STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountrail Bethel Home	615 6th St SE Stanley, ND 58784

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, resident representative interview, and staff interview, the facility failed to notify the resident representative for 1 of 2 sampled residents (Resident #34) reviewed for falls and resident to resident altercations. Failure to notify the resident representative of a fall and resident to resident altercations does not allow the representative to be fully informed of the resident's current status. Findings include: Review of the facility policy titled Fall Protocol Policy occurred 12/04/24. This policy, dated December 2020, stated, . If the resident doesn't obtain an injury during the fall, the emergency contact will be notified as soon as possible, or next morning if the fall occurs during overnight hours. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy . occurred 12/04/24. This policy, revised May 2023, stated, . All alleged violations involving abuse . are reported immediately to the facility Administrator or other designated staff . in accordance with State Law through established procedures. These include: . Resident Representative . Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia and falls. A quarterly Minimum Data Set, dated dated [DATE], identified four falls, and moderately impaired cognition. Review of Resident #34's nurse's notes identified the following: * 10/19/24 at 3:52 p.m., . Staff had heard hollering from residents [sic] room and another resident [sic] in his room and both were swinging there [sic] arms. Resident in w/c [wheelchair] in room stated the other resident hit him in face. No injuries noted at this time. Will monitor. * 11/17/24 at 6:38 p.m., . Resident yelling, 'help, help', CNA [certified nurse aide] walked into resident's room and noticed that resident was sitting upright on the floor with legs extended out towards toilet. Denying hit head. Resident stated, 'I was trying to sit in w/c [wheelchair] after coming back from the bathroom.' Vital signs WDL [within defined limits] per resident's baseline. No c/o [complaints of] pain or discomfort. MD [medical doctor] notified. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/02/24 at 4:46 p.m., Resident #34's representative stated the resident had multiple falls and was not sure the facility had contacted him for all falls. He further stated the facility did not contact him regarding the incident between Resident #34 and the other resident, he was told by Resident #34's brother who also resides in the facility. During an interview on 12/03/24 at 3:10 p.m., an administrative nurse (#2) confirmed the facility failed to notify Resident #34's representative of the resident to resident altercation until he called the facility to ask about it. During an interview on 12/03/24 at 3:33 p.m., an administrative nurse (#1) confirmed the facility failed to notify Resident #34's representative about the resident's fall on 11/17/24, and she expected staff to notify the resident representative with all falls, and resident to resident altercations.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on review of the facility reported incident and investigation documents, record review, review of facility policy, and staff interview the facility failed to protect the residents' right to be free from physical abuse and psychosocial harm for 1 of 2 sampled residents (Resident #34) and 1 supplemental resident (Resident #3) who experienced abuse by another resident. Failure to ensure an environment free from abuse placed Residents #3, #34, and other residents at risk for abuse, fear, anxiety, and/or psychosocial harm. This citation is considered past non-compliance based on review of the corrective action the facility implemented following the incident. Findings include: The surveyor determined a deficient practice existed on 10/19/24 and 11/04/24. The facility implemented and completed corrective action on 11/04/24. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy . occurred on 12/04/24. This policy, revised May 2023, stated, . Abuse, Neglect, exploitation, mistreatment . is prohibited. Physical Abuse is defined as the willfully hitting, slapping, pinching, kicking, etc. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention Facility Policy . occurred on 12/04/24. This policy, revised May 2023, stated, . Each resident has the right to freedom from all forms of abuse . Residents must not be subjected to abuse by anyone including, but not limited to . other residents . Resident to Resident Altercations: . Altercations that must be reported in accordance with regulations include ay [sic] willful action that results in physical injury, mental anguish, or pain . - Review of Resident #3's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Review of Resident #3's nurses notes identified the following: * 11/02/24 at 5:00 p.m., . [Resident #3] was in her room while staff was down the hall from her, [Resident #17] had entered [Resident #3's] room, the resident had yelled out for help so staff ran to her room and when staff entered the resident room [Resident #17] had [Resident #3's] arm grasped with his one hand and was hitting the resident with his other hand, staff quickly grabbed [Resident #17] to keep him from making contact with the resident, staff tried asking him to leave the room but he would not listen or leave and continued attempting to assault the resident, staff had to physically remove [Resident #17] from the residents room . staff tried asking ifthe[sic] resident was harmed or hurt in anyway but [Resident #3] was overwhelmed with anxiety and was very upset so staff left the resident so she could calm down. * 11/04/24 at 1:32 p.m., stated, . Incident was reported to ND HHS [North Dakota Department of Health and Human Services] due to resident being hit by another resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of Resident #34's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], identified moderately impaired cognition. Review of Resident #34's nurses notes identified the following: * 10/19/24 at 3:52 p.m., stated, . Staff had heard hollering from [Resident #34's] room and [Resident #17] in his room and both were swinging there [sic] arms. Resident in w/c [wheelchair] in room stated [Resident #17] hit him in face. No injuries noted at this time. Will monitor. * 10/22/24 at 4:27 p.m., stated, . Incident was reported to ND HHS. Maintenance has been notified to place a yellow strip in front of resident's door to try divert other resident from wanting to enter his room. Review of the facility investigation report occurred 12/04/24. This report, dated 10/19/24, stated, . Staff watched other resident enter resident's room, and got up to remove the other resident from [Resident #34's] room. While on their way to his room they heard [Resident #34] say 'get the hell out of my room.' by [sic] the time the CNA got to his room CNA observed both resident's swinging their arms and observed the other resident hit [Resident #34] on the lip one time. The report included a statement from a CNA (#1), which stated, . saw [Resident #17] enter [Resident #34's] room . observed [Resident #17] hit [Resident #34] in the lip one time. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions as follows: * The interdisciplinary team met to problem solve and implement changes and interventions for resident care and safety. * Implemented a safety plan addressing the behaviors of Resident #17. * Notified medical director and psychiatric provider for Resident #17 of the incidents. * Notified resident representatives of the incident and actions implemented. * Education provided to all staff on safety plan and behavioral interventions for Resident #17.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on review of the facility reported incidents (FRI), record review, review of facility policy, and staff interview, the facility failed to report incidents of abuse to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #34) and 1 supplemental resident (Resident #3) who experienced physical abuse. Failure to report physical abuse in the prescribed time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy occurred on 12/04/24. This policy, revised May 2023, stated, . Abuse, Neglect, exploitation, mistreatment . is prohibited. To assist our facility's staff members in recognizing incidents of abuse, the following definitions of abuse are provided: . Immediately: Means as soon as possible, in absence of a shorter State time frame requirement, but not later than . 24 hours if the events that cause the allegation . do not cause serious bodily injury. Physical Abuse is defined as the willfully hitting, slapping, pinching, kicking, etc. alleged violations and results of all investigations must be reported to the administrator of the facility and/or other designees in accordance with state law AND the state survey and certification agency. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention Facility Policy occurred on 12/04/24. This policy, revised May 2023, stated, . Each resident has the right to freedom from all forms of abuse . Residents must not be subjected to abuse by anyone including, but not limited to . other residents . All alleged violations involving . abuse . will be reported immediately . to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency). Resident to Resident Altercations: . Altercations that must be reported in accordance with regulations include ay [sic] willful action that results in physical injury, mental anguish, or pain . - Review of Resident #3's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Review of Resident #3's nursing notes identified the following: * 11/02/24 at 4:25 p.m., . CNA [certified nurse aide] reported that [Resident #17] was near resident's door and the two [Resident #3 and #17] got into an altercation. CNA also reported that [Resident #17] tried hitting her. When asking [Resident #3] what happened she was not able to answer due to the amount of anxiety she was having. No signs of injuries that nurse writing can observe. Will reapproach when she is more calmed down. