STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Nursing & Rehab Ctr	1635 East 154th Street Dolton, IL 60419

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45316 Based on observation, interview and record review, the facility failed to follow a professional standard during G-Tube medication administration for one (R27) of one resident observed for G-Tube medication administration in a sample of 29 residents. Findings Include: On 9/11/2024 at 01:15 PM - Observed V16 (LPN) administer medication to R27 via G-Tube. V27 did not check the G-Tube placement before administering the medication. On 9/11/2024 at 1:21 PM, V16 said that she checks the placement by observing and palpating G-Tube placement site. On 9/11/2024 01:38 PM, V2 (Director of Nursing/DON) said that she expects the staff to check G-Tube placement either by auscultation or residual before administering medication. R27 is a [AGE] year-old female admitted on [DATE] with a diagnosis not limited to multiple sclerosis-end stage, anxiety disorder, essential (primary) hypertension, and hyperlipidemia. Policy: Enteral Tube Medication Objective: 1. To safely and accurately administer oral medications through an enteral tube. Procedure: 5. Check placement and patency of the tube. If tube is not adequately placed, do not give the medication, adjust placement of feeding tube or insert a new one.

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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(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** 39781 Based on observation, interview, and record review the facility failed to provide feeding assistance, nail care and foot care for resident who need assistance with Activity of Daily Living (ADL). This deficiency affects one (R91) of three residents in the sample of 29 reviewed for ADL care. Findings include: On 9/10/24 at 12:17PM, Observed R91 in bed on left side lying position facing the door. V7 Social Worker (SW) said that she is on hospice care. Lunch tray untouched was left on bedside tray table on the right side of the bed towards the window. R91 said that she needs help in eating. V7 SW said that R91 eats by herself, and she does not need assistance from the staff. R91 said she is in pain and showed her swollen right arm. Noted dressing on right upper arm and right chest. Noted right fingernails long, thick, discolored and curved inward pressing the skin. On 9/10/24 at 1:00PM, V9 LPN (Licensed Practical Nurse) said that R91 does not need assistance in eating she eats by herself. V9 added that R91 is on hospice care. On 9/11/24 at 10:21AM, Rounds made with V2 DON (Director of Nursing) to R91's room. Informed of observation made yesterday to V2. Showed to V2 R91's swollen right arm and fingers. Noted right fingernails discolored, thick and curved inward pressing the skin. V2 said that R91 needs assistance in eating. V2 said that R91's fingernails should be trimmed. V2 DON removed the top linen to check the R91's bilateral legs. Observed bilateral toenails were discolored, thick and long. The toenails were curved in and pressing the skin. V2 said that she is not aware that nail care and foot care is not rendered to R91. V2 said that nail and toe care is part of daily assessment. The CNA should report to the nurse observation of long, thick, and discolored nails that were curved and pressing the skin. The nurse should notify the physician to be referred to podiatrist. On 9/11/24 at 10:25AM, V14 CNA (Certified Nurse Assistant) said that she is the regular assigned CNA for R91. V14 said that R91 does not need assistance during mealtime, R91 eats by herself. R91 said that she always has pain in her right swollen arm. R91 added that she needs assistance in eating. Surveyor asked V14 is she is aware of R91's right fingernails and bilateral toenails with long, thick, and discolored nails that were curved and pressing the skin. Surveyor showed observation to V14 CNA. V14 said that she did not take care of R91 today and the last time she took of care of her was last month. V14 said that she noticed it and reported to the nurse, but she forgot the name of the nurse. On 9/11/24 at 12:30PM, V9 LPN said that she is aware that R91 has right fingernails and bilateral toenails with long, thick, and discolored nails that were curved and pressing the skin. V9 said that she notified the physician and podiatrist but did not document it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R91 is admitted on [DATE] with diagnosis listed in part but not limited to Malignant neoplasm of right female breast-cancer lesion, Severe protein calorie malnutrition, Palliative Care. MSD/Resident assessment done on 7/2/24 Section GG 0130 indicated: Supervision or touch assistance marked for eating. Partial moderate assistance marked for personal hygiene. Comprehensive care plan indicates that she is reliant on staff to help/assist with completing her ADLs. Interventions: Provide required level of staff assistance and support to complete ADLs. Facility's policy on ADL (Activity of Daily living) updated 1/2022 indicates: A program of ADL is provided to prevent disability and return or maintain at their maximal level of functioning based on their diagnosis. Purpose: 2. A program of assistance and instructions in ADL skills is care