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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Columbia Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Columbia St Evansville, IN 47710 | |

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) |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48147</p> <p>Based on interview and record review, the facility failed to notify the physician of blood glucose levels outside of parameters for 1 of 2 residents reviewed for insulin administration. (Resident 59)</p> <p>Finding includes:</p> <p>On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period.</p> <p>Physician orders included, but were not limited to:</p> <p>Accu-check (a blood glucose monitoring system) once a day - Notify physician if Accu-check is below 60 milligram per deciliter (mg/dL) or greater than 400 mg/dL, dated 4/22/20</p> <p>A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24, included an intervention to document abnormal findings and notify the physician.</p> <p>A vital sign report, dated 7/6/24 at 10:06 A.M., indicated the blood glucometer read HI (blood glucose level greater than 600 mg/dL).</p> <p>The July 2024 MAR indicated the physician was not notified of Resident 59's elevated blood glucose level on 7/6/24.</p> <p>A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received.</p> <p>The clinical record lacked documentation of follow up with the physician about Resident 59's critical blood glucose level between 7/6/24 at 11:01 P.M. and 7/7/24 at 8:54 A.M.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A Nursing progress note, dated 7/7/24 at 8:54 A.M., indicated the nurse attempted to contact the NP again for the critical blood glucose level.</p> <p>During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated staff texted her and if there was no response after 15 to 30 minutes, they would call her. If she still didn't respond, they were to call the on-call physician.</p> <p>On 11/1/24 at 11:33 A.M., the Administrator provided a current Blood Glucose Monitoring policy, dated 2/2015, that indicated The physician will be notified when the resident's blood glucose is outside the physician stated parameters or if the resident is experiencing signs or symptoms of high or low blood sugars.</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current Resident Change of Condition policy, dated 12/17, that indicated It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs . All nursing actions, physician contacts, and resident assessment information will be documented in the Progress Notes . Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation . If unable to contact attending physician timely, the resident will be transferred for emergency services . Documentation will include time and family/physician response.</p> <p>3.1-5(a)(3)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50827</p> <p>Based on record review and interview the facility failed to ensure a resident had a care plan implemented related to frequent urinary tract infections (UTI) with multidrug resistant organisms for 1 of 1 residents reviewed for UTI. (Resident 85)</p> <p>Finding includes:</p> <p>On 10/25/24 at 10:58 A.M. Resident 85 indicated that they got frequent urinary tract infections because staff did not clean her properly.</p> <p>The clinical record was reviewed on 10/28/24 at 2:49 P.M. Resident 85 had diagnoses that included but was not limited to urinary tract infection.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, dated 9/24/24, indicated the resident was cognitively intact, used a wheel chair, required substantial to maximum assistance with bathing and personal hygiene, was incontinent of bowel and bladder, had a primary diagnosis of COPD (chronic obstructive pulmonary disease), had a urinary tract infection within the last 30 days, had an intravenous catheter, had been on intravenous medications, required isolation precautions, and was on antibiotics.</p> <p>Current physician orders included but was not limited to: Urine is colonized with ESBL (Extended-spectrum beta-lactamase, causes problems in efficacy of antibiotics making infection resistant to treatment) dated, 9/6/22.</p> <p>On 11/1/24 at 9:45 A.M., the DON (Director of Nursing) indicated that she would have expected Resident 85 to have an ongoing careplan related to recurrent urinary tract infections and colonization of ESBL in the resident's urine.</p> <p>A policy provided by the Administrator on 11/1/24, at 11:33 A.M., titled IDT Comprehensive Care Plan Policy, indicated it is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on the Resident Assessment Instrument process. The care plan must include measurable goals and resident specific interventions based on the resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being.</p> <p>3.1-35(a)</p> <p>3.1-35(b)(1)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48147</p> <p>Based on interview and record review, the facility failed to ensure effective services to treat elevated blood glucose levels were provided in accordance with the physician and Nurse Practitioner (NP) orders for 1 of 2 residents reviewed for insulin administration. (Resident 59) This deficient practice resulted in the resident requiring emergent transport to an acute care hospital intensive care unit for the treatment of diabetic ketoacidosis (DKA) (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to use blood sugar for energy.)