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 11/02/24 at 5:00 p.m., . [Resident #3] was in her room while staff was down the hall from her, [Resident #17] had entered the resident's room, the resident had yelled out for help so staff ran to her room and when staff entered the resident room [Resident #17] had [Resident #3's] arm grasped with his one hand and was hitting the resident with his other hand, staff quickly grabbed [Resident #17] to keep him from making contact with the resident, staff tried asking him to leave the room but he would not listen or leave and continued attempting to assault the resident, staff had to physically remove [Resident #17] from the residents room . staff tried asking ifthe[sic] resident was harmed or hurt in anyway but [Resident #3] was overwhelmed with anxiety and was very upset so staff left the resident so she could calm down. * 11/04/24 at 1:32 p.m., . Incident was reported to ND HHS [North Dakota Department of Health and Human Services] due to resident being hit by another resident. Two days after the altercation. - Review of Resident #34's medical record occurred on all days of survey. A quarterly MDS, dated [DATE], identified moderately impaired cognition. Review of Resident #34's nurses notes identified the following: * 10/19/24 at 3:52 p.m., . Staff had heard hollering from [Resident #34] room and another resident in his room and both were swinging there [sic] arms. [Resident #34] in w/c [wheelchair] in room stated the other resident hit him in face. No injuries noted at this time. Will monitor. * 10/22/24 at 4:27 p.m., . Incident was reported to ND HHS. Maintenance has been notified to place a yellow strip in front of resident's door to try divert other resident from wanting to enter his room. Three days after the altercation. During an interview on 12/04/24 at 12:30 p.m., administrative nurses (#1 and #2) confirmed the facility failed to report the incidents between Residents #3, #17, and #34 to the SSA within 24 hours.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46477 1. Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 1 of 2 residents (Resident #34) observed for insulin preparation and administrations. Failure to administer rapid-acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of Important safety information for NovoLog (rapid acting insulin), found at https://www.novolog.com occurred on 12/04/24 and stated, and About NovoLog(R) Rapid-Acting Insulin ., occurred on 12/04/24 and stated, Novolog starts acting fast. Eat a meal within 5 to 10 minutes after taking it. - Review of Resident #34's medical record occurred on 12/04/24. Current physician's orders included Novolog Insulin; Inject 3 unit subcutaneously three times a day. Observations on 12/04/24 showed the following: * 11:04 a.m., a nurse (#3) prepared and administered 3 units of NovoLog insulin to resident #34. * 11:45 a.m., Resident #34 was seated in the dining room without access to juice and dessert until 41 minutes after receiving rapid-acting insulin. The facility failed to follow manufacturer's instructions for rapid-acting insulin related to administration and timing of the meal for Resident #34. During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, our expectation is the nurse should administer insulin between 11:00 a.m. and 12:00 p.m. as stated on the medication administration record. 2. Based on observation and staff interview, the facility failed to ensure 1 of 1 treatment cart contained medications prescribed and labeled for residents of the facility. Failure to store and/or dispense medications not intended for residents of the facility has the potential to result in a medication error. Finding include: Observations on 12/04/24 at 10:00 a.m. showed a medication cup with several loose tablets and capsules in the corner of the first drawer of the treatment cart. During an interview on 12/04/24 at 10:00 a.m., a staff nurse (#3) stated, oh, those are mine, I need to remember to take them. The nurse (#3) removed the medication cup from the cart and put it in her pocket. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, personal medications should not be stored in the medication or treatment carts.