STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Care Centre	2313 North Rockton Avenue Rockford, IL 61103

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35541 Based on observation, interview and record review the facility failed to provide a clean, comfortable, homelike environment to 4 of 25 residents (R92, R28, R19, R84) reviewed for clean, comfortable, homelike environment in the sample of 25. The findings include: 1. On 9/9/24 at 8:31 AM, R92 was seated in a wheelchair in his room. Multiple areas of chipped paint were noted on the walls of R92's room. Large, grease-like stains were noted across the walls of R92's room. Large black scuff marks were noted on the wall behind R92's bed. A urinal, half-filled with urine, sat on the floor, by R92's bed. A strong odor of urine was noted in R92's bathroom. R92 stated, My bathroom stinks. My room is dirty looking. I don't live like this. I am a clean person. I have to empty that (urinal). They don't. 2. On 9/9/24 at 10:00 AM, V7 (Power of Attorney (POA) for R28) was in the facility, visiting R28. V7 stated, This place is filthy. The walls are chipped and dirty. V7 pointed to the wall by R28's bathroom. The wall had multiple scuff marks with missing, chipped paint. On 9/9/28 at 11:38 AM, V7 was seated in the first-floor dining room of the facility with R28. V7 pointed to ceiling tiles in the dining room. Two ceiling tiles, located on the northwest part of the dining room ceiling, were covered with a black-like substance. V7 stated, That's mold. On 9/10/24 at 11:30 AM, V5 Maintenance Director stated the facility recently hired a painter due to complaints about the chipped, scuffed walls located throughout the facility. V5 stated he was unsure when the last time the interior of the facility was painted. V5 stated, I took down two moldy ceiling tiles in the first-floor dining room this morning. I need to get better about monitor the ceiling tiles for mold. The facility's Quality of Life-Homelike Environment policy dated 5/2017 showed, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment . 35174 (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 9/10/24 at 10:15 AM, during the Resident Council Meeting, R19 and R84 stated they had problems with water dripping out of their air/heating units. R19 stated the thermostat in her room cover has been off for a long time. R19 stated the wires and innards are just sticking out. R19 stated the heat/air unit took a long time to change the temperature in the room. R19 and R84 stated the air conditioner/heater units would have water pool under them when they were running. R19 and R84 stated this has happened multiple times. R19 stated a pink basin was placed under the unit to catch the water and needed to be dumped once in a while. R84 stated housekeeping has had to place towels under the unit to collect the water. R84 stated she first time she knew about it was when she stepped in water walking around the end of the bed on the way to the bathroom. On 9/10/24 at 10:35 AM, R19's thermostat did not have a cover on it which had the internal wiring and controls exposed. The cover was not seen in R19's room. R19's air unit was running. The bottom edge of the unit felt damp with a few droples of water on it. On 9/10/24 at 10:45 AM, V5 Maintenance Director translated the interview with V13 Housekeeper. V13 stated R19 and R84's air/heating units have had problems with dripping water when they are running. V13 stated sometimes when they are running we have needed to leave towels and mop up the water when it happens. When it gets hotter out it is worse. On 9/11/24 at 10:30 AM, V5 stated the units in R19 and R84's rooms have had issues with lots of condensation when the air units are running. We need to make sure the drain tubes on the units are clear to drain the water outside which should stop the water dripping on the floor. The water should not be on the floor. We have used towels in R84's room. In R19's room we were using a basin to collect the water dripping from the unit. When it is hotter outside the units work longer which causes more condensation to occur. With the cooler weather it has not been an issue.

