STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of Surprise	14775 West Yorkshire Drive Surprise, AZ 85374

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record review, the CMS (Centers for Medicare and Medicaid Services) system for MDS (Minimum Data Set) data, staff interviews, the Resident Assessment Instrument (RAI) 3.0 User's manual, and facility policy, the facility failed to ensure completion of a quarterly MDS assessments for one resident (#43) within the regulatory time frames. The deficient practice could lead to insufficient resident assessment and impact resident care. Findings Include: Resident #43 was admitted to the facility on [DATE] with the diagnosis that included unspecified fracture of shaft of right tibia, subsequent encounter for closed fracture with routine healing. The admission MDS (Minimum Data Set) for resident #43 revealed that it was completed on February 23, 2024. Review of the clinical record revealed that the quarterly assessment was completed on June 24, 2024, transmitted June 28, 2024 and accepted July 1, 2024. The quarterly assessment was due May 18, 2024. In an interview with MDS Coordinator (Staff # 80) conducted on July 3, 2024 at 1:20 p.m., staff #80 stated that all residents should have a quarterly MDS Assessment completed and the resident's condition should be consistent with information in the progress notes. During the interview, a review of the electronic clinical record was conducted with staff #80 who stated that a quarterly MDS assessment for resident #43 was not completed within the regulatory timeframes. The MDS coordinator stated that the quarterly assessment was completed on June 24, 2024, transmitted June 28, 2024 and accepted July 1, 2024. The quarterly assessment was due May 18, 2024. The MDS coordinator stated when an assessment is not completed in a timely manner it may not reflect the current needs of the resident and may be inconsistent with the care needed. An interview was conducted on July 3, 2024 at 1:56 p.m. with the Director of Nursing (DON/Staff #76) who stated the expectation is for the MDS assessments to be completed in a timely manner and be reflective of the resident's care and needs. Staff # 76 stated the risks associated with not completing the MDS assessments in a timely manner could result in the resident not billed correctly. (continued on next page)

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 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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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Policy titled, MDS Completion and Submission Timeframes states our facility will conduct and submit resident assessments in accordance with federal and state submission timeframes.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure one resident (#15) received necessary services to maintain personal hygiene. The deficient practice may cause a decline or decrease in a resident's quality of life. Finding Includes: Resident #15 was admitted to the facility on [DATE] with diagnoses that included cellulitis of right lower limb, osteoporosis, chronic pain, dementia, and anxiety. Review of resident minimum data set (MDS) from June 16, 2024, the Brief Interview for Mental Status (BIMS) score was 15 which indicated resident cognition is intact. For performance of activities of daily living (ADL), the MDS documented that she needed substantial/maximum assistance with personal hygiene. Care plan initiated on June 12, 2024 stated that resident needed help with daily activities and 1-2 staff assistance with bathing, bed mobility, dressing and eating. The ADL shower sheet under task for June 2024 revealed that resident either refused shower or activity did not occur for shower. In an interview with resident #15 on June 30, 2024 at 9:38 a.m., she stated that this is her third week at facility and she did not received any shower. She was scheduled one for July 1, 2024. In an interview with certified nurse assistant (CNA, staff #89) on July 3, 2024 at 08:36 a.m., she stated that CNA and OT (occupational therapist) provides shower to residents. She also stated that she was in resident unit two weeks ago when she offered showered to resident and resident did not had shower because she does not like to get up. She stated she also documented it under 'TASK' in point click care as not applicable. CNA further stated that when resident refuse shower then she does not ask them again. She also stated that showers are not scheduled and residents need to ask. In an interview on July 3, 2024 at 08:45 a.m., CNA #89 went to resident #15 room and asked resident #15 regarding if shower was offered two weeks ago, resident #15 stated that she did not remember a shower was offerfed by CNA #89 or any other staff. In an interview with Director of Nursing (DON, staff #76) on July 3, 2024 at 08:52 a.m., she stated that shower are offer daily by CNA or OT and they do not have fix schedule for shower and if resident refuse shower then they explore alternative options like offering shower on different days, with different staff members and also re-approaching resident or calling family to speak with resident. She also stated that risk associated with not getting showers are poor hygiene, skin breakdown and self-dignity issues. She further stated that resident #15 is cognitively intact with BIMS score of 15 and need assistance with transfer, walking, lower body dressing and toileting. When asked regarding resident #15 not being offered shower in last 3 weeks and charted as refusal under shower sheet, the DON stated it to be concerning. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the interview, the DON went to resident's #15 room and asked regarding shower. The resident told the DON that she had her first shower on July 01, 2024 and she did not remember CNA asking for shower before that and also stated that she never refused shower before. A review of the policy titled Activities of Daily Living (ADLs), Supporting with a revised date of March 2018 states that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming and oral care).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure one resident (#123) received treatment and services in accordance with professional standards of practice regarding positioning. The deficient practice could result in residents not receiving the treatment and care based on their assessed needs. Findings include: Resident #123 was admitted on [DATE] with diagnoses that included unspecified fracture of left acetabulum, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter, muscle weakness (generalized), other lack of coordination. Review of the MDS (Minimum Data Set) 5 day dated June 21, 2024 revealed a Brief Interview for Mental Status (BIMS) was conducted revealing a BIMS of 8 indicating moderate cognitive impairment. Further review of the MDS revealed resident requires substantial/maximal assistance with oral hygiene and upper dressing, dependent with toileting hygiene, lower body dressing. Resident requires substantial/maximal assistance with roll right and left, sit to stand and dependent to sit to lying. Resident is incontinent of bowel and bladder. Further review of the MDS revealed resident is at risk for developing pressure ulcers/injuries and has one unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. Review of the Care Plan initiated on June 17, 2024 revealed resident has potential and/or actual alteration in comfort and/or pain related to recent hospitalization , deconditioning. Interventions include observing for factors that impact pain tolerance and offer interventions to eliminate or remove to promote comfort, offer frequent periods of rest. Skin integrity careplan at time of admission included sacrum Pressure Injury, deep Tissue Injury evolved into unstageable. Interventions included to encourage off-loading or frequent shifting of position while in bed or chair. Resident was assessed to have a self-care deficit as evidence by need for assist with activities of daily living (ADL's) and requires 1 - 2 staff participation to re-position and turn in bed and requires 1 - 2 staff participation to complete dressing and bathing. An initial observation was made of resident #123 on June 30, 2024 at 11:05 AM. Resident was observed in bed with both feet dangling off the end of the bed. The head of the bead was elevated to its highest position with two full size pillows behind the resident's head, forcing the head to extend forward. The resident's legs were elevated, bending the knees forcing the resident into a sitting V position with both heels lying on the mattress. The resident was observed with food debris on his beard, food was spilled on his hospital gown and there was a brown substance underneath the resident's fingernails. The resident stated he was uncomfortable and his back hurt. A second observation was made of resident #123 on July 1, 2024 at 08:51 AM. Resident was observed sitting in wheelchair, face unwashed per resident comment. Fingernails continue to have dark brown substance beneath them. Resident was dressed in khaki pants and a multi-colored yellow shirt. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another observation was made of resident #123 on July 1, 2024 at 1:02 PM. Resident was observed sitting in the wheelchair, resident had slide down in the wheelchair and was now sitting on his coccyx. The lunch tray on bedside table. A third observation was made on July 1, 2024 at 3:32 PM. resident observed in same position in wheelchair in his room, not sitting up on buttocks, resident had now slide down and was sitting on his coccyx in the wheelchair. An Observation was made of resident #123 on July 2, 2024 at 8:20 AM. Resident was observed in his room in bed eating breakfast. Head of bed was elevated to its highest position, legs were elevated to the highest position. Resident's lower back, buttocks had slide into the crease of the bed, nail bed has brown debris beneath them. Resident was observed in the same multi-colored yellow shirt from the day prior and it had gathered around the resident's upper chest, leaving his abdomen exposed. Both of the resident's feet observed dangling off end of the bed, back part of the heels lying on the mattress unsupported. Review of the physician orders revealed an order for wound care of the sacrum every twelve (12) hours as needed and every day shift, float bilateral heels while in bed every shift