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39685 Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, the facility failed to utilize the assistive devices necessary to prevent accidents for 1 of 4 sampled resident (Resident #19) observed during a transfer. Failure to use a gait belt during transfers has the potential to place residents at risk of falls with/without injury. Findings include: Review of the facility policy titled Use of Gait Belt, occurred on 12/04/24. This policy, dated December 2020, stated, . use gait belts with residents that need assistance to ambulate or transfer for the purpose of safety . Physical Therapy will assess residents upon admission and determine their need for a gait belt . [the facility] will have designated gait belts for each resident who requires one . All employees will receive education on the proper use of a gait belt . Review of Resident #19's medical record occurred on December 4, 2024. The care plan, stated, . I am at risk for falls related to physical decline . I pivot transfer with assist of 1 staff for transfers . use gait belt for safety . Observations on 12/03/24 showed the following: * At 3:56 p.m., a staff nurse (#3) and a certified nurse aide (CNA) (#5) transferred Resident #19 from the wheelchair to the bedside commode. Both staff members (#3 and #5) placed their hands under the Resident's arms and lifted her to a standing position. The staff members (#3 and #5) failed to use a gait belt during the transfer. * At 4:10 p.m., while transfering Residnt #19 from the commode both staff members (#3 and #5) again placed their hands under Resident #19's arms and lifted her to a standing position. Resident #19 lost her balance, supported herself by leaning on the arms of the wheelchair, and required staff assistance to sit back down. The staff members (#3 and #5) failed to use a gait belt during the transfer. During an interview on 12/03/24 at 8:15 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt during transfers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46477 Based on observation and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 2 medication/treatment carts observed. Failure to store all medications securely may result in unauthorized access to medications. Findings include: On 12/02/24 at 11:51 a.m., Observation showed staff nurse (#4) unlock the treatment and walk away to administer insulin. The staff nurse (#4) left the treatment cart unlocked and unattended for five minutes by the nurse's station out of the nurses' view with visitors, staff members, and residents present. During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, it is our expectation that the carts be locked when out of sight.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39685 Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 12 sampled residents (Resident #8, #10, #17, #19, and #25) observed during cares. Failure to practice infection control standards related to hand hygiene, catheter care, equipment disinfection, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene Policy occurred on 12/04/24. This policy, dated December 2020, stated, . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility policy titled Foley Catheter Care Policy occurred on 12/04/24. This policy, revised October 2022, stated, . to provide catheter care to all residents that have an indwelling catheter to reduce UTIs [urinary tract infections] . With a new moistened cloth, wipe the catheter making sure to hold the catheter in place . Review of the facility policy titled Enhanced Barrier Precautions Policy occurred on 12/04/24. This policy, revised May 2024, stated, . use of gown and gloves for use during high-risk resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organisms] as well as those at increased risk of MDRO acquisition (e.g., [examples] residents with wounds or indwelling medical devices . High-contact resident care activities include: . Urinary Catheter Care . Wound care . Dressing, AM [morning] or PM [evening] cares, peri [perineal] cares, transferring. Review of the facility policy titled, Mechanical Lift Policy, occurred on 12/04/24. This policy, revised December 2020, stated, . Total body lift . disinfect lift after each resident use . standing lift . disinfect lift after each resident use . - Observation on 12/02/24 at 3:57 p.m. showed two certified nurse aides (CNAs) (#6 and #7) assisted Resident #8 to the bathroom. The CNAs performed perineal cares after a bowel movement, removed their gloves and failed to perform hand hygiene. - Observation on 12/02/24 at 2:59 p.m. showed two CNAs (#6 and #7) transfer Resident #10 to the bathroom. After completing perineal cares, the CNAs removed their gloves and failed to perform hand hygiene. then without cleaning the lift removed it from the room, and placed it in the hallway storage area. - Review of Resident #17's medical record occurred on all days of survey. Diagnosis included history of urinary tract infection. The current care plan stated, . enhanced barrier precautions r/t [related to] placement of indwelling catheter . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/02/24 at 11:32 a.m. showed an enhanced barrier precaution sign outside of Resident #17's room. Observation on 12/02/24 at 4:59 p.m. showed two CNAs (#6 and #7) performed hand hygiene, donned gowns and gloves, and entered Resident #17's room to provide catheter and incontinence cares. The CNA (#7) performed perineal cares after a bowel movement and wiped back to front. The CNA (#7) removed her gloves and without performing hand hygiene donned clean gloves, wet a washcloth, cleaned Resident #17's groin area, and with the same cloth wiped the catheter tubing, applied a clean brief, and pulled up the resident's pants. The CNA (#7) removed gloves and performed hand hygiene before exiting the room. The CNA (#7) failed to perform hand hygiene after removing soiled gloves and donning clean gloves, and failed to use a clean washcloth for cleansing the catheter tubing. - Review of Resident #19's medical record occurred on all days of survey. Diagnosis included pressure ulcer to coccyx and heel. The current care plan stated, . staff to utilize enhanced barrier precautions per policy . stage 3 PU [pressure ulcer] to my coccyx . Observation on 12/02/24 at 12:02 p.m. showed an enhanced barrier precaution sign outside of Resident #19's room. Observation on 12/02/24 showed the following: * At 3:11p.m., two CNAs (#6 and #7) entered Resident #19's room to provide incontinence cares. The CNAs performed hand hygiene, donned gloves, and without donning gowns, performed perineal cares and removed a wound dressing after a bowel movement. The CNAs removed their gloves and without performing hand hygiene, exited the room. The CNAs failed to don gowns when performing high-contact resident cares. * At 3:50 p.m., two CNAs (#6 and #7) entered Resident #19's room to provide incontinence cares. The CNAs performed hand hygiene, donned gloves, and without donning gowns, performed perineal cares. The CNAs removed their gloves and without performing hand hygiene, exited the room. The CNAs failed to don gowns when performing high-contact resident cares. - Review of Resident #25's medical record occurred on all days of survey. The current care plan stated, . Enhanced Barrier precautions r/t [related to] stasis ulcers to BLE [bilateral lower extremities] . Observation on 12/02/24 at 11:31 a.m. showed an enhanced barrier precaution sign outside of Resident #25's room. Observation on 12/03/24 at 9:55 a.m. showed Resident #25 seated in a wheelchair. Two CNAs (#6 and #7) entered Resident 25's room. The CNAs performed hand hygiene and donned gloves, and without donning gowns, assisted the resident with incontinence cares. The CNA (#7) performed bowel movement cares, removed her gloves and without performing hand hygiene, donned new gloves, applied a new brief, pulled up the resident's pants, and assisted the resident to the wheelchair. The CNAs removed their gloves, performed hand hygiene, and exited the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountrail Bethel Home	615 6th St SE Stanley, ND 58784

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both CNAs failed to wear gowns when performing high-contact resident cares, and the CNA (#7) failed to perform hand hygiene after removing soiled gloves and before donning clean gloves. Observation on 12/03/24 at 1:13 p.m. showed Resident #25 seated in a wheelchair. A nurse (#3) entered Resident #25's room, performed hand hygiene, donned a gown and gloves, and sat on the floor and performed a dressing change to the resident's bilateral lower extremities. The nurse (#3) removed the soiled dressings from both lower extremities, removed her gloves, and without performing hand hygiene, donned new gloves. The nurse (#3) cleaned the wounds, completed the dressing change, removed her gown and gloves, performed hand hygiene and exited the room. The nurse (#3) failed to perform hand hygiene after removing soiled gloves and donning clean gloves. During an interview on 12/04/24 at 08:15 a.m., an administrative nurse (#1) confirmed she expected staff to sanitize lift equipment after each resident use. During an interview on 12/04/24 at 2:45 p.m., an administrative nurse (#1) confirmed she expected staff to perform hand hygiene after removing soiled gloves and before donning clean gloves, wipe front to back when performing cares involving bowel movements, use clean cloths for catheter cares, and for staff to wear appropriate personal protective equipment when providing high contact cares for residents in enhanced barrier precautions. 42397