

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Golden Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Prairie Mills Road Golden, IL 62339	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875</p> <p>Based on observation, interview, and record review the facility failed to cover a urinary catheter bag with a privacy bag for one of one resident (R21) reviewed for dignity in the sample of 28.</p> <p>Findings include:</p> <p>R21's current computerized medical record, documents R21 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Chronic kidney Disease, Retention of Urine, Other Specified Disorders of Bladder, and Type 2 Diabetes Mellitus.</p> <p>R21's MDS (Minimum Data Set) assessment dated [DATE] documents a BIMS (Brief Interview for Mental Status) Score of 12/15, indicating (moderate cognitive impairment) and R21 has an indwelling urinary catheter.</p> <p>R21's Physicians Order dated 1/9/24 documents R21 has an (indwelling) catheter for diagnosis of Urinary Retention.</p> <p>On 11/24/24 at 9:46 AM, R21 was sitting in the recliner in his room. R21's urinary catheter bag was attached to R21's walker. There was no cover on the urinary catheter bag. The bag was half full of urine. The catheter bag with urine was visible from the hallway.</p> <p>On 11/25/24 at 10:43 AM, R21 was sitting in his recliner in his room. The urinary catheter bag was attached to R21's walker and the urine in the bag was visible from the hallway.</p> <p>On 11/26/24 at 8:48 AM, R21 was sitting in his recliner in his room. The catheter bag was attached to R21's walker and the uncovered catheter bag was visible from the hallway.</p> <p>On 11/26/24 at 10:05 AM, V2/Director of Nursing stated that urinary catheter bags are to be covered with a privacy bag. At 11:26 AM, V2 verified that R21's urinary catheter bag had not been covered and a privacy bag had been applied.</p> <p>The Resident Rights Booklet dated 11/18, documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must be safe, clean, comfortable, and homelike.</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875</p> <p>Based on observation, interview, and record review the facility failed to ensure the call light was in reach for one resident (R2) out of 12 residents reviewed for call lights in the sample 28.</p> <p>Findings include:</p> <p>R2's Current Medical Record documents that R2 was admitted to the facility on [DATE] with diagnoses that included Dementia, Urinary Tract Infection, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Acute and Chronic Respiratory Failure with Hypoxia, Chronic Kidney Disease (stage 3), Neuromuscular Dysfunction of Bladder, and Chronic Obstructive Pulmonary Disease.</p> <p>R2's Minimum Data Set assessment dated [DATE] documents R2 has a BIMS (Brief Interview of Mental Status) of 3 (severe cognitive impairment).</p> <p>On 11/24/24 at 10:10 AM R2 was lying in bed wearing oxygen. R2 was asked if she had her call light. R2 pulled down the covers and stated, I can't find it. V6/Licensed Practical Nurse came to R2's room and found the call light draped across the bedside table that was not within R2's reach.</p> <p>On 11/26/24 at 10:03 AM V2/Director of Nursing stated that all residents should always have their call light in reach.</p> <p>The Call Light policy (not dated) documents Procedure To respond promptly to resident's call for assistance. 8. When providing care to the residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. 11. Be sure all call lights are placed on the bed at all times, never on the floor or bedside table.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on record review and interview the facility failed to ensure a resident's Physician Order and Practitioner Order for Life-Sustaining Treatment (POLST) DNR (Do Not Resuscitate) code status was updated and accurate within the resident's care plan for one of 12 residents (R35) reviewed for Advanced Directives in the sample of 28.</p> <p>Findings include:</p> <p>R35's State Agency Uniform Practitioner for Lift-Sustaining Treatment (POLST) form dated [DATE] and signed by (V11/R35's Family Representative) documents No CPR (Cardiopulmonary Resuscitation): DNR.</p> <p>R35's Physician's Order dated [DATE] and signed by V13 (Physician) documents, Code Status: DNR.</p> <p>R35's Current Advanced Directive Care Plan documents, I am not at or approaching end of life at this time. My wishes for advanced directives and end of life care will be honored. Full Code-full treatment.</p> <p>On [DATE] at 10:23 AM V10 (Social Service Director) stated, (R35) decided to change his advanced directives from a full code to a DNR on [DATE]. I did not update (R35's) Advanced Directive's Care Plan to indicate (R35's) change to a DNR.