STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN REHABILITATION AND HEALTHCARE CENTER	226 N OAKLAND AVENUE EDEN, NC 27288

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/12/24 through 11/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V2KC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/12/24 through 11/15/24. Event ID# V2KC11. The following intake was investigated: NC00219491. 1 of the 5 complaint allegations resulted in deficiency.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		12/5/24

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

Electronically Signed | 12/02/2024

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F 690	Continued From page 1 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to secure the indwelling urinary catheter to reduce tension for 1 of 2 residents (Resident #200) reviewed for urinary catheter. Findings included: Resident #200 was admitted to the facility on 11/7/24 with diagnoses that included neuromuscular dysfunction of bladder, and calculus of ureter. The physician order dated 11/08/24 was to use an indwelling catheter with closed drainage system due to neuromuscular dysfunction of bladder. The physician order dated 11/08/24 included to use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. The order included to rotate site of securement as needed and check the securement every shift.	F 690	Preparation and submission of this plan of correction has been done to comply with the requirements of State and Federal law that mandate submission of a plan of correction as a condition to participate in Title 18 Medicare Program. This plan of correction is the facility□s letter of credible allegation of compliance. F690 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A new foley securement device was placed on identified resident #200 by Nurse #5 on November 13, 2024. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All other residents utilizing the same type	

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F 690	Continued From page 2 Documentation on his care plan noted 11/9/24 for the resident had Indwelling urinary catheter related to neurogenic bladder. The approaches included to position catheter bag and tubing below the level of the bladder and away from entrance room door and to place secure tape on leg for catheter security. The Minimum Data Set (MDS) assessment dated 11/13/24 revealed Resident #200 was severely cognitively impaired. He was coded to have an indwelling urinary catheter and was always incontinent of bowel. An observation on 11/12/24 at 3:14 pm showed Resident #200 indwelling catheter was not secured on his leg. There was a tape on the catheter tubing but was loose and the tape was not attached to the leg for securement. The resident was in bed and the catheter tube was visible when observed on the right side of his bed. It was also noted that the urine color in the tubing was dark colored with some sediment. Observation of catheter care on 11/13/24 at 3:48 pm noted that the urinary catheter tube was not secured to Resident #200's leg. Nurse Aide (NA #2) stated that it was loose and not secured to resident's leg. NA #2 further stated that she didn't know anything about the securement and did not know what to do with it. The tape was dated 11/11/24. Interview with Nurse #5 on 11/13/24 at 3:57 pm stated that the Wound Nurse was the one to check the securement device daily. Interview with the Wound Nurse on 11/14/24 at 9:58 am stated that she checked Resident #200's	F 690	of foley securement device product have the potential to be affected. The new type of foley securement device product was verified to be in place, by wound nurse, for all other residents with urinary catheter, on November 13, 2024. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The previous foley securement device product has been discarded. The new type of foley securement device product will be the single device type ordered for use on residents with urinary catheter. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Two Nurses will be interviewed weekly x 12 to verify new foley securement device product is staying adhered in place. Interview results will be reported to the QAPI committee monthly x 3, by the Director of Nursing or designee, for product review and recommendation of alternate securement device product as needed. Dates when corrective action will be completed: 12/5/24	

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F 690	Continued From page 3 securement device for his catheter tubing at 7:00 am this morning and it was intact at that time. She stated that the nurse on the floor also checks the securement devices. The Wound Nurse further stated the securement devices comes off easily. Interview with the DON on 11/15/24 at 10:50 am stated that all residents with indwelling urinary catheter should have a securement device attached. She stated the nurses should check them every shift.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		12/3/24

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F 732	Continued From page 4 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post accurate Registered Nurse (RN) staffing information for 51 of 103 days reviewed for posted nurse staffing (8/12/24, 8/14/24, 8/15/24, 8/19/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/25/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24, 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/7/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/25/24, 9/26/24, 9/30/24, 10/1/24, 10/5/24, 10/7/24, 10/9/24, 10/10/24, 10/14/24, 10/15/24, 10/17/24, 10/23/24, 10/24/24, 10/26/24, 10/28/24, 10/29/24, 10/30/24, 11/6/24, 11/7/24, 11/8/24, 11/11/24, 11/12/24). The findings included: The daily posted nurse staffing sheets were reviewed from August 2024 through November 2024 and revealed the following: -August 2024 did not have any RN documented as working for all 3 shifts on the following days: 8/12/24, 8/14/24, 8/15/24, 8/19/24, 8/20/24,	F 732	F732 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No residents have the potential to be affected. The RN staff category on the Daily Staff Posting for November 14, 2024 was updated to include administrative RN□s on duty. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Daily Staff Posting Form was updated to include administrative RN□s in the RN	

