STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	**1307 N 7TH ST , WAHPETON, North Dakota, 58075**

(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
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification, complaints and facility reported incident survey started 01/25/26 and concluded 01/28/26.	F0000		02/18/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI) and investigation, and review of facility policy, the facility failed to ensure residents remained free from abuse for 1 of 1 closed record (Resident #51) who displayed physical behaviors towards another resident. Failure to protect residents from physical abuse resulted in injury and pain. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: Review of the facility policy titled "Abuse Prevention Plan" occurred on 01/29/26. This policy, dated year 2017, stated, ". . . In order to prevent abuse . . . the	F0600	"Past Noncompliance - no plan of correction required"	03/27/2025

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 reverse for further 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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F0600 SS = G	Continued from page 1 facility shall do the following . . . Identify, correct, and intervene in situations where abuse . . . occurs. . . . Assess residents with needs and behaviors that might lead to conflict . . . The facility will develop an individual abuse prevention plan for each vulnerable adult who receives services in the facility. The plan shall contain an individual assessment of . . . The resident's risk of abusing other vulnerable adults; and Specific measures to be taken to minimize the risk of abuse . . . of residents and other vulnerable adults. . . . Once suspected abuse . . . has been identified, safety measures will be implemented to ensure the safety of the suspected vulnerable adult and other residents. . . ." The surveyor determined a deficient practice existed on 03/27/25 when Resident #51 punched Resident #19 in the face. The facility implemented and completed corrective action on 04/03/25. Review of Resident #19's medical record occurred on all days of survey and identified diagnoses of traumatic brain injury and dementia with behaviors. A Brief Interview for Mental Status (BIMS), completed on 03/27/25, identified a score of 11 indicating moderately impaired cognition. Review of Resident #51's medical record occurred on all days of survey and identified diagnoses of mild vascular dementia with agitation and moderate recurrent major depressive disorder. A BIMS, completed on 03/27/25, identified a score of 13 indicating minimal cognitive impairment. The care plan identified ". . . Behavioral Symptoms. I have a hx [history] of socially inappropriate/disruptive behavioral symptoms such as threatening to cause harm to other residents, not being receptive to staff when trying to redirect or re orientate, being verbally aggressive towards other residents, and a hx of becoming physically abusive towards other residents. . . ." Staff updated the care plan after the incident on 03/27/25. The medical record identified Resident #51 transferred to another facility on 04/03/25. Review of the FRI report/final investigation, dated 04/03/25, stated, ". . . Resident [#19] was hit in the face by another resident [Resident #51]. Residents involved were immediately separated by staff witnessing incident. Resident [#19] sent to Emergency Department [ED] for further evaluation. Police on site investigating. . . . Investigation indicated that allegation of abuse was verified as occurring and meeting the definition for abuse. [Resident #51] was asked in an interview with SSD [social service director] if he meant to cause	F0600		03/27/2025