</p> <p>The Advanced Directives policy dated ,d+[DATE] documents 1. The facility defines the following in accordance with current OBRA (Omnibus Budget Reconciliation Act) definitions and guidelines: a. Advance care planning- a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. b. Advanced Directive- a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated. 3. Do Not Resuscitate (DNR)- indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. If the Resident Has an Advanced Directive 1. If the resident or the resident's representative has executed one or more advanced directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services or designee notifies the attending physician of the advanced directives (or changes in advanced directives) so that appropriate orders can be documented in the resident's medical record and plan of care. 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advanced directive.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>31682</p> <p>Based on observation, interview, and record review the facility failed to develop and implement restorative range of motion programs for two of two residents (R4 and R6) reviewed for functional limitations in range of motion in the sample of 28.</p> <p>Findings include:</p> <p>1. R4's MDS (Minimum Data Set) Assessments dated 10/6/24 and 7/7/24 document R4 is cognitively intact, has functional limitations in range of motion to one side of the upper and lower extremities, and does not receive therapy, range of motion, splint/brace assistance, or any restorative programs.</p> <p>R4's current Care Plan documents R4 has the diagnoses of Hemiplegia affecting the left nondominant side and Pain. This same Care Plan does not address R4's limitations in range of motion to the left upper and lower extremities.</p> <p>On 11/24/24 at 10:07 AM R4 was sitting in his wheelchair. R4's left hand was in a closed fist with his fingers facing inward towards his palm with no splint or assistive device. R4 was unable to open his left hand. R4 stated he does not receive any range of motion exercises and the staff do not put a roll or splint in his left hand. R4 stated he would like to receive range of motion exercises.</p> <p>2. R6's MDS Assessments dated 11/10/24 and 8/11/24 document R6 is cognitively intact, has functional limitations in range of motion to both sides of the upper extremities, does not receive therapy, range of motion, splint/brace assistance, or any restorative programs.</p> <p>R6's current Care Plan documents R6 has the diagnoses of Rheumatoid Arthritis and Limited Mobility. This same Care Plan does not address R6's limitations in range of motion to the upper extremities.</p> <p>On 11/24/24 at 10:09 AM R6 was sitting in her recliner in her room watching television. Both of R6's hands were in closed fists with her fingers facing inward towards her palms with no splint or assistive devices. R6 stated she has not had exercises in over a year and would like staff to do exercises with her.</p> <p>On 11/25/24 at 11:34 AM V4 (Agency CNA/Certified Nursing Assistant) stated, (R4 and R6) do not receive range of motion or any type of restorative programs that I am aware of. I take care of (R4 and R6) full time.</p> <p>On 11/25/24 at 12:05 PM V2 (Director of Nursing) stated, We (the facility) have not had a restorative nurse or CNA for a few months now. (R4) and (R6) do not receive any restoratives or range of motion and probably should.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Restorative Nursing Services policy dated 11/2024 documents Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Policy Interpretation and Implementation: 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g. (example) physical, occupational or speech therapies). 3. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. 5. Restorative goals may include, but not limited to supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b. developing, maintaining or strengthening his/her physiological or psychological resources; c. maintaining his/her dignity, independence and self-esteem; and d. participating in the development and implementation of his/her plan of care.</p> <p>The ROM (Range of Motion) Contracture Care Policy and Procedure dated 11/2024 documents It is the policy of this facility that residents will be assessed on admission and quarterly, or more often as a change of condition warrants, for risk factors for development of contractures. An individualized ROM program may be developed based on the resident's unique assessed risk factors and involve formalized therapy and/or restorative nursing, as applicable. This program will be reflected in the interdisciplinary care plan and will be systematically and consistently followed. Key Points Formalized therapy will work closely with nursing staff, as appropriate, communicating and planning for goals and approaches so the team can be consistent in providing the care and services for maintaining joint mobility and for contracture care. An individualized plan will be based upon the comprehensive assessment and resident/representative input after discussion on risks and benefits to include interventions for staff to follow for prevention of contractures. If the purpose of ROM is other than prevention 1.e.(example), building muscle strength, Physical Therapy may assist in determining the repetition program. The program will also be modified for those residents that for whatever reason are unable to tolerate the recommended repetitions. 