for skin prophylaxis and float bilateral heels while in bed every shift for skin prophylaxis. An interview was conducted with certified nursing assistant (CNA/Staff #36) on July 2, 2024 at 10:13 AM. Staff #36 stated her responsibilities for positioning residents are based on the resident's care plan. Staff #36 stated she was assigned to resident #123 and was responsible for positioning him every two hours and set up his food. Staff #36 stated the resident is incontinent of bowel and bladder, has a fractured pelvis and a wound on his sacrum. She stated on July 1, 2024 the resident sat in his wheelchair from 10am-4pm and would try to reposition him in his wheelchair. She stated the resident did not want to go back to bed and was aware when he was uncomfortable when he would slide down in the chair. She stated she did not inform the nurse of his refusal to rest. An interview was conducted on July 7, 2024 at 10:21 a.m., with a licensed practical nurse (LPN/staff #36). Staff #36 stated resident is incontinent of bowel and bladder and has a low air loss mattress to help with skin break down. Staff #36 stated resident is very compliant with staff requests but resident does complain of pain and discomfort and prefers to be in bed. Staff #36 stated resident is a maximum assist with positioning and mobility. Staff #36 stated resident has not progressed with therapy and will often refuse his showers. Staff #36 stated resident had been referred to hospice, but family declined services. An interview was conducted with Director of Nursing (DON/Staff #76). Staff #76 stated when a resident is positioned with both knees and back in the highest position places a resident with sacral wounds at risk for further skin breakdown and places additional pressure an the sacrum. Staff #76 stated the resident had an order for a low air loss mattress, but being placed in the position with head and knees up does not allow the mattress to work to its full potential. Staff #76 stated the risks of not floating a resident's heels as ordered places the resident at risk for pressure ulcers and further skin breakdown. Staff #76 stated additional interventions should have been used to allow a resident with a sacral wound and incontinent of bowel and bladder to remain in a wheelchair from 10am to 4pm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Repositioning states the purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development on and individualized care plan for repositioning, to promote comfort for all bed-or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.

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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. 50553 Based on observation, staff interviews, and policy review, the facility failed to ensure that medications were stored in a secure manner that prevents accident hazards. The deficient practice could result in medication being taken by someone other than the intended recipient. Findings include: On July 2, 2024 around 7:52 AM, surveyors observed two medicine cards left unattended on top of a medicine cart. The surveyors picked up the cards and confirmed there was still medication left in the cards. A Licensed Practical Nurse (LPN / Staff #13) shortly after emerged from a resident room and agreed to assist the surveyors once she finished in the room. The LPN then re-entered the resident room, closing the door behind her. Surveyors waited approximately 2 minutes for the LPN to return. After the LPN returned, she continued with the med pass and did not touch or move the medication cards. An interview was conducted with Staff #13 on July 3, 2024 at 10:20 AM, who stated that medications should always be put away in the cart and the cart should be locked. She denied recalling any medications being left out unattended. She stated that the risks of leaving medication unsecured and unattended is that someone could take them. An interview was conducted with the Director of Nursing (Staff #76) on July 3, 2024 at 09:23AM, who stated that leaving medications unattended on med carts is not the standard of care, and medication should not be left unsupervised on top of the med cart. She elaborated that the behavior is not in accordance with facility policy or her expectations for her staff. The DON stated that potential risks with this behavior is that anyone could grab the medications, including confused patients. The medications could be ingested and staff may not know it. Review of facility policy titled Storage of Medications indicated that compartments (including carts) containing drugs and biologicals shall be locked when not in use, and trays and carts used to transport such items shall not be left unattended if open or otherwise available to others.