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F0600 SS = G	Continued from page 2 physical harm and wished to cause pain, this resident stated 'yeah, that's why I punched him.' . . ." Resident #51's progress note, dated 03/27/25 at 5:14 p.m., stated, "At 4:45pm heard hollering coming from commons area. Assessed situation and witnessed resident [Resident #51] standing over a male resident [Resident #19] while holding his fist up towards resident. . . . RN [registered nurse] present and intervened, preventing resident throwing another punch. . . . This nurse assisted resident [#51] back to his room via wheelchair. Resident appeared angry with red eyes. Resident comments on how he 'hates that guy', 'I just wanted to hit him'. Interview completed with resident [#51]. Resident states, 'My lady bumped into him [Resident #19] and he [Resident #19] told her to knock it off. I told him [explicative] and punch [sic] him in the face'. Informed resident [Resident #51] there will likely be consequences, resident states 'I don't care, it was worth it!' Resident told to stay in his room. Resident states understanding. SW [social worker] and administrator informed right after. . . ." Resident #19's progress note, dated 03/27/25 at 4:45 p.m., stated, ". . . On initial assessment, resident [Resident #19] complained of pain on left temporomandibular area. Noted redness on said area with no immediate swelling. . . . Re-assess after 10 minutes and resident still complains of pain and claims to be increasing; resident rated 7-8/10 headache. Rated pain on mentioned area on face as 2/10; no worsening of swelling or redness noted. . . . sending resident to ER [emergency room] for further evaluation. . . ." A note, dated 03/27/25 at 8:12 p.m., stated, ". . . Resident returned from ED . . . with no new orders. Noted to have mild redness on left side of face without bruising developing. Resident rates pain on area 1/10 and denies headache. . . ." Based on the following information, non-compliance at F0600 is considered past non-compliance. The facility implemented corrective actions for the residents affected by the deficient practice as follows: *Staff immediately intervened, separated the residents, assessed for injury, and sent Resident #19 sent to the ER for further evaluation. *Notified the Executive Director and SSD. Camera footage reviewed. *Notified local law enforcement and law enforcement	F0600		03/27/2025

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F0600 SS = G	Continued from page 3 took statements. *Notified family, primary care providers, and psychiatric providers for both residents. *Notified the State Ombudsman. *Resident #51's medication reviewed by psychiatric provider. *Interviewed Resident #19 and #51. *Implemented one-to-one support and 15-minute safety checks for both residents. *Educated Resident #51 on nursing home guidelines and physical aggression is not tolerated. *Care plans updated for both residents. *Held a team huddle with staff on duty to discuss the incident, immediate actions taken, how to handle resident to resident altercations, and reviewed the facility abuse policy.	F0600		03/27/2025
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F812 SS=E (Food Procurement, Store/Prepare/Serve - Sanitary) Affected Resident(s): No residents were affected negatively by this deficient practice at the time of the observation. Potential Affected Residents: All residents have the ability to be affected by the indicated deficient practice. Three audits were completed on or before 02/23/26 as follows; a sanitation audit of both north and south kitchen areas to ensure all sanitation concerns are identified, an audit to ensure tableware was placed on resident meal trays in a sanitary manner, and an audit to ensure the ware washing machine is free from food, dust, and mineralization debris. Any areas identified from the audit will have corrective action completed accordingly. Measures/Systemic Changes: Education to be provided to all culinary associates	02/26/2026

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F0812 SS = E	Continued from page 4 Based on observation and review of professional reference, the facility failed to maintain a clean and sanitary kitchen for 2 of 2 kitchens (North Kitchen and South Kitchen). Failure to ensure tableware is placed on resident meal trays in a sanitary manner and ensure floors, cabinets, and the warewashing machine are free from food, dust, and mineralization debris has the potential for contamination of dishware/food and may result in foodborne illness to residents, staff, and visitors. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, Section 4-904.13, page 455, stated, "The presentation or setting of . . . cleaned and sanitized utensils shall be done in a manner designed to prevent the contamination of food- and lip-contact surfaces. Section 6-501.17, page 476, stated, "Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. . . ." Observations on 01/25/26 at 12:20 p.m. showed the following: * North Kitchen: Burnt loose and baked-on debris in two ovens located under a stove and scattered food/debris on the floors throughout the kitchen and in the mechanical warewashing room. * South Kitchen: Burnt loose and baked-on debris in the double ovens, an approximate 14-inch linear area of dried food on the side of a silver lower cabinet, scattered food/debris on the floors throughout the kitchen, and mineral buildup and food debris located under the handwashing sink. Observations on 01/27/26 at 9:30 a.m. showed the following: * North Kitchen: Loose debris, dust, and mineralization accumulated on the top of the mechanical warewashing machine and the scattered food/debris remained on the floors throughout the kitchen and the mechanical warewashing room. * South Kitchen: Dried food on the side of the cabinet and the scattered food/debris remained on the floors throughout the kitchen and under the handwashing sink. New debris present on the floor from cleaning the double ovens. - Observation on 01/28/26 at 8:20 a.m. showed two	F0812	Continued from page 4 (to be completed on or before 02/23/26) related to Hand Hygiene, Sanitation of the Culinary Department, Infection Control – General Practice, Cleaning Guidelines, daily/weekly cleaning schedules, and proper placement of tableware on resident trays. Monitoring: The Certified Dietary Manager (CDM) and/or designee will complete sanitation audits weekly for 1 month for both kitchens areas, then monthly for 3 months to assure that kitchen areas are clean and sanitary. An audit of random culinary staff (3 weekly) will be conducted for proper handling of hand hygiene and drinkware x 4 months. The audits will be reviewed by the CDM and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The CDM and/or designee will follow up on further training and process improvements as needed. Completion Date: 02/26/26	02/26/2026