3. A physician's order will be obtained for physical or occupational therapy to evaluate and treat if there is any indication that the resident could benefit from these services. 4. Nursing orders can be initiated to start a preventative ROM movement program if there is no indication for formalized therapy or if there is no contradiction to the ROM movements. When in doubt, consult with physician and therapy for limitations and precautions for specific movements. 5. The nurse will review functional assessment to assure specific risk factors for contractures and contracture care are identified, addressed, and planned for. 7. When a resident has been identified as at risk for contractures and there is no indication to involve formalized therapy, the resident's name and ROM interventions will be added to the nursing tracking tool for Restorative, goals and approaches determined and care planned, and a restorative nursing flow sheet implemented. 8. When a resident has a contracture or contractures already present, formalized therapy will evaluate and work with nursing department in setting up goals and approaches for the plan that specifically addresses this individual's unique needs. 10. Individual plans for preventive ROM and contracture care will be followed as planned seven days a week or as indicated based upon assessed needs. 14. Initial flow sheet or document in the electronic health record daily.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>38396</p> <p>Based on interview and record review the facility failed to ensure physician ordered daily weights were obtained for a resident with congestive heart failure for one of one resident (R1) reviewed for hydration in the sample of 28.</p> <p>Findings include:</p> <p>R1's current care plan, dated 11/8/24, documents R1 has diagnoses including but not limited to: Edema, Retention of Urine, Atherosclerotic Heart Disease of Native Coronary Artery, Heart Failure, Atrial Fibrillation, Presence of Cardiac Pacemaker, Volume Depletion, Dehydration (history), Chronic Diastolic Congestive Heart Failure (CHF), Hypertensive Heart and Chronic Kidney Disease. This care plan documents I have diagnosis of Hypertension with routine medication to treat. Intervention: Weigh me as ordered. This same care plan also documents I am at risk for dehydration. I receive a diuretic medication two times a day for edema. Intervention: Weigh me as ordered 5/02/24, Daily weight for CHF.</p> <p>R1's Current Physician Order sheet, dated 11/26/24, documents an order for Daily weight everyday shift for CHF. This order has a start date of 5/3/2024.</p> <p>R1's Treatment Administration Record (TAR), dated September 2024 documents 17 scheduled daily weights were not completed. Of the 17 undocumented weights, this same TAR documents R1's weights were not completed from 9/17/24-9/25/24, totaling of nine consecutive missed weights.</p> <p>R1's TAR, dated October 2024, documents nine scheduled daily weights were not completed throughout the month.</p> <p>R1's TAR, dated November 1st-24th, 2024, documents ten scheduled daily weights were not completed over 24 days.</p> <p>On 11/26/24 at 10:40 AM, V3 (Certified Nursing Assistant) confirmed the CNA staff are the ones who complete resident weights. V3 stated To be honest we have a lot of nursing assistants who are agency and don't always know the routine. They may be responsible for vitals but not realize that weights are included in that. If the weight isn't done, then the nurse should be notified. I know (R1) can sometimes refuse weights or be difficult but not all of the time. I know sometimes her weights have been missed in error.</p> <p>On 11/26/24 at 12:20 PM, V2 (Director of Nursing) confirmed that R1 does not have daily weights documented every day, as ordered. V2 stated that if R1 is refusing to be weighed or the facility staff miss a weight then documentation and physician notification should be completed and R1's medical record does not reflect that documentation related to R1's missed daily weights from September- November 2024.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Weight Measurement policy, dated 11/2018, documents It is the policy of (the facility) that resident's weights are taken upon admission, re-admission, monthly and as indicated. Residents with congestive heart failure will be weighed as ordered by physician. Ordering physician will be notified of weight gains and losses of two pounds or greater in one day or five pounds or greater in one week unless other parameters are specified by their physician.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>38396</p> <p>Based on Observation, Interview and Record Review, the facility failed to document a diagnosis and identify target behaviors to warrant the use of Risperidone (antipsychotic medication), complete a psychotropic medication assessment, and attempt a gradual dose reduction of Risperidone for one of three residents (R31) with a diagnosis of Dementia, reviewed for antipsychotic medications in the sample of 28.</p> <p>Findings include:</p> <p>1. On 11/24/24 at 11:40 PM R31 was sitting in the facility's dining room in a wheelchair awaiting lunch. R31 was quiet, looking forward, smiled and did not exhibit any behaviors.