</p> <p>Finding includes:</p> <p>On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The most recent comprehensive Significant Change Minimum Data Set (MDS) Assessment, dated 3/21/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 6 days during the 7-day lookback period.</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period.</p> <p>A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24, included an intervention to document abnormal findings and notify the physician.</p> <p>The July 2024 Physician's order recapitulation included, but was not limited to, orders for staff to administer 20 units of insulin glargine (a long-acting insulin) once daily at bedtime, measure the resident's blood glucose once daily, and notify the physician if Accu-check result is below 60 milligram per deciliter (mg/dL) or greater than 400 mg/dL.</p> <p>A vital sign report, dated 7/2/24 at 10:14 A.M., indicated Resident 59's blood glucose level was 490 mg/dL.</p> <p>The July 2024 Medication Administration Record (MAR) indicated the physician was notified of the elevated blood glucose level on 7/2/24.</p> <p>The Progress notes, medication administration notes, and event forms, dated 7/2/24, lacked documentation to determine the physician responded to or the facility staff made attempts to follow-up with the physician to address the elevated blood glucose level.</p> <p>The progress notes, assessments, monitoring/evaluation tools, physician orders, and medication administration notes lacked documentation to indicate a physician response was received or the facility staff followed up with the physician between 7/2/24 at 10:14 P.M. and 7/6/24 at 1:55 P.M.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>A vital sign report, dated 7/6/24 at 10:06 A.M., indicated the blood glucometer read HI (blood glucose level greater than 600 mg/dL).</p> <p>The July 2024 MAR indicated the physician was not notified of Resident 59's elevated blood glucose level on 7/6/24.</p> <p>The progress notes, assessments, monitoring/evaluation tools, physician orders, and medication administration notes lacked documentation to indicate the physician was contacted between 7/6/24 at 10:06 A.M. and 7/6/24 at 1:55 P.M.</p> <p>A Physician Communication note, dated 7/6/24 at 1:55 P.M., indicated the physician was notified the resident was not acting like herself. The resident did not want to eat, refused to drink her fluids, was not walking according to her baseline, and was urinating a large amount. The note indicated the resident had an increased heart rate of 119 beats per minute (bpm) and respirations of 24 respirations per minute (rpm).</p> <p>A Physician/NP order, dated, 7/6/24 at 2:09 P.M., indicated orders were received for staff to immediately (STAT) obtain blood draws for a complete blood count (CBC) (a laboratory test to measure the number and type of cells in blood and a comprehensive metabolic panel (CMP) (a laboratory test that measures 14 substances in your blood to provide information about your metabolism and chemical balance).</p> <p>A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received.</p> <p>A message screenshot, dated 7/6/24 at 6:50 P.M., indicated staff texted the critical blood glucose level to the NP and requested orders, but did not receive a response.</p> <p>A laboratory report, dated 7/6/24 at 4:53 P.M., indicated Resident 59 had a blood glucose level of 526 mg/dL. An untimed handwritten note on the report, signed by the Director of Nursing (DON) indicated the NP was notified on 7/7/24.</p> <p>The report did not include sufficient documentation to determine the facility notified the physician or the NP, between 7/6/24 at 4:54 P.M. and 7/7/24 at 8:53 A.M., of the elevated blood glucose level.</p> <p>A Nursing progress note, dated 7/7/24 at 8:54 A.M., indicated the nurse attempted to contact the NP again for the critical blood glucose level.</p> <p>The July 2024 Physician's recapitulation dated 7/7/24 at 9:39 A.M., indicated the following order was received:</p> <p>Humalog (insulin lispro) KwikPen - insulin lispro (a short-acting insulin) - Give per Sliding Scale subcutaneous, three times a day,</p> <p>If Blood Sugar is less than 60 mg/dL, call physician.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>If Blood Sugar is 0 to 199, give 0 Units.</p> <p>If Blood Sugar is 200 to 249, give 1 Units.</p> <p>If Blood Sugar is 250 to 299, give 2 Units.</p> <p>If Blood Sugar is 300 to 349, give 3 Units.</p> <p>If Blood Sugar is 350 to 399, give 4 Units.</p> <p>If Blood Sugar is 400 to 499, give 5 Units.</p> <p>If Blood Sugar is greater than 500, call physician.</p> <p>A vital sign report, dated 7/7/24 at 12:24 P.M., indicated Resident 59's blood glucose level was 548 mg/dL.</p> <p>The July 2024 Medication Administration Record (MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 548 mg/dL.</p> <p>A vital sign report, dated 7/7/24 at 4:25 P.M., indicated Resident 59's blood glucose level was 582 mg/dL.</p> <p>The progress notes, medication administration notes, monitoring/evaluation tools, and physician orders, dated 7/7/24, did not include documentation to indicate the physician was notified of the elevated blood glucose levels or new orders were received to treat the blood glucose levels of 548 mg/dL or 582 mg/dL.