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F0812 SS = E	Continued from page 5 unidentified dietary staff members failed to perform hand hygiene and touched the rims of the water, juice, milk, and coffee cups with their bare hands when removing the covers and/or arranging them onto the resident meal plates.	F0812		02/26/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F0584	F584 SS=D (Safe/Clean/Comfortable/Homelike Environment) Affected Resident(s): Resident #9 and #34. Upon inspection on 01/26/26, the toilet in the shared bathroom was cleaned with no residual matter visible in the toilet and will continue to be audited for cleanliness. Potential Affected Residents: All residents have the ability to be affected by the indicated deficient practice. An audit of all resident bathrooms was completed on or before 02/23/26 to ensure all areas were clean and sanitary promoting a homelike living environment. Any areas identified from the audit will have cleaning completed accordingly. Measures/Systemic Changes: Education to be provided to all environmental associates (to be completed on or before 02/23/26) related to policy titled “Environmental Services Cleaning” and facility daily/weekly cleaning schedules. Implemented a daily checklist for accountability of cleaning tasks and responsible party. Monitoring: The Environmental Services Director and/or designee will complete fifteen toilet cleanliness audits weekly for 1 month then monthly for 3 months to assure that resident bathrooms are clean and sanitary. The audits will be reviewed by the Environmental Services Director and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Environmental	02/26/2026

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F0584 SS = D	Continued from page 6 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to ensure a clean and homelike environment for 2 of 9 sampled residents (Resident #9 and #34) with a shared bathroom. Failure to maintain a clean and sanitary bathroom does not promote a homelike living environment or enhance the resident's quality of life. Findings include: Review of the facility policy titled "Environmental Services - Cleaning" occurred on 01/29/25. This policy, dated 2020, stated, " . . . It is the policy of Benedictine communities that they be maintained in a clean and hygienic condition . . . Clean surfaces such as . . . toilet seats . . . according to the schedule established by EVS [environmental service] supervisor. . . . Community trash containers should be lined . . ." Observations of Resident #9 and #34's shared bathroom showed the following: *01/25/26 at 2:01 p.m., Bowel movement (BM) splattered throughout the inside of the toilet bowl and smeared on the back and top of the toilet seat. A trash can without a liner located beside the toilet contained several soiled wipes. Resident #34 stated housekeeping had not cleaned her bathroom yet today. *01/25/26 at 2:28 p.m., Resident #34 stated staff just completed her toileting cares in her bathroom. BM remained present in the toilet bowl and on the toilet seat. *01/26/26 at 8:10 a.m. and 1:54 p.m., BM splattered in the toilet bowl and smeared on the toilet seat. Resident #34 stated housekeeping had still not been in to clean her room/bathroom. *01/26/26 at 4:44 p.m., The toilet bowl and seat remained the same. Resident #34 stated no housekeeping occurred in her room again today. During an interview on 01/26/26 at 8:35 a.m., a housekeeping staff member (#5) indicated housekeeping staff are present at the facility seven days a week.	F0584	Continued from page 6 Services Director and/or designee will follow up on further training and process improvements as needed. Completion Date: 02/26/26	02/26/2026