</p> <p>On 11/25/24 at 9:15 AM, R31 was sitting in his wheelchair being pushed through the hallway of the facility. R31 was cooperative with mobility assistance throughout the building and was not exhibiting any behaviors.</p> <p>R31's current Physician Order sheet, dated 11/26/24, documents R31 has an order for Risperidone 0.25 milligrams (antipsychotic medication), Give one tablet by mouth two times a day for Dementia with behavioral disturbance.</p> <p>R31's current Care Plan, dated 11/21/24, documents R31 has diagnoses of Non-traumatic Chronic Subdural Hemorrhage, Cognitive Communication Deficit, Major Depressive Disorder, Unspecified Dementia and Insomnia. This same care plan documents I (R31) take psychotropic medication(s) related to dementia with behavioral disturbances. Interventions/Tasks: I am on behavior tracking for my verbal aggression, including but not limited to outburst of yelling out directed at others.</p> <p>R31's behavior summary reports for November 1-26th, 2024 document R31 is being monitored for behaviors of insomnia, verbal aggression, getting up on his own, resisting care, physical aggression, threats to staff, inappropriate verbal behaviors, depression, exit seeking and agitation. These weekly summary reports document R31 has exhibited zero behaviors for the month.</p> <p>On 11/26/24 at 10:08 AM, V2 (Director of Nursing) stated Since admission in February 2024, (R31) has been resistive to cares. For a while he wanted to leave. He is not harmful to other residents or himself. (R31) has not had any dose reduction of his Risperidone due to the Psychiatrist (V17) not allowing it. We (the facility) do not have psychotropic medication assessments. I wasn't aware they needed to be done.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24 at 10:30 AM, V3 (Certified Nursing Assistant) stated (R31) has some behaviors depending on your approach and patience that you give him. (R31) doesn't like to be told what to do. He can be aggressive with cares when staff are trying to help or get him to do something. (R31) will get up on his own and walk when he's not supposed to. He's not a threat to himself and hasn't shown signs of aggressive or psychotic behaviors towards other residents. (R31's) behaviors get more increased in the evenings as with typical dementia. When his family leaves, he wants to also leave and do the things he used to do. (R31) has more confusion in the evening.</p> <p>On 11/26/24 at 11:12 AM, V10 (Social Service Director) stated When (R31) came to us he was placed on all of his home medications. He admitted in February 2024 and has been on the Risperidone since just after his admission. (R31) had a procedure done in May 2024 for bleeding in his brain and his behaviors are better since the surgery. At first (R31) was just angry. He would not get angry with other residents; it was mainly only with hands on care. (R31) was confused but he's gotten better and is more stable now. V10 then confirmed that aggression towards staff with cares, getting up on his own and exit seeking are not behaviors of psychosis and correlate to typical behaviors of dementia.</p> <p>On 11/26/24 at 12:04 PM V2 (Director of Nursing) confirmed R31 had surgery in May and since then, his behaviors have lessened. V2 stated Since the procedure he's actually more tired now and he has leveled off with behaviors.</p> <p>The Psychotropic Medication Program policy (not dated) documents Facility staff will ensure that all psychotropic medications are properly ordered, monitored for effectiveness, and side effects. Physicians will be notified for review of medications for possible dosage reduction according to current guidelines: the entire psychotherapeutic regimen will be taken into account when reductions are made. Purpose: To prevent the use of unnecessary psychotropic medications. To prevent adverse effects to all residents receiving psychotropic medications. Procedures and Key Points 1. Resident Assessment - Assessment will begin when facility staff determines the resident is exhibiting untoward behaviors that place the resident, or their peers in danger. The social service department shall be alerted when noting any untoward behavior. Upon the noting of behaviors focus charting will be initiated for ongoing assessment. The nursing staff along with the IDT will attempt to identify any potential causes for the untoward behavior. This may include but not limited to, acute health conditions, social settings, personal choices and interests, etc. (etcetera). Screening for depressive symptoms will be formally completed by 14-day assessment, quarterly, as needed, by the social services department or nursing. The family or responsible party will be notified of all significant behaviors. Behavior tracking will be instituted at this time to provide documentations of the frequency and intensity or the behavior occurrence. 