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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. 35541 Based on interview and record review the facility failed to provide the necessary care and services for a resident that required a sleep study for 1 of 25 residents (R28) reviewed for necessary care and services in the sample of 25. The findings include: R28's Admission Record dated 9/29/23 showed R28 was admitted to the facility with diagnoses of insomnia, dysarthia (difficulty speaking), dysphagia, and CVA (cerebrovascular accident) with right arm/leg hemiplegia (weakness). R28's current care plan showed R28 was dependent on staff for toileting, repositioning, mobility, and transfers. On 9/9/24 at 10:00 AM, V7 (Power of Attorney (POA) for R28) was in the facility, visiting R28. V7 stated, He (R28) was supposed to have a sleep test done months ago but it was never done. They said it was because they didn't have a way to transport him (to the test) after 5 PM. I can't take him myself. He's dead weight. I can't lift him in and out of the car. I also live an hour away. R28's Nurse Practitioner (NP) note dated 12/4/23 showed, Sleep medicine study if ok with PCP (primary care physician) . A physician order for R28, dated 12/5/23, showed, Sleep study, r/o OSA (rule out obstructive sleep apnea). R28's nurses notes and appointment notes dated 12/6/23-3/16/24 were reviewed and showed a sleep study was never completed on R28. R28's nurses note dated 3/16/24 showed, Resident states he is not sleeping well at night. Resident states that current sleep regimen is not working. He was found with his head down on the table sleeping in the dining room. R28's nurses notes and appointment notes dated 3/17/24-5/2/24 were reviewed and showed a sleep study was never completed on R28. R28's nurses note dated 5/2/24 showed, Resident had an appointment today and needs to call to schedule for a sleep study . R28's appointment note dated 6/17/24 showed R28's outpatient sleep study, that had been scheduled for 6/17/24, was canceled by the facility due to the POA (V7) not being able to provide care to R28 during his sleep study testing. R28's notes dated 6/18/24-8/2/24 were reviewed and showed R28 a sleep study was never completed on R28. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order for R28, dated 8/2/24, showed V3 Assistant Director of Nursing (ADON), canceled R28's order for a sleep study. On 9/10/24 at 9:20 AM, V3 ADON stated R28's sleep study, ordered in December 2023, was ordered because R28 was having trouble sleeping. When V3 was asked why she canceled R28's sleep study order in August 2024, V3 stated, I am not sure. I might have been going through resident's charts and cleaning up old orders. V3 stated she canceled R28's order for a sleep study without contacting R28's physician. V3 stated, I know we attempted to schedule his study but there was some issue he couldn't go. No family to go with. He still needs the study. We could check to see if it could be done in-house or maybe a staff member could go with him. On 9/10/24 at 9:35 AM, V2 Director of Nursing (DON) stated any outpatient testing or studies ordered on residents should be scheduled as soon as possible. V2 stated, We have had residents go out (out of the facility) for a sleep study before. We have also had residents that have had sleep studies done in-house (in the facility). V2 stated, If family can't go to the test with the resident, I would see if the test could be done here (in the facility) or see if a staff member could go with the resident. The facility's Lab and Diagnostic Test Results-Clinical Protocol policy dated 9/2012 showed, The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for test .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to identify a resident's pressure injury prior to the injury becoming a Stage 2. The facility also failed to implement pressure injury prevention interventions and pressure relieving interventions. These failures apply to 2 of 6 residents (R28, R120) reviewed for pressure injuries in the sample of 25. The findings include: 1. R28's Admission Record dated 9/29/23 showed R28 was admitted to the facility with diagnoses of dysarthia (difficulty speaking), dysphagia, diabetes mellitus, and CVA (cerebrovascular accident) with right arm/leg hemiplegia (weakness). R28's care plan dated 9/21/24 showed R28 was dependent on staff for toileting, repositioning, mobility, and transfers. The plan showed, Check all of body for breaks in skin and treat promptly as ordered by doctor. R28's Monthly Summary report dated 8/10/24 showed R28 had no pressure injuries or impairments to his skin. R28's nurse notes dated 8/11/24-9/8/24 showed no documentation of R28 having any pressure injuries or wounds. On 9/9/24 at 10:00 AM, V7 (Power of Attorney (POA) for R28) was in the facility, visiting R28. R28 was seated in a wheelchair. R28 appeared sleepy. When R28 was asked if he had any pain, R28 stated, My butt. R28 was unable to state when the pain to his buttocks started. V7 stated, I don't think he has any wounds to his butt. No one has reported that to me, but they get him up in the morning and don't lay him down again until after lunch. Some days, he is up in his wheelchair for hours. On 9/9/24 at 10:50 AM, R28 remained seated in a wheelchair. On 9/9/24 at 11:30 AM, R28 remained seated in a