</p> <p>The July 2024 MAR indicated Resident 59's 8:00 A.M. dose of insulin lispro on 7/8/24 was given by Registered Nurse (RN) 15, but did not indicate the blood glucose was measured prior to administration, how much insulin was given, or the body site where the insulin was given.</p> <p>Progress notes and the vital sign report, dated between 7/7/24 at 4:25 P.M. and 7/8/24 at 11:25 A.M., lacked documentation to indicate a blood glucose level was obtained.</p> <p>A nursing progress note, dated 7/9/24 at 9:04 A.M., indicated Resident 59 became unresponsive during a meal, staff performed a sternal rub, and a blood glucose check was conducted. The Accu-check measured the blood glucose as, HI, the heart rate was 123 bpm the respirations were 22 rpm, and the resident was panting. The progress note indicated the resident had no recent fluid intake. The note indicated the NP was notified and orders were received to send the resident to the emergency room (ER) for evaluation and treatment.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>A hospital admission assessment, dated 7/9/2024 at 9:54 A.M., identified the resident had a urinary tract infection (UTI). The assessment included, but was not limited to, the following laboratory results: The blood glucose measured 742 mg/dL with a reference range of 70 - 99 mg/dL. The white blood cell count measured 21.2 thousands per microliter (THOUS/uL) with a reference range of 4.0 - 10.3 THOUS/uL. The urinalysis measured positive for greater than 1000 mg/dL glucose with a reference range of negative. The assessment indicated Resident 59 was admitted to the Intensive Care Unit (ICU) for treatment of diabetic ketoacidosis (DKA).</p> <p>Hospital discharge papers, dated 7/15/24 at 10:14 A.M., indicated Resident 59 was discharged back to the facility after being admitted to the hospital for acute metabolic encephalopathy (ME) (a condition that occurs when the body lacks oxygen, glucose, or vitamins), DKA, and UTI.</p> <p>During an interview with the DON on 10/30/24 at 11:59 A.M., she indicated all notifications to the physician was documented as a progress note.</p> <p>During an interview with the Director of Nursing (DON) on 10/30/24 at 1:44 P.M., she indicated the nurse called the NP for the blood sugars over 500 mg/dL on 7/7/24. The NP said to give five units over the maximum units on the sliding scale. The documentation system would not let her input that she gave 10 units, so she put she gave zero units. She did not document the notification to the NP, the new order, or the insulin administration amount in a progress note or as a medication administration note, but she should have. At that time, the DON was unable to provide documentation to indicate the nurse gave 10 units of insulin.</p> <p>During an interview with the DON on 10/30/24 at 1:59 P.M., she indicated Licensed Practical Nurse (LPN) 6 did not remember if she gave the 8 A.M. dose of insulin lispro or not. The DON was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 at 8:00 A.M., or how many units of insulin lispro were given if any.</p> <p>During an interview, on 11/1/24 at 8:15 A.M., the Administrator indicated text messages were not part of the clinical record.</p> <p>During an interview with the Administrator on 11/1/24 at 8:51 A.M., she indicated staff texted the NP and didn't need to document all communication in the progress notes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated staff texted her and if there was no response after 15 to 30 minutes, they would call her. If she still didn't respond, they were to call the on-call physician. She did not have a record of being contacted on 7/2/24 in relation to Resident 59's elevated blood glucose level. She indicated she would have advised staff to recheck the blood sugar in an hour and call back if it was still high. The NP indicated she was unable to find a recheck of blood glucose levels for Resident 59 on 7/2/24. The NP indicated the sliding scale insulin order was for one week on a trial basis and then the resident would be re-evaluated. At that time, the NP was unable to provide documentation that the insulin order was on a trial basis and when the resident was to be re-evaluated. The NP indicated she did not have documentation of being contacted on 7/7/24 in relation to Resident 59's elevated blood glucose level. She indicated she would have ordered four units of insulin above the highest number on the sliding scale to be given, making the total insulin nine units for that administration time. She indicated four units of insulin above the highest number on the sliding scale for a blood glucose level over 400 mg/dL should have been a standing order from that point on. The NP indicated that she was not contacted by a nurse on 7/8/24 about Resident 59's blood glucose level, insulin, or a missed dose. The NP was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 or how many units of insulin lispro were given.</p> <p>On 11/1/24 at 11:33 A.M., the Administrator provided a current Blood Glucose Monitoring policy, dated 2/2015, that indicated, .The physician will be notified when the resident's blood glucose is outside the physician stated parameters or if the resident is experiencing signs or symptoms of high or low blood sugars .