planned and implemented. C. Feeding d. Adaptive equipment, assistance and instruction are given as required. Facility's policy on Care of Fingernails/Toenails revised April 2007 indicates: Purpose: To clean the nail bed, to keep nails trimmed and to prevent infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. General Guidelines: 1. Nail care includes daily cleaning and regular trimming 2. Proper nail care can aid in the prevention of skin problems around the nail bed 5. Watch for and report any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain or if nails are too hard or too thick to cut with ease. Documentation: The following information should be recorded in the resident's medical record, if applicable: 3. The condition of the resident's nails and nail bed Reporting: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Report other information in accordance with facility policy and professional standards of practice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement fall preventive measures to resident who is at high risk for falls. This deficiency affects two (R91 and R141) of three residents in the sample of 29 reviewed for Fall Prevention Program. Findings include: On 9/10/24 at 12:17PM, Observed R91 in bed on left side lying position facing the door. The bed is in high position. On 9/11/24 at 10:21AM, Observed R91 in bed on left side lying facing the door. Her bed is in high position. Showed observation to V2 DON (Director of Nursing), V2 said that the bed should be in the lowest position when resident in bed for safety. The bed control is hanging underneath the bed frame, unable for the resident to reach. V2 took the bed control and placed the bed in the lowest position. On 9/11/24 at 10:25AM, V14 CNA (Certified Nurse Assistant) said that she is the regular assigned CNA for R91. V14 said that R91 is not high risk for falls, her bed should not be in the lowest position. V2 DON informed V14 that R91's bed should be in the lowest position when in bed for safety. On 9/11/24 at 1:19PM, V15 ADON (Assistant Director of Nursing) said that she is the fall coordinator in the facility. V15 said that she is responsible for fall investigation/root cause analysis of the fall incident. Discussed the fall incident with (IDT Interdisciplinary Team) and develop new fall intervention to prevent falls. V15 said that some of the fall intervention measures are frequent rounding, place the bed in the lowest position when resident in bed, scheduled toileting, call light within reach, free from clutter, etc. V15 said that R91 is at high risk for fall and her bed should be at lowest position when she is in bed. V15 said that R91 had recent fall incident last July 2024. Review R91 most recent unwitnessed fall incident dated 7/7/24 with V15 ADON indicated that she fell in her room attempted to get out from bed to the bathroom without assistance. R91 sustained cut on the left side of her forehead and was sent to the hospital for evaluation. R91 was admitted on [DATE] with diagnosis of Malignant neoplasm of right female breast-cancer lesion, Severe protein calorie malnutrition, Seizures disorder, Palliative care. Admission fall assessment indicated that he she is at high risk for fall. Comprehensive care plan indicated that she is at high risk for falls due to requiring use of assistive device and unsteady gait and balance. R91 most recent unwitnessed fall dated 7/7/24 indicated that she fell in her room attempted to get out from bed to the bathroom without assistance. R91 sustained cut on the left side of her forehead and was sent to the hospital for evaluation. Facility's policy on Safety and Supervision of residents revised July 2017 indicates: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Individualized, Resident- Centered Approach to safety: 1. Our individualized, resident centered approach to safety addresses safety and accidents hazards for individual residents. 4. Implementing interventions to reduce accident risk and hazard shall include the following Systems Approach to Safety: 1. The facility-oriented and resident -oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors and then adjust interventions accordingly. 2. Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Resident Risks and Environmental Hazards: 1. Due to their complexity and scope, certain risk factors and environment hazards are addressed in dedicated policies and procedures. These risk factors and environment hazards include: a. Bed safety. Facility's Falls- Clinical Protocol revised August 2008 indicates: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 40001 On 9/11/2024 at 1:30pm R141 was observed in his room with slide open toe shoes on feet. R141 said I fell a week ago in water in the hallway, it was not a wet sign down, the nurse told me it was my fault because I had on these slides, I was not using a cane until I fell , the facility did not give me any shoes and I do not have any extra money for shoes. On 9/11/2024 at 1:45pm V6 (Licensed Practical Nurse-LPN) said R141 wears whatever shoes he wants; he knows he should wear proper shoes. On 9/11/2024 at 2:00pm V2(Director of Nursing-DON) said R141 should have non-skid shoes for fall prevention. I will make sure he's provided some tennis shoes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An