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F 732	Continued From page 5 8/21/24, 8/22/24, 8/23/24, 8/25/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24. -September 2024 did not have any RN documented as working for all 3 shifts on the following days: 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/7/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/25/24, 9/26/24, 9/30/24. -October 2024 did not have any RN documented as working for all 3 shifts on the following days: 10/1/24, 10/5/24, 10/7/24, 10/9/24, 10/10/24, 10/14/24, 10/15/24, 10/17/24, 10/23/24, 10/24/24, 10/26/24, 10/28/24, 10/29/24, 10/30/24. -November 2024 did not have any RN documented as working for all 3 shifts on the following days: 11/6/24, 11/7/24, 11/8/24, 11/11/24, 11/12/24. An interview with the Office Assistant occurred on 11/13/24 at 12:19pm. The Office Assistant confirmed she was responsible for completing the daily posted nurse staffing sheets. She explained she was provided with the schedule for the day by the Scheduler and from the schedule she completed the daily posted nurse staffing sheet. The Office Assistant stated that when she was not available to complete the daily posted nurse staffing sheets, the manager on duty was responsible for the completion of the daily posted nurse staffing sheet. The Office Assistant stated she was trained in completing the daily posted nurse staffing sheet by the Scheduler and that she was aware there needed to be a RN in the building at least 8 hours a day. The Office Assistant explained if there was not a RN listed on the daily posted nurse staffing sheet then	F 732	category of staff. Office assistant and manager on duty employees educated on updated form on November 14, 2014 by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will review the Daily Staff Postings weekly x 12 weeks to ensure administrative RN□s are acknowledged in the RN staff category. Review findings will be reported to the QAPI committee monthly x 3, by the Administrator, for further recommendations. Dates when corrective action will be completed: 12/3/24	

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F 732	Continued From page 6	F 732		

there was a salaried RN in the building such as the Staff Development Coordinator, Assistant Director of Nursing, and/or the Minimum Data Set Nurse. She said she was told by the Scheduler that a salaried RN could not be counted on the daily posted nurse staffing sheet.

The Scheduler was interviewed on 11/13/24 at 12:37pm. The Scheduler confirmed she had trained the Office Manager in completing the daily posted nurse staffing sheets. She stated she was aware a RN had to be present in the building for at least 8 hours a day but said she was not informed that a salaried RN could be placed on the daily posted nurse staffing sheets.

During an interview with the Director of Nursing (DON) on 11/13/24 at 12:44pm, the DON discussed that there was no process in place to check the daily posted nurse staffing sheets. She explained she looked at the assignment sheets every day but not the daily posted nurse staffing sheets. The DON stated she would want to see on the daily posted nurse staffing sheets the census, how many LPN's, how many RNs, and how many Nursing Assistant's were working on each shift. She also stated she was aware a RN needed to be in the building at least 8 hours a day. The DON explained that a salaried RN had not been typically placed on the daily posted staffing sheets because they were not working on the halls.

An interview with the Administrator occurred on 11/13/24 at 12:51pm. The Administrator stated she would want to see on the daily posted nurse staffing sheets the date, census, and how many hours per discipline. She explained she had used the daily posted nurse staffing sheets as who was

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F 732	Continued From page 7 providing "hands on" care to the residents not who was present in the building. The Administrator stated there had been a RN in the building every day at least 8 hours each day.	F 732		
F 761 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 observations and staff interviews, the facility failed to (1a) remove expired medication from hall 3 medication cart, (1b) discard loose pills from hall 1,2, and 4 medication carts, and	F 761	F761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient	12/5/24

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F 761	Continued From page 8 (1c) failed to date an open vial of lidocaine (local anesthetic) found in hall 4's medication cart for 4 of 5 medication carts reviewed for medication storage. The findings included: 1a. Observation of Hall 3 medication cart occurred on 11-15-24 at 10:31am with Nurse #3. The following item was found: -Bisacodyl (laxative) 5 milligrams (mg) bottle expired in September 2024. During an interview with Nurse #3 on 11-15-24 at 10:33am, Nurse #3 stated she was unaware the medication had expired. She explained the night shift nurses were responsible for checking the medication carts for expired medication. b. Observation of the medication cart for halls 1 and 2 occurred on 11-15-24 at 10:48am with Nurse #4. The following item was found: - one small pink round pill was loose in the top drawer of the medication cart. Nurse #4 was interviewed on 11-15-24 at 10:50am. The nurse stated she was unaware of the pill being loose in the drawer and stated if she had known she would have disposed of the pill. c. During an observation of hall 4's medication cart on 11-15-24 at 11:08am with Nurse #2, the following items were found: - one oblong white pill was loose in the top drawer of the medication cart.	F 761	practice: No residents were affected by alleged deficient practice. On 11/15/24, one loose pill removed from Halls 1 and 2 med cart , one bottle of dulcolax with manufacturer expiration of September 2024 removed from Hall 3 medication cart, two loose pills removed from Hall 4 cart and the one open multi-dose vial was dated per pharmacy dispense date. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All other Over The Counter medications on each of the four medication carts were in date. No other multi-dose vials without open date identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education of all licensed nurses employed by the facility, provided by Director of Nursing or designee, on routinely checking medication carts for loose pills, expiration date of OTC medication and dating multi-dose vial when opened, completed on 12/3/24. All new licensed nurses employed by or licensed nurses sourced through agency will be educated upon hire or prior to next scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing or designee to audit,	