</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current Resident Change of Condition policy, dated 12/2017, that indicated, .It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs . All nursing actions, physician contacts, and resident assessment information will be documented in the Progress Notes . Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation . If unable to contact attending physician timely, the resident will be transferred for emergency services . Documentation will include time and family/physician response .</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated .Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms .</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current Authorization and Communication of Orders policy, dated 6/1/24, that indicated .Facility should ensure that the authorized person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of physician/prescriber, the signature of the person recording the order and other information as permitted by and in accordance with applicable law .</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>The article, About Diabetic Ketoacidosis, dated 5/15/24, was retrieved on 11/5/24 from the Center for Disease Control and Prevention (CDC) website at https://www.cdc.gov/diabetes/about/diabetic-ketoacidosis.html#:~:text=also%20develop%20DKA-,DKA%20develops%20when%20your%20body%20doesn't%20have%20enough%20insulin,dangerous%20levels%20in%20your%20body. The guidance included: .DKA is a serious complication of diabetes that can be life-threatening. DKA is most common among people with type 1 diabetes. People with type 2 diabetes can also develop DKA.</p> <p>DKA develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in your body .</p> <p>The article, Metabolic Encephalopathy, dated 7/10/24, was retrieved on 11/5/24 from the Cleveland Clinic website at https://my.clevelandclinic.org/health/diseases/metabolic-encephalopathy. The guidance included: . Metabolic encephalopathy is a brain dysfunction caused by an underlying condition. Many possible conditions can cause metabolic encephalopathy, but these mainly target your metabolism. Your metabolism is the chemical process that converts the things you eat and drink into energy. Brain dysfunction can affect your mood, thinking and memory or cause a loss of consciousness (coma). All metabolic encephalopathies require medical attention. If left untreated, they can be life-threatening or cause permanent brain damage .</p> <p>3.1-37(a)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>48057</p> <p>Based on interview and record review, the facility failed to ensure a resident did not develop an avoidable pressure ulcer by monitoring skin for 1 of 3 residents reviewed for facility acquired pressure ulcers. (Resident 89)</p> <p>Finding includes:</p> <p>During an interview on 10/24/24 at 2:22 P.M., Resident 89 indicated she had pressure injuries on her right leg from her knee immobilizer not being monitored.</p> <p>On 10/28/24 at 2:40 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but were not limited to congestive heart failure and diabetes mellitus.</p> <p>The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 8/7/24, indicated resident 89 was cognitively intact, was fully dependent on staff for transfers, required substantial assistance from staff (staff do more than half the work) for toileting and bathing, and did not have any unhealed pressure ulcers.</p> <p>Current physician orders included, but were not limited to:</p> <p>Right calf: cleanse wound with wound cleanser, pat dry; wound to be packed by wound NP (nurse practitioner) with skin sub, cover with silicone dressing, then steri-strips, then cover with a dry dressing. Change 1x weekly by Wound NP. Outer dressing to be changed PRN if soiled/dislodged. Once a day on Wednesday, Start date 10/2/24.</p> <p>Current care plans included, but were not limited to:</p> <p>Impaired mobility related to: right nondisplaced fracture medial tibial plateau; Assess and document skin condition weekly and as needed. Date initiated 6/12/24.</p> <p>The care plan did not specify to remove the immobilizer and check skin under the immobilizer.</p> <p>A nursing progress note, dated 6/12/24 at 10:14 P.M. indicated Resident 89 returned from a hospital stay, from 6/8/24 through 6/12/24 due to fall with fracture in facility that occurred on 6/8/24, with a knee immobilizer to the right leg.</p> <p>A nursing progress note, dated 7/23/24 at 2:33 P.M., indicated Resident 89 had returned from an orthopedic appointment with orders to discontinue the knee immobilizer on Resident 89's right leg.</p> <p>An IDT (interdisciplinary team) note, dated 7/26/24 at 9:48 A.M., indicated Resident 89's right lateral calf noted to have two unstageable pressure wounds related to the knee immobilizer.</p> <p>A skin and wound note, dated 7/31/24 at 6:45 P.M., indicated Resident was assessed by the wound NP due to a deep tissue injury to the right posterior leg caused by right leg</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>brace, measured at 4.8 centimeters (cm) by 1.3 cm by 0.1 cm.</p> <p>The clinical record, including assessments, observations, events, progress notes, and documents, lacked skin assessments completed during the following weeks while Resident 89 had a right knee immobilizer in place:</p> <p>6/12/24-6/18/24</p> <p>6/20/24-7/2/24</p> <p>7/4/24-7/23/24</p> <p>During an interview on 11/1/24 at 2:09 P.M., the Director of Nursing indicated there were not skin assessments completed during the missing weeks in June and July.