2. Alternatives - The initial plan for treatment of behaviors will include such alternatives as; diversional activities, change in environment, psycho-social programming, treatment of acute medical conditions, etc. Treatment will be added to care plan. When all alternatives have been exhausted, the use of a psychotropic may be deemed necessary by the attending physician. When possible, the expertise of a psychologist or psychiatrist will be consulted. 9. Dose Reduction - Gradual dose reductions are to occur unless documented by physicians/psychiatrist that they are clinically contraindicated. (Many mental illnesses require the use of psychotropic medications).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Psychotropic Medication Policy and Procedure (not dated) documents Psychotropic medications will be utilized appropriately by working with the physicians and the interdisciplinary team through evaluations and monitoring. Standards 1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in long term care to include regular review for continued need, appropriate dosage, side effects, risks and/ or benefits. Primary Care Physician 1. Orders for psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches. 2. Documents rationale and diagnosis for use and identifies target symptoms. 5. Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than 3 (three) months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 (two) separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants, unless the physician has documented at least annually that this would not be indicated or in the patient's best interest. Nursing 3. Review the use of the medication with the physician and interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and /or the presence of any adverse effects of the medication use.</p>		

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NAME OF PROVIDER OR SUPPLIER Golden Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Prairie Mills Road Golden, IL 62339	
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on record review and interview the facility failed to ensure a resident was free of significant medication errors for one of one resident (R4) reviewed for significant medication errors in the sample of 28. These failures resulted in R4 ingesting a toxic amount of medication, experiencing increased lethargy, arrhythmia, sedation, and respiratory depression resulting in R4 requiring emergency department services and intravenous fluids.</p> <p>Findings include:</p> <p>R4's Progress Notes dated [DATE] at 5:25 PM and signed by V2 (Director of Nursing) documents, (R4) received the wrong medication this evening. Doctor and family notified. Vitals obtained and will be monitored closely through the night, (R4) is alert and orientated. No need to go the ER (emergency room) at this time. Continue to monitor.</p> <p>R4's Progress Notes dated [DATE] at 10:08 PM document, (R4's) O2 (Oxygen Saturation) noted to be 82 percent. At 9:30 PM on-call (physician) returned call and asked for updated O2 which was 72 percent on two liters (oxygen) per minute. Order received to send to ER. Call placed to 911. Resident has been loaded into the ambulance and left (the) facility at this time.</p> <p>R4's Emergency Department (ED) Notes dated [DATE] at 10:38 PM document, (R4) is a [AGE] year-old who presents to the emergency department with complaints (c/o) accidental ingestion of medication at 5:00 PM today. (R4) had been inadvertently given medication meant for another patient. (R4) appears to be somnolent at point of examination hence history was obtained by EMS (Emergency Medical Staff). Life-threatening and function threatening differential diagnoses considered on ED evaluation include toxic ingestion, arrhythmia, sedation, respiratory depression, or other metabolic causes of sedation. 12:04 AM reassessment of (R4) shows (R4) to be in stable condition. (R4) shows improvement after the following was given in the ED: Sodium Chloride 0.9% (percent) 1000 milliliters intravenous.</p> <p>R4's Emergency Department Clinical Care Summary dated [DATE] documents, You (R4) were seen in the emergency department on [DATE] with the chief complaint of overdose.</p> <p>R4's Progress Notes dated [DATE] at 7:06 AM document, (R4) returned from the ER. (R4) remains lethargic and hard to arouse. Respirations are even and non-labored. Transporter reports, It was a mess. It took five people to get (R4) in the wheelchair, (R4) is out of it.</p> <p>R4's Progress Notes dated [DATE] at 11:02 PM documents R4 continues to be lethargic.</p> <p>R4's Progress Notes dated [DATE] at 8:49 AM documents, This nurse fed (R4) for breakfast. (R4) asked, What is wrong with me? This nurse explained. (R4) stated, Oh wow. I guess that's why I feel this way. (R4) stated he was full and would like to go back to sleep.</p> <p>R4's Progress Notes dated [DATE] at 12:46 PM and 11:02 PM document R4 remained lethargic and remained in bed throughout the day.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:30 AM V2 (Director of Nursing) provided a list of R31's medications that were administered by V12 (RN/Registered Nurse) to the wrong resident (R4) on [DATE] at 5:00 PM. That list included the following medications: Mirtazapine 30 mg (milligrams) one tablet, Atorvastatin 80 mg one tablet, Tamsulosin 0.4 mg one tablet, Clonazepam 0.25 mg one tablet, Colace 100 mg one tablet, Gabapentin 200 mg one tablet, Levetiracetam 500 mg one tablet, Memantine 10 mg one tablet, Senna 8.6 mg one tablet, and Vitamin C 500 mg one tablet.