STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165228	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubuque Specialty Care	2935 Kaufmann Avenue Dubuque, IA 52001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, the facility failed to incorporate recommendations from the PASRR (Pre-admission Screening and Resident Review) Level II Determination into the Care Plan for 2 of 3 residents reviewed (Residents #10 and Resident #52). The facility reported a census of 57 residents.Findings include:1.The Minimum Data Set (MDS) dated [DATE] identified Resident #10 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 out of 15, and had the following diagnoses: Seizure Disorder/Epilepsy, Depression, Bipolar Disorder and Schizophrenia. Daily observations of Resident #10 on July 21, 22, 23, 24 revealed he was well groomed, wearing clean clothing and shoes and did not display any behaviors that would require staff interventions.Review of an assessment of PASRR compliance report dated 4/16/25 revealed Resident #10 had a Level II Outcome dated 3/10/25. The Clinical Reviewer Assessment section revealed the facility was noncompliant with disability specific specialized services, rehabilitative services, and community placement supports. The report noted the facility lacked multiple required components of Resident #10's Care Plan. 2. The MDS dated [DATE] identified Resident #52 as cognitively intact with a BIMS of 15 and had the following diagnoses: Diabetes Mellitus, Anxiety Disorder, Depression and Post Traumatic Stress Disorder.Multiple observations of Resident #52 daily on July 21, 22, 23, 24 and 28 revealed she was tearful and upset over the events that have occurred recently, ie: Care Plan changed to require staff to provide cares in pairs and being sent out to the Emergency Department for an evaluation.Review of an assessment of PASRR compliance report dated 3/19/25 revealed Resident #52 had a Level II Outcome dated 12/19/24. The Clinical Reviewer Assessment section revealed the facility was noncompliant with disability specific specialized services, rehabilitative services, and community placement supports. The report noted the facility lacked multiple required components of Resident #52's Care Plan.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review the facility failed to update the Care Plan after a new mental health diagnosis for 1 of 4 residents reviewed (Resident#2). The facility reported a census of 57 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE], list of diagnoses for Resident #2 included Post Traumatic Stress Disorder (PTSD) and anxiety.Review of the Medical Diagnosis list in the electronic health record for Resident#2 revealed a diagnosis of PTSD, date 5/11/2023. Review of the Pre-admission Screening & Resident Review (PASRR) dated 7/11/24, revealed a diagnoses of PTSD. The Care Plan for Resident #2, revised date of 6/20/25, failed to reflect the updated PASRR, and address the diagnosis of PTSD. Review of the Trauma Informed Intake assessment dated [DATE], directed review or update the Trauma Care Plan. During an interview on 07/30/25 at 9:33 AM, the MDS Coordinator reported Resident#2 did not know her PTSD triggers, as a result the facility lacked the information to put in the Care Plan. She reported the facility did not have a policy that directed what to put on the Care Plan. The MDS Coordinator reported she followed the Resident Assessment Instrument (RAI).During an interview on 07/30/2025 at10:49 AM, the Director of Nursing (DON) reported she expected a diagnosis of PTSD to be addressed on the Care Plan.The facility provided a policy titled Goals and Objectives, Care Plans dated 4/09. The policy directed goals and objectives are reviewed and/or revised:a. When there has been a significant change in the resident's condition;b. When the desired outcome has not been achieved;c. When the resident has been readmitted to the facility from a hospital/ rehabilitation stay; andd. At least quarterly.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and facility policy review the facility failed to respond to call lights in a timely manner for 2 out of 10 residents reviewed (Resident # 2 and Resident #51). The facility reported a census of 57 residents.Finding include:1. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a list of diagnosis for Resident #2 which included heart failure, and anxiety disorder. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated cognition intact. The MDS identified Resident #2 dependent for transfers to bed and chair, and dependent with toileting hygiene. Review of the Care Plan, dated 9/8/22, identified Resident #2 dependent and required the assist of 1 staff with toileting and the assist of 2 staff for transferring in and out of bed. The Care Plan further identified the resident needed the substantial assist of 1 staff for personal hygiene, and bed mobility.During an interview on 7/21/25 at 2:48 PM, Resident #2 stated staff can take up to 30 minutes to get her call light before and after meals. She said between 11 AM to 2 PM is when it happens the most, and on the weekends. She stated the staff failed to explain to her why staff took so long to get her call lights.2. Review of the MDS assessment dated [DATE], revealed a list of diagnoses for Resident #51 which included heart failure, cancer, and high blood pressure. The BIMS score of 13 out of 15 indicated intact cognition. The MDS identified Resident #51 as dependent on staff with toileting transfers and toileting hygiene. Review of the Care Plan, dated 4/25/25, identified Resident #51 as non-ambulatory, dependent on the assist of 2 staff for toileting and transfers. The Care Plan directed the assist of 1 staff for personal hygiene. During an interview on 07/30/2025 at 9:22 AM, Staff L, Certified Nurse Assistant (CNA) stated staff need to get to the call lights in 15 minutes. She revealed at times residents reported call lights took longer than 15 minutes. She stated never on her hall. During an interview on 7/22/25 at 8:42 AM, Resident #51 stated it can take 40 minutes to an hour for staff to come get his light and help him after lunch. He stated he's been incontinent due to waiting so long for help. Resident #51 explained he felt frustrated and upset after the incontinence because of the waiting. He stated the staff told him they were busy helping others, and doing the best they could. During an interview on 07/30/2025 at 10:49 AM, the Director of Nursing reported she expected the call lights answered in 15 minutes. During an interview on 07/30/2025 at 11:13 AM, the Administrator confirmed she knew residents complained of long call light times. She reported she's filled out grievances for long call light times and she does audits. Review of a Resident Council Meeting note dated 5/22/25, revealed a concern of the CNAs took a while to answer the call lights. Review of the facility policy titled Answering the Call Light dated 3/2021, identified the purpose of this procedure is to ensure timely responses to the resident's requests and needs.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to ensure ongoing care planning to address a resident's behavioral health needs, including timely implementation of a Crisis Intervention/Safety Plan per Preadmission Screening and Resident Review (PASRR) recommendation for 1 of 1 resident reviewed for behavioral healthcare (Resident #52). The facility reported a census of 57 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #52 as cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15, and had the following diagnoses: diabetes mellitus, anxiety disorder, depression, and post traumatic stress disorder. The MDS also identified Resident #52 had little interest or pleasure in doing things several days over the past two weeks, and did not respond when asked if feeling depressed or hopeless. Per the MDS, the resident sometimes felt lonely and isolated from those around her. The Care Plan initiated 1/6/23 and revised on 3/13/24 revealed the following for Resident #52: I have a history of using attention seeking behaviors. I have a history of suicidal ideations, with no active plan. The care plan interventions included the following: a. I have been noted to have issues staying on topic when discussing things I don't want to discuss (Initiated 3/14/23, revised 3/13/24). b. I refuse care on occasion, so cares in pairs is recommended (Initiated 3/3/23, revised 5/2/23). c. I will not have any items in my room that I could harm myself with while on suicidal precautions. Suicidal precautions will remain until cleared by a physician (Initiated 1/6/23, revised 3/13/24).d. I write myself notes to remind myself of self-affirmations (Initiated 1/6/23). e. My counselor from [Behavioral Health Services Provider] (counselor)/[Name Redacted] (Psychiatrist) will continue to attempt to talk to me, despite me refusing at times. (Initiated 1/6/23, revised 3/14/23).Additional Care Plan interventions included the following: f. I refuse to talk to [Behavioral Health Services Provider] counselor. I am going to get an appointment with [Name Redacted] (Initiated 1/6/23, revised 12/9/24).g.I wear a rubber band on my wrist and will snap it. This helps me manage my mental health more independently. (Initiated 12/6/24).The Encounter Note for psychiatric follow up dated 12/5/24 at 12:00 AM, revealed the resident was seen for an acute visit due to an increase in agitation and self-harm. The note further revealed, It has been noted that she has been punching herself in the chest, scratching her arms and slapping her face. She also has some suicidal ideation with no specific plan at this time.