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#123) had an order for oxygen use. The deficient practice could result in residents receiving oxygen without a physician's order. Findings include: Resident #123 was admitted to the facility on [DATE], with diagnoses that included unspecified fracture of left acetabulum, subsequent encounter for fracture with routine healing, diffuse large b-cell lymphoma, unspecified site, unspecified asthma, uncomplicated, personal history of nicotine dependence. The admission Minimum Data Set (MDS) assessment dated [DATE], revealed a score of 08 on the Brief Interview for Mental Status (BIMS) which suggests the resident had moderate cognitive impairment. The assessment included the resident experienced shortness of breath with exertion, when sitting at rest and when lying flat. The assessment also included the resident did not receive oxygen therapy during the look-back period. During an observation conducted on June 30, 2024 at 11:8 a.m., the resident was observed lying in bed with oxygen on at 3 liters per minute (LPM) via nasal cannula. The nasal cannula was improperly placed and was observed to be placed on the left side of the resident's nostril. An observation was conducted of the resident on July 1, 2024 at 8:51 a.m. The resident was observed in his wheelchair receiving oxygen at 2 LPM via nasal cannula. Another observation was conducted on July 1, 2024 at 1:02 p.m. Resident was seated in wheelchair, lunch meal on bedside table. Nasal Cannula properly placed at 2LPM via oxygen concentrator. An observation was conducted of the resident on July 2, 2024 at 8:20 a.m. The resident was observed in bed. Nasal cannula properly placed at 3LPM via oxygen concentrator. Review of the clinical record revealed no order for oxygen at 2-3 LPM via nasal cannula for resident #123. Review of the Medication and Treatment Administration Record (MAR/TAR) for June and July 2024 revealed no documentation of administration for oxygen therapy nor the care and replacement of the oxygen tubing for resident # 123. Review of Baseline Care Plan dated June 17, 2024 revealed no plan of care for oxygen therapy for resident # 123. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with a licensed practical nurse (LPN/staff # 106) on July 2, 2024 at 2:05 p.m., the LPN stated the resident was receiving 2 LPM of oxygen via nasal cannula. Staff #106 reviewed the physician orders in Point Click Care (PCC) revealing no orders, past or present for resident #123. Staff #106 further reviewed the MAR/TAR for the months of June and July and found no documentation for oxygen therapy or nasal cannula care. Staff #106 refused to discuss further or make any additional comments. During an interview conducted with the Director of Nursing (DON/staff #76) on July 2, 2024 at 2:05 p.m., the DON reviewed PCC for resident #123 and stated there was no order for oxygen use and oxygen is a medication. The DON stated residents receiving oxygen need to have a physician order and staff need to document the resident's vitals and oxygen saturation. She also stated the use of oxygen should have been care planned in the resident record. After reviewing the clinical record, the DON did not comment as to why there was no physician order or documentation for the use of oxygen for resident #123. The DON stated administering oxygen without a physician's order, can cause respiratory complications when it is unknown if the resident is tolerant; which to her would be a safety concern. The DON stated not monitoring the care of the oxygen tubing can cause pneumonia or a bacterial infection. Review of the facility policy titled Oxygen Administration revised October 2010 stated the purpose of the procedure is to provide guidelines for safe oxygen administration. Preparation included to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of the facility policy titled Medication and Treatment Orders revised July 2016, stated orders for medications and treatment will be consistent with principles of safe and effective order writing. The policy stated medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of the facility policy titled Documentation of Medication Administration stated a medication administration record is used to document all medication administered. It further stated a nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's administration record (MAR).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on review of clinical records, facility policy and staff interviews, the facility failed to ensure an order for pain medication was followed as prescribed for one resident (#15).The deficient practice may result in undesirable medication-induced harm. Findings Include: Resident #15 was admitted into the facility on [DATE] with diagnoses that included cellulitis of right lower limb, osteoporosis, chronic pain, dementia, and anxiety. Review of the physician orders revealed the following: - Percocet Oral Tablet 10 -325 milligram (Oxycodone with Acetaminophen/ Narcotic), give 1 tablet by mouth every 6 hours as needed for pain 4-6 and give 2 tablets by mouth every 6 hours as needed for pain 7-10 with start date of June 10, 2024. Resident #15's minimum data set (MDS) assessment from June 16, 2024 included the Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Review of June 2024 Medication Administration Records (MAR) revealed that Percocet 10-325 milligram 1 tablet was administered 6 times when resident pain level was below 4 and when resident pain level was over 6 which was outside of physician ordered parameters of pain level (4-10). Review of June 2024 MAR revealed that Percocet 10-325 milligram 2 tablets was administered 15 times when resident