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F 761	Continued From page 9 - one round off white pill was also loose in the top drawer of the medication cart. - one 10 cubic centimeter (cc) vial of lidocaine 1% was found to be open with no open date documented. An interview with Nurse #2 occurred on 11-15-24 at 11:11am. Nurse #2 explained she did not see the loose pills in the drawer, and she had not administered the lidocaine, so she was unaware the vial had been opened but not dated. The Assistant Director of Nursing (ADON) was interviewed on 11-15-24 at 11:45am. ADON explained that the third shift nurses were responsible for cleaning the medication carts, checking for expired medication and ensuring medications had an open date if needed. She also explained that the nurses assigned to a medication cart were also responsible for checking expiration dates, checking for any loose pills, and open dates if needed. The ADON stated the nurses were aware of their duties and said she could not explain why the above issues were found.	F 761	at random, one med cart weekly x 12 to verify no loose pills, expired OTC's or open multi-dose vials without open date present on med cart. Audit results will be reported to the QAPI committee monthly x 3, by the Director of Nursing or designee, for review and any further recommendations. Dates when corrective action will be completed: 12/5/24	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident	F 810	F810	12/3/24

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F 810	Continued From page 10 and staff interviews, the facility failed to provide adaptive eating utensils to a resident who required light weight utensils with a rubber grip. This occurred for 1 of 1 resident (Resident #28) reviewed for accommodation of needs. The findings included: Resident #28 was admitted to the facility on 4-9-24 with multiple diagnoses that included multiple sclerosis and muscle weakness. Physician order dated 4-9-24 revealed Resident #28 was to receive a divided plate, a special cup (a cup with 2 handles and a lid), and built-up utensils. Resident #28's care plan with a revision date on 7-21-24 revealed the resident had nutritional problems or the potential for nutritional problems related to multiple sclerosis. The goal for Resident #28 involved her maintaining adequate nutritional status. The interventions included Resident #28 having a lightweight fork with a rubber grip handle. The quarterly Minimum Data Set (MDS) dated 10-11-24 revealed Resident #28 was cognitively intact, had upper extremity impairment on one side, and required set up/clean up assistance with eating. Observation of Resident #28's lunch meal occurred on 11-12-24 at 12:20pm. Resident #28's meal ticket had that she was to receive light weight rubber handles utensils with meals. The observation revealed Resident #28 had received weighted utensils with a rubber grip, however, when the surveyor picked up the utensils by the	F 810	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #28 provided light weight utensils with next accepted meal on 11-12-24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All other residents utilizing the same type of light weight utensils have the potential to be affected. No other residents currently utilizing the same type of light weight utensils. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education provided on 11-12-24, by the dietary manager to the individual, and all other, dietary staff on the difference between light weight and weighted utensils. New dietary staff will be educated upon hire. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Dietary Manager to audit two random meals per week x 12 weeks to validate light weight utensils provided on meal tray. Interview results will be reported to the QAPI committee monthly x 3, by the Director of Nursing or designee, for product review and recommendation of	

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	345241	A. BUILDING _____ B. WING _____	C 11/15/2024

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EDEN REHABILITATION AND HEALTHCARE CENTER	226 N OAKLAND AVENUE EDEN, NC 27288

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F 810	Continued From page 11	F 810		

handle, the weight of the utensils was heavy.

Resident #28 was interviewed on 11-12-24 at 12:21pm. Resident #28 was sitting in a small dining room with one other resident. The resident stated she was not able to eat with the utensils because "they are too heavy for me, and I cannot hold them." She said no staff had checked on her since bringing her tray, so she was not able to tell anyone about the utensils.

During an interview with the Dietary Manager on 11-12-24 at 12:25pm, the Dietary Manager came to where Resident #28 was eating. He reviewed Resident #28's meal ticket and confirmed the resident was to receive light weighted utensils with her meals. The Dietary Manager picked up Resident #28's utensils and stated, "oh no these are the heavy weighted utensils." Resident #28 told the Dietary Manager she could not eat with heavy weighted utensils, so she was not going to eat. The Dietary Manager did not respond to Resident #28 but stated there was a new Dietary Aide on the tray line and "must have gotten confused between the heavy weighted and light weight utensils" and then the Dietary Manager left the room.