wheelchair. On 9/9/24 at 1:11 PM, V6 and V8 Certified Nursing Assistants (CNA) wheeled R28 into his room to provide cares to R28. V6 CNA was asked when she last toileted or provided incontinence care to R28, V6 stated, When I got him up this morning, around 8 AM. V6 and V8 transferred R28 via mechanical lift from his wheelchair to bed. V6 and V8 repositioned R28 in bed and removed R28's incontinence brief. R28's incontinence brief was saturated with urine. Multiple, large, creases were noted to the skin of R28's buttocks. A large, reddened area was noted to R28's sacral area with a quarter-sized, fluid-filled blister noted to R28's right inner sacral area. V6 CNA stated, His bottom is a little red, but he's had that. R28's Wound Assessment Report dated 9/10/24 showed R28 had a new, facility-acquired Stage 2 pressure injury to his sacrum, measuring 4.0 centimeters (cm) x 8.0 cm x unknown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 10:15 AM, V9 Wound Nurse stated R28 is wheelchair bound and dependent on staff for most cares due to his CVA. V9 stated R28 is unable to reposition himself and is incontinent of bowel and bladder. V9 stated she initially assessed R28's sacral wound, on 9/9/24, as a MASD (moisture associated skin damage) that was caused by R28 most likely being wet with urine for periods of time. He is someone who need to be kept clean and dry. He needs to be repositioned every two hours. V9 stated that when she reassessed R28's sacral area on 9/10/24, she staged R28's sacral injury as a Stage 2 pressure injury due to her finding an opened blister to R28's sacrum. The facility's Prevention of Pressure Ulcers/Injuries policy dated 7/2017 showed, The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors . Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living) . Keep the skin clean and free of exposure to urine and fecal manner . At least every two hours, reposition residents who are reclining and dependent on staff for repositioning . 33760 2. On 9/9/24 the facility provided the Pressure Report List. The document show, R120 with an admitted [DATE], has pressure injuries present on admission: stage 4 pressure injury to right hip and stage 3 pressure injury to sacral area. R120's Braden Scale dated 9/9/24 show R120 was a high risk for pressure injuries. R120's careplan date initiated 6/12/24 show Apply pressure reduction or low air loss therapy pressure relieving cushion when up in wheelchair. On 9/9/24 at 9:10 AM, R120 was in bed, a regular mattress was noted in her bed. R120 had a regular foam cushion to her wheelchair. On 9/10/24 at 8AM, (V9) Wound Nurse assessed and provided wound treatment to R120's pressure injuries to right hip stage 4 measuring 1.0 centimeters x1.0 cm x 0.30 cm and sacral area.sacral area stage 3- 2.5cm x.0.5cm x0.10cm V9 said R120's pressure injuries were in advanced stages of stage 3 and stage 4. V9 confirmed that R120 just have a regular mattress. This regular mattress is not indicated for stage 3 or 4. V9 said the facility will order a lo air loss mattress today. V9 said R120 prefers to stay in bed most of the time but will also get a better relieving cushion to R120's wheelchair On 9/10/24 at 1:25 PM, V2 (Director of Nursing) said the facility regular mattress is a pressure relieving mattress indicated only for up to stage 2, not appropriate for R120 who has stage 3 and stage 4 pressure injuries. The facility policy on Prevention of Pressure Ulcers/Injuries dated 2017 show, Support Surfaces and pressure redistribution, Select appropriate support surfaces based on residents mobility, continence, skin moisture and perfusion body size, weight and overall risk factors.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview and record review the facility failed to provide treatment and services to residents with limited range of motion to to 2 of 10 residents (R120, R34) reviewed for limited range of motion in the sample of 25. The findings include: 1.R120's diagnoses include stroke and transient ischemic attack (TIA) with right sided limitations. R120's admitted [DATE]. On 9/9/24 on 9:10 AM, R120 was in bed. R120 was alert and smiling but aphasic (inability to express herself/communicate) R120's right hand was contracted closed fist and whole right hand curled inward. R120's latest Restorative assessment dated [DATE] show R120 has limitations to extremities including R120's upper extremities. On 9/10/24 at 8:25 AM- (V4) previous Restorative Nurse said R120 was admitted from home due to stroke (admitted [DATE]), with right hand contractures. R120 was assessed at that time due to limited range of motion to her right hand but R120 was not on any Restorative Program (range of motion-ROM). R120 also has no device to her contracted right hand. ROM should have been implemented to prevent further decline. V4 said she will have therapy assessed R120 today. On 9/10/24 at 11 AM, V4 said R120 was just now placed on passive ROM to right hand and AROM to left hand. On 9/10/24 V4 and V12 (present Restorative Nurse) presented this surveyor an Occupational Therapy note dated 9/10/24 (today) documenting, R120 will now have right hand splint. The facility policy entitled Restorative Nursing Services dated 7/2017 show, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. 