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F0584 SS = D	Continued from page 7 During an interview on 01/26/26 at 4:53 p.m., an administrative staff member (#1) stated she expects staff to notify housekeeping to address bathroom cleanliness or clean areas with sanitizing wipes after care provided.	F0584		02/26/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 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 accurate medication labeling and storage for 1 of 1 resident (Resident #3) observed receiving insulin and 1 of 3 medication carts (cart #700). Failure to ensure proper medication labeling and storage may result in medication errors and unauthorized access to medications. Review of the facility policy titled “Labeling of Medications due to order change” occurred on 01/28/26. This undated policy stated, “ . . . 1. If change in medication dose pharmacy either A) sends a “see mar for orders” label . . . or B) sends new label . . . 2. If pharmacy does not send a “see mar	F0761	F761 SS=D (Label/Store Drugs and Biologicals) Affected Resident(s): Resident #3. A “Directions Changed” label was placed on the insulin pen by the nurse and new label was ordered from the pharmacy. Potential Affected Residents: All residents who receive insulin have the ability to be affected by the indicated deficient practice. An audit of all insulin pens was completed on or before 02/23/26 to ensure proper medication labeling. Any areas identified from the audit will have “directions changed, see MAR for instructions” label in place, pharmacy notified, and new label sent/applied by pharmacy. A secondary audit was completed on or before 02/23/26 to ensure medication carts were locked when unattended. Any areas identified from the audit will require the medication cart to be immediately locked and real time staff education accordingly. Measures/Systemic Changes: Education to be provided to all Licensed Nursing associates (to be completed on or before 02/23/26) related to policy titled “Labeling of Medications due to order change” and policy titled “Administering Medications” specific to locking the medication cart when unattended. Monitoring: The Director of Nursing (DON) and/or designee will complete insulin pen label audits, and medication cart lock audits weekly for 1 month on all residents that receive insulin, then monthly for 3 months to assure that insulin pen labels are correct according to MAR and physician orders and that medication carts are locked when unattended. The audits will be	02/26/2026

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F0761 SS = D	Continued from page 8 for order" label the nursing staff are to continue to administer the correct does per the physician orders in the electronic records until pharmacy has complied." Review of the facility policy titled "Administering Medications" occurred on 01/28/26. This policy, revised on 08/31/23, stated, " . . . 14. Medication cart is to be locked at all times when unattended. . . . " - Observation on 01/26/26 at 9:12 a.m. showed the label on Resident #3's insulin pen identified Lantus Solostar (an insulin medication) ten units in the morning. A nurse (#2) prepared twelve units of insulin and stated the provider changed the insulin order on 11/17/25, and the correct dose of 12 units is in the electronic medication administration record (eMAR). Review of Resident 3's eMAR occurred on 01/26/26 showed Lantus Solostar twelve units; with a start date of 11/17/2025. During an interview on 01/26/26 at 4:00 p.m., an administrative nurse (#1) confirmed the medication label did not match the physician's order in the eMAR. The administrative nurse (#1) stated the insulin pen labels typically say, "See MAR for dose" and she expects staff to follow the eMAR. -Observation on 01/25/26 at 4:00 p.m. showed a medication cart (#700) unlocked and unattended and a staff nurse (#4) down the hallway. -Observation on 01/27/26 at 7:45 a.m. showed a medication cart (#700) unlocked and unattended. Eight minutes later, an administrative nurse (#1) walked by the medication cart (#700) and locked it. During an interview on 01/27/26 at 3:39 p.m., an administrative nurse (#1) stated she expects staff to lock the medication cart when unattended.	F0761	Continued from page 8 reviewed by the DON and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The DON and/or designee will follow up on further training and process improvements as needed. Completion Date: 02/26/26	02/26/2026
F0880 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.	F0880	F880 SS=D (Infection Prevention & Control) Affected Resident(s): Resident #14 and #30. Residents #14 and #30 had no negative health outcomes related to the deficient practice at the time of observation. Potential Affected Residents:	02/26/2026