Continuous observation of the dining room where Resident #28 was sitting occurred on 11-12-24 from 12:28pm to 12:59pm. The observation revealed no staff member had entered the dining room to bring Resident #28 the proper utensils. Resident #28 was observed to be eating crackers during this time and not her meal.

Nursing Assistant (NA) #1 was interviewed on 11-12-24 at 1:01pm. NA #1 explained prior to giving a resident their meal tray, she will read the

alternate securement device product as needed.

Dates when corrective action will be completed: 12/3/24

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F 810	Continued From page 12	F 810		

meal ticket to ensure the resident received the correct meal. She stated she had not read Resident #28's meal ticket today and was unaware the resident needed light weight rubber grip utensils. The NA said she did see there were special utensils on the tray but did not know they were not the right ones. NA #1 stated if Resident #28 had told her the utensils were not right, she would have gone to the kitchen to retrieve the right utensils. NA #1 confirmed that she had not checked on Resident #28 after providing the resident with her tray.

An interview with Dietary Aide #1 occurred on 11-12-24 at 2:06pm. The Dietary Aide explained she had been working at the facility for 3 weeks and she was still in training. She stated she was taught to get a meal ticket from the pile of tickets, place the ticket on the tray, read the ticket to see if there are special needs in silverware or cups, and then wrap the silverware in a napkin. Dietary Aide #1 stated she was aware Resident #28 received light weighted utensils and that she "just grabbed the wrong utensils."

A follow-up interview was conducted with the Dietary Manager on 11-13-24 at 1:17pm. The Dietary Manager confirmed he had not provided Resident #28 the lightweight utensils on 11-12-24 after he had discovered the resident had the wrong utensils. He explained he did not provide the utensils because Resident #28 had told him she was not going to eat cold food. The Dietary Manager stated he should have asked Resident #28 if she would like her food heated and provided the lightweight utensils but said, "I didn't think about it."

During an interview with the Administrator on

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F 810	Continued From page 13 11-13-24 at 12:59pm, The Administrator stated she would have wanted the Dietary Manager to bring Resident #28 the light weighted utensils so she could eat but said the Dietary Manager explained to her Resident #28 said she was not going to eat because her food was cold.	F 810		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		12/5/24

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F 880	Continued From page 14 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) when a nurse aide	F 880	F880 Address how corrective action will be	

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F 880	Continued From page 15 provided catheter care for Resident #200 and did not wear a gown for 1 of 1 staff members observed for infection control practices. Findings included: The facility policy for Enhanced Barrier Precautions dated 2024 read in part that they required the use of gown and gloves for high-contact resident care activities in the resident's room when doing device care or use of urinary catheter. The physician order dated 11/08/24 to use indwelling catheter with closed drainage system due to neuromuscular dysfunction of bladder. Another order included for enhanced barrier precautions related to indwelling catheter every shift and to provide catheter cleansing and perineal hygiene every shift and as needed if soiled. An observation for the urinary catheter care was done on 11/13/24 at 3:48 PM. NA #1 washed her hands in the bathroom and collected her water in a basin with soap and towels for the catheter care. She wore her gloves during the entire urinary catheter care but did not wear any gown during the process. Interview with NA #1 on 11/13/24 at 5:07 PM stated she forgot to wear her gown during the catheter care, and she only realized after she was done cleaning. She stated she should have worn a gown as part of the enhanced barrier precautions. Interview with Director of Nursing (DON) on 11/15/24 at 10:50 am stated that nurses doing	F 880	accomplished for those residents found to have been affected by the deficient practice: Gown, in addition to gloves, was worn for resident #200 at next high contact care activity on 11/13/24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Other residents identified as needing enhanced barrier precautions have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Re-education on enhanced barrier precautions, provided by Infection Preventionist or designee beginning on 11/13/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Infection Preventionist or designee to complete two random observations per week x 12 weeks to validate gown, in addition to gloves, in use during high contact activities such as foley cath care to ensure enhanced barrier precautions are being followed. Observation results will be reported to the QAPI committee monthly x 3, by the Infection Preventionist or designee, for	

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F 880	Continued From page 16 close personal care for resident with EBP would wear a gloves and gowns when doing catheter care. Interview with Administrator on 11/15/24 at 11:55 am stated that nursing staff should wear gloves and gowns when doing catheter care.	F 880	any further recommendation as needed. Dates when corrective action will be completed: 12/5/24	