45540 2. R34's Restorative: ROM (range of motion): AROM (active range of motion) to all extremities/all joints x10 reps twice daily do PROM (passive range of motion) if unable to preform AROM. Look Back 30 days. On 8/18/2024, 8/22/2024, 9/1/2024, 9/8/2024 R34 only received AROM one time on those days. On 9/10/2024 at 9:46AM, V4 Registered Nurse Previous Restorative Nurse stated [R34] is part of restorative services. V4 said [R34] should be seen twice a day for restorative AROM or PROM. V4 said the restorative services provided should be documented in the computer twice a day. V4 said if a resident is unavailable staff should follow up with the resident another time to make sure the resident receive services twice a day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Restorative Nursing Services policy revised July 2017 states residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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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** 35174 Based on observation, interview, and record review the facility failed to ensure a resident did not attempt to exit the facility out a fire exit door, and failed to transfer a resident with a gait belt which applies to 2 of 25 residents (R39, R104) reviewed for safety in a sample of 25. The findings include: 1. R39's Facility assessment dated [DATE] showed R39 to be a [AGE] year old male male with moderate cognitive deficits. This Assessment showed R39 was admitted to the facility with diagnoses which include: cognitive communication deficit, hemiplegia an hemiparesis following a cerebral infarction, and history of traumatic brain injury. On 9/9/24 at 12:10 PM, R39 was attempting to go out the South East fire exit door in his wheelchair at the end of the hallway. The exit door is adjacent to R39's room. R39 pushed the release bar to open the door. The door alarm was not going off when the door was opened. There was no staff in the hallway at the time R39 opened the door. R39 was in his wheelchair having difficulty exiting the door. V14 Human Resources Manager was alerted by this writer to check on R39 as he attempted to exit the doorway. V14 was able to stop R39 from exiting the door. V14 redirected R39 into his room. V14 stated the alarm should have gone off for the door being opened. At the top of the metal doorway the door sensor was hanging down and a wire was sticking out approximately 6 inches. On 9/9/24 at 12:20 PM, V5 Maintenance director arrived at the doorway. V5 opened the door, and the alarm did not go off. V5 pointed to a yellow light on the ceiling. V5 stated that light should flash, and it should have an alarm go off. V5 stated he did not know what happened to the alarm sensor. V5 stated the alarm had been working during morning rounds this morning. V5 stated the sensor may have been damaged and wire looked like it had been hit or pulled by something. V5 stated they had brought in some of the personal protective equipment (PPE) boxes this morning from the storage container (pointed to container in the parking area), and it could have been hit by one of the bigger boxes. V5 stated the alarms should be working all the time. On 9/9/24 at 12:45 PM, V15 (R39 Family) was interviewed with R39 present. V15 stated R39 used to garden a lot, and they have tomato plants we check on. V15 asked R39 if he was trying to go see the tomato plants. R39 nodded yes to the question. On 9/10/23 at 11:35 AM, V2 Director of Nursing stated R39 has had no previous exit seeking behaviors. V2 stated the door alarm should have activated when R39 attempted to go out the door. The facility Door Alarm Policy dated 12/2023 showed .the door alarm system needs to be maintained in proper repair and equipment is functioning appropriately 33760 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 09/9/24 at 9:25 AM, V11 (Ccertifide Nursing Assistant-CNA) was in R104's room to transfer R104 from the bed to the wheelchair. R104 scooted himself at the edge of the bed and tried to boost himself up by putting both of his hands in the wheelchair arms in front of him. R104 tried to stand up but then sits back down unable to pull himself up. R104 tried again but still unable to pull himself to standing position, then said to V11, I think I need help V11 (CNA) applied a gait belt around R104 waist, then pulled R104 up by pulling the back of R104's pants then placed R104 in his wheelchair. V11 did not use the gaitbelt that was already in R104's waist to transfer R104 to his wheelchair. R104's careplan dated 6/8/24 show, (R104) has terminal diagnosis of Multiple Sclerosis-hospice services . R104 has intention tremor, nystagmus, other tremors, poor coordination, ataxia, (poor muscle control that causes clumsy movements) history of falls. On 9/10/24 at 1:25 PM, V2 (Director of Nursing) said staff should use gait belt for safe transfers for both staff and the resident. The facility policy entitled Safe Lifting and Movement of Residents dated 7/17 show, In order to protect the safety and well being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 4. Staff responsible for direct resident care will be trained in the use of .(gait/transfer belts.)