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ST CATHERINES LIVING CENTER	**1307 N 7TH ST , WAHPETON, North Dakota, 58075**

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F0880 SS = D	Continued from page 9 §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 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	F0880	Continued from page 9 All residents have the ability to be affected by the indicated deficient practice. Audits were completed on or before 02/23/26 to ensure infection control and prevention standards are followed by associates in relation to hand hygiene and dressing changes. Any areas identified from the audit will require real time staff education and competency completion accordingly by 02/26/26. Measures/Systemic Changes: Education to be provided to all facility associates (to be completed on or before 02/23/26) related to standard of infection control and prevention and facility policy titled “Hand Hygiene”. Dressing change competency review to be completed with licensed nurses on or before 02/26/26. Monitoring: The Director of Nursing (DON) and/or designee will complete infection control and prevention and hand hygiene and dressing change audits weekly for 1 month on 5 associates, then monthly for 3 months on 5 associates to assure that hang hygiene and dressing changes are completed according to facility policy. The audits will be reviewed by the DON and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The DON and/or designee will follow up on further training and process improvements as needed. Completion Date: 02/26/26	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 10 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 1 of 3 sampled residents (Resident #14) and one supplemental (Resident #30) observed during cares. Failure to practice infection control standards related to glove use and hand hygiene has the potential to spread infection throughout the facility. Review of the facility policy titled “Hand Hygiene” occurred on 01/29/26. This policy revised September 2023, stated, “. . . Times to Perform Hand Hygiene are, but not limited to: . . . Before and after direct resident contact . . . assisting a resident with personal cares . . . assisting a resident with toileting . . . After removing gloves . . .” - Observation on 01/25/26 at 1:12 p.m. showed a certified nurse aide (CNA) (#3) transferred Resident #30 to the toilet using a stand lift. Without wearing gloves, the CNA (#3) removed the resident’s wet brief, applied gloves without performing hand hygiene, placed a clean brief on the resident, removed her gloves and wiped her hands on her pants. Without completing hand hygiene, the CNA (#3) applied new gloves and completed perineal care for Resident #30, removed her gloves, assisted the resident to bed and exited the room without completing hand hygiene. During an interview on 01/28/26 at 10:45 a.m., an administrative nurse (#1) stated she expects staff to perform hand hygiene with an alcohol-based hand sanitizer after resident cares and in between glove changes. -Review of Resident #14’s medical record occurred on all days of survey. The care plan stated, “. . . I require enhanced barrier precautions [EBP] r/t [related to] chronic ulcer on right thigh and	F0880		02/26/2026

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F0880 SS = D	Continued from page 11 colostomy . . . suspected carrier of MRSA [methicillin resistant Staphylococcus aureus]. . .” Observation on 1/26/26 at 10:10 am. showed a nurse (#6) applied a gown and gloves and entered Resident #14's room. The nurse (#6) obtained supplies from a dresser in the resident's room and placed the supplies on the bedside table. The nurse (#6) removed the dressing from Resident #14's right hip wound and cleaned the drainage from the wound. Without removing the soiled gloves, the nurse opened clean dressings, cleansed the wound with normal saline, and patted it with a gauze. The nurse (#6) opened another dressing, placed it on the wound, and taped the dressing in place. The nurse (#6) then removed the gown and soiled gloves and exited the room. The nurse failed to perform hand hygiene before entering and exiting the resident's room and failed to remove the soiled gloves and perform hand hygiene between soiled and clean dressing changes. During an interview on 01/28/26, an administrative nurse (#1) stated she expected staff to perform hand hygiene with dressing changes.	F0880		02/26/2026