</p> <p>On [DATE] at 11:30 AM R4 stated, When I was given someone else's medications I was worried. I did not feel well and was having a hard time breathing. It scared me. I was tired for several days after that and stayed in bed most of the time.</p> <p>On [DATE] at 12:05 PM V2 (Director of Nursing) stated, Both (R4) and (R31) have the same first name. (V12) had given (R4) the other resident's (R31's) medications by accident. (V12) realized what she had did after it was too late.</p> <p>On [DATE] at 12:20 PM V12 stated, On [DATE] at around 5:00 PM I was giving medications and I realized I had given (R4) a different resident (R31's) medications. I only asked (R4) his first name and not his last name before giving (R4) his medications. I reported it to (V2) and then called the physician and was told to monitor (R4) and if (R4) had a change in condition to send (R4) to the emergency room . I know after I left my shift, (R4) had a condition change and had to be sent to the emergency room .</p> <p>The Adverse Consequences and Medication Error policy dated ,d+[DATE] documents The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation 1. An adverse consequence refers to an unwanted, uncomfortable, or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include a. Adverse drug/medication reaction; b. Side effect; c. Medication-medication interaction; or d. Medication-food interaction. 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturers specifications for use, dose, administration, duration, and monitoring of the medication. Medication errors 1. A medication error is defined as the preparation of administration of drugs for biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medication errors include b. Unauthorized drug-a drug is administered without a physician's order; f. Wrong drug (e.g. (example), vibramycin ordered, vancomycin given). 3. A significant medication-related error is defined as: b. Requiring hospitalization or extending a hospitalization . e. Resulting in cognitive deterioration or impairment. f. Life threatening. Procedures 3. Evaluate the resident for possible medication-related adverse consequences when the resident has clinically significant change in condition/status, including a. Unexplained decline in function, cognition, or behavior. b. Worsening of an existing problem or condition. 4. Monitor the resident for medication related adverse consequences when there is a (an): f. Medication error, e.g., wrong or expired medication.</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Administration of Medication policy dated ,d+[DATE] documents Medications are administered in a safe and timely manner, and as prescribed. 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38396</p> <p>Based on observation, interview and record review, the facility failed to ensure use of an effective sanitation solution and prevent spread of potential contamination to food and food preparation surfaces in the kitchen. This failure has the potential to affect all 35 residents residing in the facility.</p> <p>Findings include:</p> <p>On 11/24/24 at 11:45 AM V7 (Dietary Manager) and V8 (Dietary Cook) were in the kitchen preparing to serve lunch. At this time V8 removed a food thermometer from a storage cup containing other kitchen utensils. V8 then retrieved a folded kitchen cloth from the kitchen's storage closet and soaked the cloth in the kitchen's quaternary (bleach) sanitation bucket. V8 proceeded to wipe down the thermometer and began taking temperatures of hot food on the kitchen's steam table. V8 used the same wet cloth to clean the thermometer between each hot food item including roasted pork, sweet potatoes, mixed vegetables, and ground pork. After completing temperatures of hot items, V8 used the same cloth to clean the thermometer and checked the temperature of cold lettuce salad mixed with ranch dressing. Upon completion of all temperatures, V8 took the same wet cloth and wiped down the kitchen's metal food preparation table which contained crumbs and food particles from lunch preparation. At this time V7 (Dietary Manager) used a testing strip and checked the kitchen's quaternary sanitation bucket and the result was ten PPM. At this time V8 stated I haven't changed that (sanitation solution) yet. V7 confirmed the chemical solution concentration needs to be at 50-100 PPM to be used in the kitchen when cleaning. V7 confirmed the sanitation solution at only ten PPM concentration was used to sanitize the kitchen's thermometer during the steam table food temperature checks. V7 stated We normally would use an alcohol wipe when doing the steam table temperatures, but we are out of those until more come in. That is why (V8) used the cloth. The bleach solution needs changed though because ten PPM is not effective for sanitation.