</p> <p>On 11/1/24 at 11:36 A.M., the Administrator provided a policy titled Skin Management Program, revised 5/22, that indicated the purpose of the policy was To promote the prevention of pressure/ulcers/injury development. Avoidable pressure ulcer/injury: means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions.</p> <p>3.1-40(a)(1)</p> |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>48057</p> <p>Based on interview, observation, and record review, the facility failed to administer non-pharmalogical or pharmalogical interventions for pain prior to performing wound care for 1 of 2 residents observed for wound care. (Resident 104)</p> <p>Finding includes:</p> <p>On 10/29/24 at 9:46 A.M., Resident 104's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of lymph nodes of head, face, and neck and squamous cell carcinoma of skin of scalp and neck.</p> <p>A Significant Change MDS (Minimum Data Set) Assessment, dated 9/3/24, indicated Resident 104 was cognitively intact, was completely dependent on staff for transfers required substantial assistance from staff (staff does more than half the work) for toileting and bathing, received as needed pain medication in the last five days and had not received non-medication intervention for pain in the past five days.</p> <p>Current physician orders included, but were not limited to:</p> <p>hydrocodone-acetaminophen schedule II tablet 5-325 mg; oral every four hours as needed, start date 9/10/24.</p> <p>Betadine (povidone-iodine) solution; 10%; 1 application; topical. Special Instructions: Betadine wash to left heel once a day, start date 8/28/24.</p> <p>Care plans included, but were not limited to:</p> <p>Resident is at risk for pain. Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition. Administer medications as ordered. Start date 8/5/24.</p> <p>During an observation on 10/30/24 at 10:56 A.M., RN 12 entered Resident 104's room and told Resident 102 she was going to start the wound treatment on his foot. Resident 104 requested pain medication before RN 12 started the wound treatment. RN 12 started to perform wound care and Resident 102 began grimacing and stating he was in pain and would like pain medication before wound care. RN 12 yelled into the hall for another nurse; RN 10 entered Resident 104's room and RN 12 handed RN 10 the medication cart keys and asked her to get a narcotic pain medication for Resident 102. RN 12 continued cleaning Resident 102's wound and painted the left heel with Betadine. Resident 104 continued to grimace and request pain medication. RN 10 returned to Resident 104's room and handed RN 12 a medication cup. RN 12 spoon the medication and applesauce slurry into Resident 104's mouth. RN 12 did not offer to reposition Resident 104 or to postpone the wound treatment.</p> <p>During an interview on 11/1/24 at 1:42 P.M., Resident 104 indicated he does not receive routine pain medications and that staff never give the pain medication time to take effect before beginning wound treatments.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/1/24 at 11:36 A.M., the Administrator provided a policy titled Pain Management, revised 7/24, that indicated It is the policy to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management. A plan of care will be written with the initiation of pain medication and individualization to the resident and alternative pain relief techniques.</p> <p>3.1-37(a)</p> |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>46758</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered according to manufacture and professional standard for 1 of 5 residents observed during medication pass. (Resident 89) Two medication errors were observed during 26 opportunities for error in medication administration. This resulted in a 7.69% error rate. (Resident 89)</p> <p>Findings include:</p> <p>During a medication administration on 10/25/24 at 7:55 A.M., LPN (Licensed Practical Nurse) 13 prepared Glargine Insulin 30 Units SQ (Subcutaneous) bid (two times a day) and Lispro 10 units SQ tid (three times a day) and did not prime the two insulin injection pens with two units prior to administering.</p> <p>On 10/25/24 at 1:45 P.M., Resident 89's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and Systemic Lupus erythematosus.</p> <p>Physician orders included, but were not limited to,</p> <p>Insulin Glargine-insulin pen; 100 unit/mL (Milliliters) (3 mL); amt (amount): 30 units; subcutaneous. Special Instructions: Give half dose of insulin if BS (Blood Sugar) < (Less Than)120, Twice A Day, 8:00 A.M. and 8:00 P.M, dated 10/24/24.</p> <p>Lispro Insulin pen; 100 unit/mL; amt: 10 units; subcutaneous. Special Instructions: Do not administer if BS is below 100. Give Three Times A Day, 8:00 A.M., 12:00 P.M., and 5:00 P.M. dated 9/10/24.</p> <p>During an interview on 10/25/24 at 8:00 A.M., LPN 13 indicated she was unaware of priming the insulin prior to administering.</p> <p>On 10/25/24 at 12:59 P.M., the Administrator provided a current, non-dated Patient Information Insert for Humalog Kwik Pen. The insert indicated .turn the knob to 2 units .priming ensures the Pen is ready and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin .</p> <p>3.1-48(c)(1)</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were properly dated, labeled, and not expired in 5 of 5 medication carts and 2 of 2 treatment carts.