event report dated 9/4/2024 at 8:25pm indicates that R141 had a witnessed fall while ambulating with flip flops on and did not see the water on the floor and slid due to improper footwear. A care-plan dated 9/5/2024 indicates a problem of at risk for falls and intervention for staff will encourage to wear proper footwear. A after visit summary from the local hospital dates 9/4/2024 indicates R141 has a diagnosis of Sprain of the left knee, unspecified ligament. Facility Policy: Fall-Clinical Protocol dated 2008. Assessment and recognition 2. b. Recent injury, especially fracture or head injury c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc. Cause: 1. For an individual who had fallen staff will attempt to define possible causes within 24 hours of the fall. Treatment: 1. Based on the preceding assessment the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Monitoring and follow up. 2. The staff and physician will monitor and document the individual's response interventions intended to reduce falling or the consequences of falling.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to follow physician order in administration of enteral feeding. This deficiency affects one (R108) of three residents in the sample of 29 reviewed for Enteral feeding management. Finding include: On 9/10/24 at 12:16PM, Observed R108 up in high back wheelchair by the hallway in front of nursing station. No enteral feeding was attached. On 9/12/24 at 10:37AM, Observed R108 in the Restorative gym for his restorative exercise treatment. No enteral feeding tube attached. On 9/12/24 at 10:40AM, Informed V2 DON that R108 was observed intermittently not receiving continuous enteral tube feeding. Reviewed R108's medical records with V2 DON and V9 LPN. V2 said that they should be following physician order for R108's enteral feeding instruction. R108 has ordered of continuous G-tube feeding Osmolite 1.2 at 70ml/hour x 24 hours with FWF (Free water flushes) 200ml every shift (TID /3x/day). V19 RD (Registered Dietitian) ordered it on 8/15/24 due to recent weight loss. V9 LPN said that R108's feeding tube was off during ADLs and treatment. R108 feeding tube was also off when he went to dental appointment from 10am to 2pm yesterday (9/11/24). R108's primary care physician was not notified of time that the enteral feeding was not given continuously as ordered. On 9/12/24 at 11:30AM, V20 Restorative Aide (RA), V21 RA, and V22 RA said that they provide restorative treatment exercises to R108 in the restorative gym 6-7 times per week. R108 was disconnected to his feeding tube when providing treatment in the gym. R108 is readmitted on [DATE] with diagnosis listed in part but not limited to Cerebral infarction, Dysphagia, Gastrotomy. Active physician order sheet indicates continuous feed Gastrotomy tube feeding Osmolyte 1.2 at 70ml/hour x 24 hour with FWF 200ml every shift (TID/three times a day). R108's dietary documentation dated 8/15/24 indicated that he was seen by V19 RD. V19 recommended and ordered Osmolite 1.2 at 70ml/hour with FWF 200ml every shift due to 12% weight loss past 6 months, 11.8% loss past 3 months, 6% loss past month. Comprehensive care plan indicated that he requires tube feeding due to history of CVA (Cerebral Vascular Accident). He is NPO (nothing by mouth) and requires tube feeding related to dysphagia. Care plan interventions is not updated. Reviewed R108's progress notes from 8/15/24 to 9/10/24 indicated that R108 was receiving Osmolite 1.2 two cans bolus were administered instead of Osmolite 1.2 continuously at 70ml/hour on the following dates: 8/16/24, 8/19/24, 8/31/24, 9/1/24, 9/2/24 and 9/9/24. Facility's policy on Enteral Nutrition revised April 2007 indicates: Policy Statement: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Adequate nutritional support through enteral feeding will be provided to residents unable to consume adequate nutritional intake by mouth. Policy interpretation and implementation: 1. A dietitian will assess residents who are dependent on tube feeding and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feeding. 5. Enteral feeding orders will be written to ensure consistent volume infusion. The following information will be included to ensure that any necessary interruption of feeding will not decrease volume infused.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40001 Based on observation, interview and record review the facility failed to follow its pain management policy and reassess for pain for 1 of 3 resident's (R141) reviewed for pain management in a sample of 29. Findings Include: On 9/11/2024 at 1:30pm R141 said that his left knee is very painful from a fall in the hallway and the nurses will only give him acetaminophen. On 9/11/2024 at 1:40pm V6 (Licensed Practical Nurse-LPN) said that R141 does not ask for pain medication and the only thing he has ordered is acetaminophen, I'll call the physician for a stronger pain medication. On 9/11/2024 at 2:10pm V2 (Director of Nursing-DON) said I expect the nurses to assess for pain every shift and as needed, and if a resident complains of pain, I expect for the nurses to follow up with the physician. An event report dated 9/4/2024 at 8:25pm indicated that R141 had a witnessed fall in water on the floor due to