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45540 Based on observation, interview, and record review the facility failed to maintain resident catheters below the level of the bladder and keep the drainage bag off the floor. This applies to 3 of 8 (R66, R90, R39) residents reviewed for catheters in the sample of 25. The findings include: 1. On 9/9/2024 at 11:09AM, R66's urinary catheter drainage bag was observed hanging on the resident's walker level with the resident's bladder. Urine was observed sitting in the catheter tubing with sediment present in the tubing. On 9/10/2024 at 11:53AM, V2 Director of Nursing (DON) said catheter bags should be kept below the level of the resident's bladder to prevent infections. R66's Order Summary Report dated 9/9/2024 shows an order for Foley Catheter, change monthly and PRN (as needed). 33760 2. On 9/9/24 at 11:00 AM, R90 was sitting in his reclined wheelchair in his room. R90's urinary catheter drainage bag was tucked to R90's right side hip level above the level of the bladder. At 12: 15 pm- R90 was still in his room watching TV, catheter bag remained in the same position, tucked on his right side hip level above the level of the bladder, urine was noted backflowing in the tube. V10 (Registered Nurse) who was with this surveyor said the catheter bag needs to be lowered, below the level of the bladder to prevent from urine backing flow to prevent infection. R90's latest careplan show, The resident has a Foley Catheter 16fr 10cc Balloon: Neurogenic bladder, has history of Urinary Tract Infections (UTI's.) 35541 3. R39's Admission Record dated 5/31/24 showed R39 was admitted with diagnoses of a urinary tract infection and benign prostatic hyperplasia with lower urinary tract symptoms. R39's care plan dated 6/5/24 showed R39 had a urinary catheter placed to drain his urine. On 9/9/24 at 9:03 AM, as this surveyor entered R39's room, V6 Certified Nursing Assistant (CNA) was repositioning R39 in his wheelchair. V6 then placed R39's (uncovered) urinary catheter drainage bag directly on the floor, underneath the seat of R39's wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Care Centre	2313 North Rockton Avenue Rockford, IL 61103

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 9:35 AM, V2 Director of Nursing stated urinary catheter bags are to be kept off the floor for to prevent infection. The facility's Catheter Care Urinary policy revised September 2014 states, the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The facility policy entitled Catheter Care Urinary revised 9/2013 show, The purpose of this procedure is to prevent catheter- associated urinary tract infections. 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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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. 33760 Based on observation, interview and record review the facility failed to wash hands and change gloves and failed to implement Enhance Barrier Precaution (EBP) for 2 of 25 residents (R104, R39) reviewed for infection control in the sample of 25. The findings include: 1. On 9/9/24 at 9:10 AM, V11 (Certified Nursing Assistant-CNA) was providing incontinence care to R104. R104 had a bowel movement. After providing incontinence care and without changing her soiled gloves, V11 turned R104 side to side and applied new incontinent brief, applied R104's blanket, pulled the privacy curtain, opened R104's closet looking for clothings then said she needs to go out and get something. V11 then removed her soiled gloves and left R104's room without washing her hands. On 9/11/24 at 8:10 AM, V3 (Assistant Director of Nursing -ADON) said staff should change their gloves and wash their hands when completing dirty task to clean task, when the gloves is visibly soiled and when a tasks was completed wash hands to prevent the spread of infection. The Facility Policy entitled Personal Protective Equipment dated 9/2010 -Using gloves, Purpose the use of gloves, 1. To prevent the spread of infection. Handwashing/Hand Hygiene dated 8/2015 show, This facility considers hand hygiene the primary means to prevent the spread of infections. 35541 2. The facility's Residents on Enhanced Barrier Precautions list dated 9/9/24 showed R39 was on Enhanced Barrier Precautions (EBP) due to having a urinary catheter in place. On 9/9/24 at 9:03 AM, an EBP sign hung on the door to R39's room. As this surveyor entered R39's room, V6 Certified Nursing Assistant (CNA) was repositioning R39 in his wheelchair. V6 then placed R39's urinary catheter drainage bag on the floor, underneath the seat of R39's wheelchair. V6 CNA wore gloves but no gown. V6 stated, I just did catheter care and peri-care (incontinence care) on (R39). When V6 was asked if R39 was on Enhanced Barrier Precautions, V6 stated, No, (R39) is not. His roommate is because he (the roommate) has a (urinary) catheter. On 9/10/24 at 9:35 AM, V2 Director of Nursing stated, Anyone with wounds, IV lines (intravenous), or someone that has a (urinary) catheter should be on Enhanced Barrier Precautions. Staff are to wear gowns and gloves when providing cares to residents. The facility's Enhanced Barrier Precautions (EBP) policy dated 3/2023 showed, EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Indwelling medical devices, regardless of MDRO (multidrug-resistant organisms) colonization status (central lines, urinary catheters, feeding tubes, hemodialysis catheters, tracheostomies and ventilators) . The policy showed staff are to don a gown and gloves prior to providing high-contact activities, such as urinary catheter care or incontinence care, to residents.