</p> <p>(1500 Hall Medication Cart, 1400 Hall Medication Cart, Memory Care Medication Cart, ,d+[DATE] Hall Medication Cart, 2500 Hall Medication Cart, First Floor Treatment Cart, Second Floor Treatment Cart)</p> <p>Findings include:</p> <p>1. On [DATE] at 8:45 A.M., 1500 Hall Medication Cart was observed to with the following:</p> <p>RN (Registered Nurse) 12 indicated each resident had their own glucometer (Instrument to measure blood sugars) and insulin is kept in the pouches.</p> <p>[Resident Name]106's insulin pouch had the following:</p> <p>1 vial of opened Humulin R (Regular) insulin with no open date</p> <p>2 Glargine Insulin Pen with no label</p> <p>[Resident Name] insulin pouch had the following:</p> <p>Glargine Insulin pen with no open date</p> <p>1 bottle of Nasal Saline for [Resident Name] expired ,d+[DATE]</p> <p>1 bottle of Liquid Protein no label</p> <p>During an interview on [DATE] at 8:45 A.M., RN 12 indicated medication bottles should have an open date and label. There should not be anything expired in the carts.</p> <p>2. On [DATE] at 9:02 A.M., the 1400 Hall Medication cart was observed with the following:</p> <p>1 bottle of Sterile Water with an expiration of [DATE]</p> <p>3. On [DATE] at 9:08 A.M., the Treatment Cart for the First Floor was observed to have:</p> <p>1 opened bottle of Betadine (Antiseptic Cleaner) labeled with [Resident Name] in black Sharpee without and open date.</p> <p>During an interview on [DATE] at 9:10 A.M., RN 12 indicated when a resident is discharged the medication will be returned or destroyed.</p> <p>(continued on next page)</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. On [DATE] at 9:20 A.M., the Medication Cart for the Memory Care Unit was observed with the following:</p> <p>In the top drawer of the medication cart:</p> <ul style="list-style-type: none"> 1 silver colored necklace 1 silver colored ring 1 silver colored with blue stones watch 1 unopened 0.1 mg (Milligrams) Clonidine pill package 1 Bottle of MiraLAX (laxative) with no label <p>During an interview on [DATE] at 9:25 A.M., RN 16 indicated there should not be any jewelry in the medication drawer and it should be labeled</p> <p>5. On [DATE] at 9:30 A.M., the ,d+[DATE] Hall Medication Cart was observed with the following:</p> <ul style="list-style-type: none"> 1 small white oblong pill 1 opened bottle of Nitroglycerin (Antianginal) for [Resident name] with no date <p>6. On [DATE] at 9:49 A.M., the 2500 Medication Cart was observed with the following:</p> <p>,d+[DATE] small round orange pill</p> <ul style="list-style-type: none"> 1 small round white pill # 49 3 opened bottles of MiraLAX with no open date <p>7. On [DATE] at 10:15 A.M., the Second Floor Treatment Cart was observed with the following:</p> <ul style="list-style-type: none"> 1 bottle of Nystatin Powder for [Resident Name] no open date 1 bottle of antifungal cream no label or date open 1 bottle of Ketoconazole shampoo that expired in ,d+[DATE] 3 tubes of open hydrophile for [Resident Name] no open date 9 bottles of Ketoconazole shampoo with [Resident's Names] that were not dated when opened 1 opened container of Bag Balm (ointment) that had no label or open date <p>There was a sticky white substance on a drawer of the treatment cart</p> <p>(continued on next page)</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on [DATE] at 10:20 A.M., LPN (Licensed Practical Nurse) 13 indicated the Bag Balm should be labeled and dated. LPN 13 also indicated that she would date any tubes that were opened.</p> <p>During an interview on [DATE] at 12:29 P.M., the DON (Director of Nursing) indicated antifungals were stock medications until they were opened at which time they would be assigned to a resident and require a label.</p> <p>8. On [DATE] at 10:27 A.M., the 2200 Hall Medication Cart was observed with the following:</p> <p>2 opened bottles of MiraLAX for [Resident Named] no open date</p> <p>9. On [DATE] at 10:40 A.M., the Medication Refrigerator in the Medication Storage room was observed with the following:</p> <p>1 container of Mary's Magic cream for [Resident Name] with no open date.</p> <p>On [DATE] at 12:59 P.M., the Administrator provided a current policy Storage and Expiration Dating of Medications and Biologicals revised on [DATE]. The policy indicated .facility should ensure that medications and biologicals that: have an expired dated on the label and have been retained longer than the recommended manufacturer or supplier guidelines until destroyed .Once any medication or biological is opened .facility staff should record the date opened on the primary container</p> <p>3XXX,d+[DATE](j)</p> <p>3XXX,d+[DATE](o)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>48147</p> <p>Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for insulin use. (Resident 59)</p> <p>Finding includes:</p> <p>On 10/29/24 at 12:59 P.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 9/29/24, indicated Resident 59 was not assessed for cognitive impairment because the resident was rarely or never understood and the resident received insulin 7 days during the 7-day lookback period.</p> <p>The July 2024 Physician's recapitulation orders dated 7/7/24 at 9:39 A.M., indicated the following order was received:</p> <p>Humalog (insulin lispro) KwikPen - insulin lispro (a short-acting insulin) - Give per Sliding Scale subcutaneous, three times a day,</p> <p>If Blood Sugar is less than 60 mg/dL, call physician.