improper footwear. A local hospital after visit summary dated 9/4/2024 indicted that R141 sustained a sprain of the left knee, unspecified ligament. A medication list dated 9/5/2024 indicated a physician order for acetaminophen 325mg tablet for pain was recommended. A physician order report dated 8/12/2024-9/12/2024 indicates an as needed order for acetaminophen 325mg 2 tablets every six hours for pain. A medication administration record dated 8/20/2024 - 9/11/2024 indicates an order for acetaminophen 325mg 2 tablets for pain every six hours no pain medication given and no assessment for pain observed. Facility Policy: Pain-Clinical Protocol Revised 2008 Assessment and Recognition 2. Identify the nature and severity of pain including characteristic's (location, intensity, frequency, duration, etc.) 3. Evaluate how pain is affecting mood, activities of daily living, sleep, and selected quality of life measures, including complications such as deconditioning, gait disturbances, social isolation. Cause: 1. For example, hospital discharge summary may indicate that the resident has a painful condition or was receiving medication that may cause of exacerbate pain. Treatment: A. Any pain medication should be selected based on pertinent guidelines. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitoring: The staff will reassess the individual's pain and consequences of pain at regular intervals. Pain Assessment: Revised 2008 Purpose: The purposed of this procedure is to assess the resident's pain level and provide optimal comfort through a pain control plan which is mutually established with the resident, family, and members of the health care team. General guidelines: 3. Continuing assessment of pain management will occur daily and will focus on the effectiveness of the program and the comfort level of the resident. 4. Pain will be assessed and documented at regular intervals. Evaluation of the effectiveness of analgesic medication in relieving pain should be performed consistent with facility protocol. Reporting: 2. Notify the physician of any unrelieved pain.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to collaborate coordinated care by failure to ensure that resident's updated hospice medical records are available and accessible to all interdisciplinary team (IDT) in the facility. This deficiency affects one (R91) of three residents in the sample of 29 reviewed for Hospice care services. Findings include: On 9/10/24 at 12:17PM, Observed R91 in bed on left side lying position facing the door. The bed is in high position. V7 Social Service (SW) said that she is on hospice care. R91 as swollen right arm. Noted right fingernails long, thick, discolored and curved inward pressing the skin. On 9/10/24 at 1:10PM, Reviewed R91's hospice record binder with V2 DON (Director of Nursing). Noted plan of care (POC) dated 9/28/22. No updated POC in chart. Interdisciplinary progress notes documented in white bond paper without properly identification of IDT documenting. The dates notes for last 2 pages indicated 1/20/24, 2/1/24, 2/3/24, 8/5/24 and 8/14/24. V2 said that the hospice POC should be updated indicating frequency of IDT visits. V2 added that the hospice staff should use appropriate hospice progress notes not just a piece of white paper. On 9/11/23 at 1:48PM, Informed V1 Administrator of above concern. R91 is admitted on [DATE] with diagnosis listed in part but not limited to Malignant neoplasm of right female breast-cancer lesion, Severe protein calorie malnutrition, Palliative Care. Active physician order sheet indicates R91 is admitted to Chicago Hope Hospice. Comprehensive care plan indicates that R91 has diagnosis of Malignant neoplasm of the breast as the admitting medical condition for hospice care. She is admitted to hospice for palliative care due to overall decline in health. Interventions: Coordinate plan of care with hospice agency. Communicate with hospice team any changes in resident condition. Facility's policy on Hospice Services indicates: Policy: It is the policy of this facility to honor the advance directives and care alternatives residents may desire when terminally ill and to afford residents with care that allows for dignity and comfort during the end stage of their lives. Standards: 1. Residents will be provided hospice care upon physician's order indicating need and related terminal illness diagnosis has been documented. The physician will confirm the need for hospice services at least every 60 days by signing the re-cap physician orders indicating same. 5. Hospice service will conduct assessments and develop a hospice plan of care which will be integrated with the resident's overall plan of care and maintained in the medical record or other location with the interdisciplinary care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. All hospice service staff will write a progress note for each resident visit indicating treatment provided and pertinent information related to the resident's condition which is available in the medical record for all interdisciplinary staff to access. 