards related to hand hygiene, enhanced barrier precautions (EBP), and disinfecting of mechanical lifts has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 05/21/25. This policy, revised November 2024, stated, ". . . hand hygiene will be done: a. Before and after resident contact	F 880	1. Staff will be educated on proper infection control process with EBP, glove use with peri cares, and proper disinfecting of lifts after use. Education was provided to staff who were working during the observations on 5/19/25-5/21/25. 2. All residents have the potential to be affected. 3. Education will be provided to all nursing staff on facility policies Hand Hygiene, Infection Control- Enhanced Barrier Precautions, and proper disinfection of mechanical lifts to ensure infection control standards are met by June 19th, 2025. 4. The DON or designee will audit proper infection control practices related	

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F 880	Continued From page 13 (before you leave the room) . . . After every dirty procedure . . ." Review of the facility policy titled "Transmission-Based Precautions" occurred on 05/21/25. This policy, revised December 2024, stated, ". . . Enhanced barrier precautions . . . gown and gloves must be worn during high-contact care activities such as . . . assisting with toileting . . ." - Observation on 05/19/25 at 12:33 p.m. showed two certified nurse aides (CNAs) (#6 and #7) applied gloves and used a mechanical lift to transfer Resident #52 to the toilet. The CNA (#6) removed the resident's pants and wet brief, provided incontinence cares, and with the same gloves, the CNA (#6) utilized the mechanical lift to position the resident upright. The CNA (#7) dressed the resident and both CNAs (#6 and #7) transferred the resident to the recliner. The CNA (#7) pulled the lift away, helped remove the torso strap, retrieved the TV remote from a dresser drawer, and offered the resident a drink of water. The CNAs (#6 and #7) failed to remove gloves after completing toileting cares, failed to perform hand hygiene with glove removal, and failed to cleanse the lift before removing the lift from the room. - Observation on 05/19/25 at 4:35 p.m. showed a CNA (#14) assisted Resident #43 with perineal cares after a bowel movement. The CNA (#14) applied gloves, performed perineal care, removed her gloves, applied clean gloves, assisted the resident into her wheelchair and removed her gloves. The CNA (#14) assisted the resident to her room, gave the resident the call	F 880	to hand hygiene and glove use during and after peri cares weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. Proper use of isolation items and personal protective equipment (PPE) for residents on isolation precautions will be audited weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. Proper disinfecting of mechanical lifts after each resident use will be audited weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be June 20th, 2025.	

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light, collected the garbage, and exited the room. The CNA (#14) failed to perform hand hygiene after removing the soiled gloves, before applying clean gloves, and before exiting the resident's room.

- Observation on 05/20/25 at 8:24 a.m. showed Resident #49 in bed and two CNAs (#4 and #5) performed perineal care. The CNA (#4) completed the perineal care and without removing the soiled gloves, performing hand hygiene, and applying clean gloves, utilized the mechanical lift and transferred Resident #49 to the toilet. The CNAs (#4 and #5) pulled down the pants and brief, and sat the resident on the toilet. The CNA (#4) completed perineal care, transferred the resident to the wheelchair, offered water, and combed the resident's hair. The CNA (#4) then removed the soiled gloves and performed hand hygiene.

- Review of Resident #272's medical record occurred on all days of survey. The care plan stated, ". . . skin integrity r/t [related to] surgical incision . . . Enhanced Barrier Precautions . . ."

Observation on 05/20/25 at 9:35 a.m. showed a nurse (#15) assisted Resident #272 with toileting. The nurse applied gloves and performed perineal care. The nurse (#15) failed to follow EBP guidelines and apply a gown during a high contact care activity of toileting.

During an interview on 05/21/25 at 10:45 a.m., an administrative nurse (#16) stated she expected staff to perform hand hygiene after glove changes, before leaving a resident's room, and to follow EBP guidelines.

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