</p> <p>If Blood Sugar is 0 to 199, give 0 Units.</p> <p>If Blood Sugar is 200 to 249, give 1 Units.</p> <p>If Blood Sugar is 250 to 299, give 2 Units.</p> <p>If Blood Sugar is 300 to 349, give 3 Units.</p> <p>If Blood Sugar is 350 to 399, give 4 Units.</p> <p>If Blood Sugar is 400 to 499, give 5 Units.</p> <p>If Blood Sugar is greater than 500, call physician.</p> <p>A risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus care plan, dated 4/7/20 and reviewed 9/25/24, included an intervention to document abnormal findings and notify the physician.</p> <p>A vital sign report, dated 7/2/24 at 10:14 A.M., indicated Resident 59's blood glucose level was 490 mg/dL.</p> <p>The July 2024 Medication Administration Record (MAR) indicated the physician was notified of the elevated blood glucose level on 7/2/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Progress notes, medication administration notes, and event forms, dated 7/2/24, lacked documentation to determine the physician responded to or the facility staff made attempts to follow-up with the physician to address the elevated blood glucose level.</p> <p>A Physician/NP order, dated, 7/6/24 at 2:09 P.M., indicated orders were received for staff to immediately (STAT) obtain blood draws for a complete blood count (CBC) (a laboratory test to measure the number and type of cells in blood and a comprehensive metabolic panel (CMP) (a laboratory test that measures 14 substances in your blood to provide information about your metabolism and chemical balance).</p> <p>A Nursing progress note, dated 7/6/24 at 11:01 P.M., indicated the lab called the facility at 6:00 P.M. to report Resident 59 had a critical blood glucose level of 526 mg/dL. The NP was texted and called by Licensed Practical Nurse (LPN) 6 about critical lab value. A response was not received.</p> <p>A message screenshot, dated 7/6/24 at 6:50 P.M., indicated staff texted the critical blood glucose level to the NP and requested orders, but did not receive a response.</p> <p>A vital sign report, dated 7/7/24 at 12:24 P.M., indicated Resident 59's blood glucose level was 548 mg/dL.</p> <p>The July 2024 Medication Administration Record (MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 548 mg/dL.</p> <p>A vital sign report, dated 7/7/24 at 4:25 P.M., indicated Resident 59's blood glucose level was 582 mg/dL.</p> <p>The July 2024 Medication Administration Record (MAR) indicated no insulin lispro was administered to Resident 59, on 07/07/24, to treat the blood glucose level of 582 mg/dL.</p> <p>The July 2024 MAR indicated Resident 59's 8:00 A.M. dose of insulin lispro on 7/8/24 was given by Registered Nurse (RN) 15, but did not indicate the blood glucose was measured prior to administration, how much insulin was given, or the body site where the insulin was given.</p> <p>During an interview with the Director of Nursing (DON) on 10/30/24 at 1:44 P.M., she indicated the nurse called the NP for the blood sugars over 500 mg/dL on 7/7/24. The NP said to give five units over the maximum units on the sliding scale. The documentation system would not let her input that she gave 10 units, so she put she gave zero units. She did not document the notification to the NP, the new order, or the insulin administration amount in a progress note or as a medication administration note, but she should have. At that time, the DON was unable to provide documentation to indicate the nurse gave 10 units of insulin.</p> <p>During an interview with the DON on 10/30/24 at 1:59 P.M., she indicated Licensed Practical Nurse (LPN) 6 did not remember if she gave the 8 A.M. dose of insulin lispro on 7/8/24 or not. The DON was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 at 8:00 A.M., or how many units of insulin lispro were given if any.</p> <p>During an interview, on 11/1/24 at 8:15 A.M., the Administrator indicated text messages were not part of the clinical record.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview with the Administrator on 11/1/24 at 8:51 A.M., she indicated staff texted the NP and didn't need to document all communication in the progress notes.</p> <p>During an interview with the Nurse Practitioner (NP) on 11/1/24 at 9:00 A.M., the NP indicated that she did not have a record of being contacted on 7/2/24 in relation to Resident 59's elevated blood glucose level. She indicated she would have advised staff to recheck the blood sugar in an hour and call back if it was still high. The NP indicated she was unable to find a recheck of blood glucose levels for Resident 59 on 7/2/24. The NP indicated the sliding scale insulin order was for one week on a trial basis and then the resident would be re-evaluated. At that time, the NP was unable to provide documentation that the insulin order was on a trial basis and when the resident was to be re-evaluated. The NP indicated she was not contacted by a nurse on 7/8/24 about Resident 59's blood glucose level, insulin, or a missed dose. The NP was unsure what Resident 59's blood glucose was at 8:00 A.M. on 7/8/24 or how many units of insulin lispro were given.</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current General Dose Preparation and Medication Administration policy, dated 4/30/24, that indicated Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms.</p> <p>On 11/1/24 at 2:06 P.M., the Administrator provided a current Authorization and Communication of Orders policy, dated 6/1/24, that indicated Facility should ensure that the authorized person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of physician/prescriber, the signature of the person recording the order and other information as permitted by and in accordance with applicable law.</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Columbia Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Columbia St Evansville, IN 47710 | |