8. Hospice staff involved in direct resident care will be responsible for reviewing the care plan, CNA assignment sheets and physician's order as applicable to assure care is provided in accordance with the resident's individual needs. Facility's contact with hospice service provider documents faxed on 9/10/24 indicates: g. Hospice services means those services that hospice would provide to a hospice patient if such hospice patient were residing in his or her personal residence that are related to and medically necessary for the palliation and management of such hospice patient's terminal illness as specified in a hospice patient's hospice plan of care or resident plan of care. m. Resident plan of care means a written care plan established, maintained, reviewed, and modified, if necessary, at intervals identified by the hospice IDG in coordination with the facility and each hospice patient's attending physician if any. 2. Responsibilities of Facility. d. Coordination of care i. General. Hospice and facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. 3. Responsibilities of Hospice f. Provision of information. Hospice shall promote open and frequent communication with facility and shall provide facility with sufficient information so that the provision of facility services under this agreement is in accordance with each hospice patient's resident plan of care, assessments, treatment planning and care coordination. At a minimum, hospice shall provide the following information to facility's designated interdisciplinary team member for each hospice patient residing at facility. i. Resident Plan of Care, Medications, and orders. The most recent resident plan of care, medications information and physician orders specific to hospice patient residing at facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Nursing & Rehab Ctr	1635 East 154th Street Dolton, IL 60419

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement infection control policy for resident who is on Enhanced Barrier Precaution (EBP). This deficiency affects one (R108) of three residents in the sample of 29 reviewed for infection control. Findings include: On 9/10/24 at 12:16PM, Observed R108's room without signage posted of Enhanced Barrier Precaution at the door. V7 Social Worker said that R108 is not on isolation. There is no sign at the door. R108 is readmitted on [DATE] with diagnosis listed in part but not limited to Cerebral infarction, Dysphagia, Gastrotomy. Physician order sheet indicates continuous feed Gastrotomy tube feeding Osmolyte 1.2 at 70ml/hour x 24 hour with FWF (Free water flushes) 200ml every shift (TID/three times a day). No order for Enhanced Barrier Precaution in active physician order sheet. On 9/10/24 at 12:25PM, Rounds made with V4 Infection Coordinator to R108's room. V4 said that R108 is on EBP because of enteral feeding/GT feeding. There should be signage of EBP posted at the door. Informed V4 that there is no order of EBP in R108's chart. V4 said that it does not need an order just signage at the door and isolation set up. On 9/10/24 at 1:00PM, V9 LPN (Licensed Practical Nurse) said that R108 is on EBP due to his Tube feeding. There should be posting outside the door. V9 said she did not notice that it was not posted when she made round this morning. V9 said that there should be order in the chart for EBP. On 9/11/24 at 1:26PM, V2 DON (Director of Nursing) said that R108 is on EBP because of enteral feeding. R108 should have a written physician order for EBP and EBP signage posted at the door. On 9/12/24 at 11:30AM, V9 LPN wheeled R108 to room. R108 is on EBP. V9 donned gloves and disconnect the GT feeding. V20 Restorative Aide (RA), V21 RA and V22 RA weighed R108 donned gloves and used mechanical lift to weigh R108. During the procedure, they worked close contact with R108. On 9/12/24 at 11:48AM, V4 Infection Control Coordinator said that the staff should wear gloves and gown for resident on EBP when handling GT feeding such as disconnecting it, when working in close contact with resident such as taking weight. Facility's policy on Enhanced Barrier Precaution (EBP) indicates: EBP is designed to reduced transmission of multidrug -resistant organism (MDROs) and extensively drug-resistant organism (XDROs) in nursing homes. It is the policy of this facility that EBP, in addition to standard and contact precautions will be implemented during high contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO or XDRO. Overview: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of EPB is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. Procedure: 2. In addition to Standard Precautions, residents will be assessed to determine whether contact precautions or EBP will be implemented. 3. EBP will be used for residents with MDRO, XDRO and resident had covered wounds, contained drainage, and can maintain adequate hygiene. 8. Post clear signage on the door/wall outside resident room a. Type of precautions: IV EBP (Enhanced Barrier Precaution) Facility's policy on Infection Prevention and Control Manual indicates: Personal Protective Equipment (PPE) Policy: It it's the policy of this facility that the appropriate personal protective equipment will be worn to protect the potential routes of exposure such as inhalation, skin contact, ingestion, contact with mucous membranes of other areas of the body or clothing from any hazards that can cause injury and to protect the employee, residents and visitors from the transmission of infection.