</p> <p>The facility's (undated) Cleaning For Kitchen Staff policy, documents Basic responsibility- all dietary staff: To maintain clean worked environment. To keep work areas sanitary for food production. To inhibit the growth of bacteria and food born illness. This policy also documents Use general guidelines made by manufacturers when using chemicals. A sanitizing solution is made using water and bleach to reach a 50 PPM (Part Per Million) ratio. Check with test strips.</p> <p>The facility's Sanitation policy, dated 11/2022, documents The food service area is maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. Service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration.</p> <p>The facility's Long Term Care Application for Medicare and Medicaid, dated 11/24/24 and signed by V1 (Administrator) documents 35 residents reside in the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>31682</p> <p>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) and Universal Standard Precautions while providing incontinence cares to a resident with a pressure ulcer for one of 12 residents (R35) reviewed for Infection Control in the sample of 28.</p> <p>Findings include:</p> <p>R35's current Care Plan documents R35 has a stage two pressure ulcer to his coccyx.</p> <p>On 11/24/24 at 9:40 AM R35's door had a sign on his door that stated, Stop. Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, during device care or use, and during wound care. R35 was lying in bed and had a four-by-four gauze covering a pressure ulcer to his coccyx. During this time V3 (CNA/Certified Nursing Assistant) and V4 (CNA) were providing incontinence cares to R35. During these cares V3 and V4 were not wearing gowns. V4 applied gloves, removed R35's soiled adult brief, and washed R35's buttocks and groin area. Using the same soiled gloves opened R35's restroom door and opened R35's side table drawer looking for incontinence cream. V3 and V4 then proceeded to roll R35 over to his left side and V4 placed her soiled gloves on the back of R35's shirt while rolling R35, applied a clean adult brief, and rolled R35 to his back while using the same soiled gloves. V3 and V4 then removed their gloves, placed the gloves in a trash bag, and exited R35's room without washing their hands.</p> <p>On 11/25/24 at 11:00 AM V4 stated, I did not change my gloves after providing incontinence cares to (R35) and I did not wash my hands before leaving (R35's) room after doing incontinence cares. I did not wear a gown while doing (R35's) incontinence cares. I realized what I did but it was too late.</p> <p>On 11/25/24 at 12:05 PM V2 (Director of Nursing) stated, (V3 and V4) should have worn gowns and gloves when providing incontinence cares to (R35) since (R35) is supposed to have enhanced barrier precautions due to having a pressure ulcer. (V4) should have changed her gloves after providing incontinence care and should have washed her hands before leaving (R35's) room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Enhanced Barrier Precautions policy dated 4/2024 documents Enhanced Barrier Precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. EBPs are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. (etcetera)); and h. wound care (any skin opening requiring a dressing). 5 EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. a. Wounds generally include chronic wounds (i.e. (example), pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.</p> <p>The Standard (Universal) Precautions policy dated 11/2008 documents Basic Responsibility: All Staff Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. The purpose of this policy is to provide guidelines to decrease the risk of occupational exposure to blood or body fluids. These precautions are based on the current CDC (Center for Disease Control) guidelines. Handwashing 1. Hands should be washed before, after, and between contact with persons and after touching intimate objects likely to be contaminated by blood and body. 2. Hands should be washed after removing gloves. 3. Hands should be washed if contaminated with blood or body fluids as soon as possible. 4. Hands should be washed for 10-15 seconds under running water with soap using vigorous mechanical friction. 5. An alcohol based antiseptic hand cleaner may be used to decontaminate hands following thorough hand washing with soap and water. Gloves the use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated for procedures where body fluids are handled. 1. Gloves should be worn in the following circumstances: a. If the worker has cuts, broken skin, chapped hands, dermatitis, or other breaks in skin b. During invasive procedures c. During cleaning of body fluids and decontaminating procedures d. If worker judges that hand contamination with blood or body fluids may occur e. During contact with mucous membranes. 2. Gloves should be worn when handling soiled linens. 3. Gloves should be changed after contact with each person when body fluids are present and between clean and dirty procedures. Gowns flood resistant or flood proof gowns should be worn during procedures that are likely to generate splashes of blood or body fluids to skin or clothing.</p>		