| 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 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>50827</p> <p>Based on observation and interview, the facility failed to ensure infection control practices were in place for 2 of 2 residents during incontinence care and 1 of 1 resident during wound care. Staff failed to sanitize hands and change gloves between soiled to clean tasks, as well as failed to use enhanced barrier precautions during wound care. (Resident 64, Resident 85, and Resident 86)</p> <p>Findings included:</p> <p>1. On 10/24/24 at 10:43 A.M., CNA (Certified Nurses Aide) 3 went into Resident 64's room. CNA 3 donned gloves, checked the resident's brief to see if they were incontinent, started to act upon changing the soiled brief but then indicated they would go get another staff member to assist. CNA 3 touched the resident's remote to their bed, and bedside table with soiled gloves before removing them then did not sanitize or wash hands.</p> <p>On 10/29/24, at 11:44 A.M., Resident 64's clinical record was reviewed. The Annual MDS (Minimum Data Set) Assessment on 8/5/24 indicated the resident was not cognitively intact, required substantial or maximum assistance with toileting and personal hygiene, was always incontinent of bowel and bladder, and had a diagnosis that included but was not limited to dementia.</p> <p>2. On 10/25/24 at 10:58 A.M. Resident 85 indicated that they got frequent urinary tract infections because staff did not clean her properly.</p> <p>The clinical record was reviewed on 10/28/24 at 2:49 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 9/24/24, indicated the resident was cognitively intact, used a wheel chair, required substantial to maximum assistance with bathing and personal hygiene, was incontinent of bowel and bladder, had a primary diagnosis of COPD (chronic obstructive pulmonary disease), had a urinary tract infection within the last 30 days, had an intravenous catheter, had been on intravenous medications, required isolation precautions, and was on antibiotics.</p> <p>On 10/31/24, at 9:22 A.M., while peri care and linen change was performed for Resident 85 CNA (Certified Nurses Aide) 7 stopped QMA (Qualified Medication Aide) 5 to remind them to change their gloves before proceeding after the resident's soiled incontinence brief was removed and skin was cleansed. QMA 5 took off soiled gloves and put on clean gloves, did not wash or sanitize hands. CNA 7 did not change their gloves, wash or sanitize hands, after removing soiled bed pan from underneath the resident before continuing with care, including assisting the resident with washing their face.</p> <p>48147</p> <p>3. On 10/29/24 at 10:15 A.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, stage 4 pressure ulcer of sacral region.</p> <p>The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 10/11/24, indicated Resident 86 had no cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for all Activities of Daily Living (ADLs), and had one stage 4 pressure ulcer on admission to the facility.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Columbia Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Columbia St Evansville, IN 47710 | |
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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 most current wound assessment, dated 10/23/24, indicated Resident 86 had a pressure ulcer on the sacrum that measured 8.8 centimeters (cm) in length, 8 cm in width, and 1.3 cm in depth.</p> <p>Care plans included, but were not limited to:</p> <p>Resident is at risk of transferring or becoming colonized with an MDRO (multi-drug resistant organism) and requires enhanced barrier precautions due to an indwelling medical device and a chronic wound that requires a dressing, dated 9/16/24. Interventions included, but were not limited to, enhanced barrier precautions and wear gown and gloves prior to high contact resident care activities.</p> <p>The clinical record lacked physician orders for EBP.</p> <p>On 10/30/24 at 9:40 A.M., Licensed Practical Nurse (LPN) 4 was observed performing wound care for Resident 86. LPN 4 was not wearing a gown while performing the wound care. A sign indicating Resident 86 was on Enhanced Barrier Precautions (EBP) was observed hanging on the wall by the gloves in the room.</p> <p>On 10/31/24 at 10:44 A.M., the Infection Preventionist (IP) indicated that residents with wounds automatically got placed on EBP. Staff should wear gown and gloves while performing any major care for the resident on EBP.</p> <p>On 10/31/24 at 10:56 A.M., the Administrator provided a current undated Enhanced Barrier Precautions policy that indicated Enhanced Barrier Precautions expands the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO status .</p> <p>3.1-18(b)(2)</p> <p>3.1-18(l)</p> | | |