pain level was below 7 which was outside of physician ordered parameters. An interview was conducted with Licensed Practical Nurse (LPN/ staff # 33) on July 02, 2024 at 11:48 a.m., she stated that medication orders will show the pain scale and if pain is outside of the parameter then will hold medication and notify provider. An interview was conducted with Director of Nursing (DON/ staff # 76) on July 02, 2024 at 1:20 p.m., she stated the risk of administering medication outside of parameter to residents were drowsiness, slowing of reflexes and reaction time and risk of fall. She further stated that she educated nurses regarding pain medication administration. A review of the policy titled Opioid Medication Use with a review date of August 2017 states that patients will only receive opioid medications when necessary to treat specific conditions for which they are indicated and effective. A review of the policy titled Medication and Treatment Orders with a review date of July 2016 states that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled Documentation of Medication Administration with a review date of November 2022 states that documentation of medication administration includes, as a minimum: reason(s) why a medication was withheld, not administered, or refused (as applicable).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, staff interviews, and policy review, the facility failed to ensure that EBP (Enhanced Barrier Protection) was implemented when providing care for one resident (#324). Findings include: Resident #324 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, dysphagia, and unspecified severe protein-calorie malnutrition. Review of the physician orders dated June 28, 2024 revealed that resident #324 received enteral feed of Glucerna 1.5 via G-tube (Gastrostomy tube/ tube that's surgically inserted into the stomach to provide direct access for feeding, hydration, or medicine) every 6 hours. He received water flushes every 6 hours and between medications. According to physician orders dated June 27, 2024, the resident was to be receiving nothing by mouth (NPO) and medications should be crushed and given through his G-tube. On June 30, 2024, surveyors observed that resident #324 had a gastrostomy tube (G-tube) in which he received enteral feeding and medications pushed through the G-tube. Upon initial screening of the resident on June 30, 2024 at 11:29AM, surveyors noted EBP signage on the door of the resident's room. PPE (Personal Protective Equipment) was found inside the room, within the cabinets. Surveyors also visualized that the resident had a G-tube. Surveyors observed the Registered Nurse (RN/Staff #26) assigned to Resident #324 give the resident his medications through his G-tube on July 2, 2024 at 09:52AM. The surveyors observed the nurse applied hand sanitizer and don gloves, but the nurse failed to don a gown prior to administering the ordered medications through the G-tube. Surveyors again observed Staff #26 on July 2, 2024 at 10:10AM. Staff #26 again conducted hand hygiene and donned gloves. The nurse again did not don a gown. The nurse then administered enteral feed to Resident #24 as ordered by the physician. An interview was conducted with the RN (Staff #26) on July 2, 2024 at 01:22PM which revealed that this nurse was not aware of when EBP should be donned. The nurse correctly identified that EBP requires gown and gloves, but she could not verbalize instances in which PPE was required. When asking Staff #26 when she should wear a gown and gloves when caring for Resident #324, she stated that this resident is on EBP because he received breathing treatments, and therefore gown and gloves are required only when he was receiving these treatments. When asked the nurse of other instances EBP was required, she identified residents with Foley catheters, contaminated urine, and c-diff. She failed to identify interacting with a G-tube as a situation requiring EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of Surprise	14775 West Yorkshire Drive Surprise, AZ 85374

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 - Few	An interview with the Director of Nursing (DON/ Staff #76) was conducted on July 3, 2024 at 09:23AM, who stated EBP should be in place for anyone with an indwelling device. She elaborated that her expectations for EBP with a resident on tube feeds is that the staff uses PPE when handling the G-tube, administering medications, and when doing dressing changes on the G-tube. The DON also confirmed that all staff have been educated on EBP in their in-service training. CMS guidelines on Enhanced Barrier Precautions in Nursing Homes dated March 20, 2024 states that EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. It is also stated that EBP is employed when performing high-contact resident care activities, which includes device care or use. This includes feeding tubes. Review of facility policy titled Enhanced Barrier Precautions lists examples of high-contact resident care activities requiring the use of gown and gloves for EBPs. This list includes device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.). This policy also states that EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.