[Resident #52] also states that she has called the suicide hotline over 5 times and they have not been able to help her. She is not currently seeing a therapist. Does report being severely depressed and anxious. [Resident #52] also tells me that she has a butter knife that was kept off of her room tray and is having ideations of continuous self-harm. Order given to the facility to facility to send to ED (Emergency Department) for further evaluation and treatment due to the acuity of the situation and residents inability to remain safe or make safe decisions at this time.The Encounter Note further revealed Resident #52 had disorganized thought process, poor insight, suicidal ideation with means, and current self harming behaviors. Recommendations to address depression included, in part, regularly observing the patient's behavior and emotional state to detect any changes or signs of improvement, and to implement safety protocols to prevent self-harm or harm to others, especially if the patient was at risk of suicide. The Behavior Note dated 12/5/24 3:30 PM revealed, in part, Resident #52 has called the suicide hotline 5 times this week. She has held a knife back from her tray and has been punching and slapping herself. The psych provider gave an order to be evaluated and treated at the hospital. A Nurses Note dated 12/5/24 at 6:15 PM indicated Resident #52 returned from the hospital, and was currently one on one (one on one supervision).The Progress Note dated 12/6/24 at 12:00 AM note by Psychiatric Nurse Practitioner reported resident seen in person for acute suicidal ideation, behaviors, and actions. The Progress Note further revealed, today, staff reports that the patient is continuing her self-harm behaviors and suicidal threats. Behaviors include punching herself in the chest, scratching skin to excoriation and bleeding, and slapping herself. Additionally staff reported finding additional knives and forks in her room (removed by staff) that the patient had previous stated she would use for self-harm. Upon in-person interview today by this Provider, patient is found to be despairing and tearful. She verbalizes that I am bad and need to be punished. Patient is seen to be continuously scratching her arms, causing open wounds. When asked if she is aware of scratching herself, she shakes her head as if to indicate no and does not respond verbally. When asked questions, her verbal response is delayed, halting, and agitated. When she provides no responses. Her mood is despondent, frustrated, and downcast; her affect is consistent with mood. [Resident #52]

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, clinical record review, facility policy review and staff interview, the facility failed to prime an insulin pen prior to 2 of 2 observations for insulin administration (Resident #25). The facility reported a census of 57 residents. Findings include: Review of the Minimum Data Set assessment, dated 7/10/25 revealed a list of diagnoses for Resident #25 which included diabetes mellitus, renal insufficiency, and osteomyelitis (infection of bone) to the right ankle and foot. The Brief Interview for Mental Status score of 13 out of 15 indicated intact cognition. The MDS identified Resident #25 had orders for insulin (a hypoglycemic medication used to lower blood sugars) to be administered at least daily.A review of the July 2025 Medication Administration Record revealed the following orders:a. NovoLOG Solution 100 UNIT/ML (unit per milliliter) (Insulin Aspart) Inject 2 units subcutaneously three times a day .Start date: 7/18/25. b. Tresiba FlexTouch Subcutaneously Solution Pen-Injector 200 UNIT/ML (Insulin Degludec) Inject 10 units subcutaneously one time a day .Start date: 7/19/25.During an observation on 7/22/25 at 7:26 AM, Staff G, Licensed Practical Nurse removed 2 insulin pens from the medication cart. Staff G placed a new needle on the Novolog pen (dated as opened 7/8/25) and dialed to 2 units; and on the Tresiba pen (dated as opened 7/21/25) and dialed to 10 units. Staff G did not prime needles prior to administering both insulins.During an interview on 7/23/25 at 2:00 PM, the Director of Nursing reported she would expect the nurse to prime the needle after putting on the insulin pen with 2 units and waste the 2 units.During an interview on 7/29/25 at 1:07 PM, Staff G, LPN reported when administering insulin from a pen, she should prime the pen with 2 units. She thought she primed the needles when she administered the insulins to Resident #25 during the observation on 7/22/25 at 7:26 AM. A review of the facility policy titled: Insulin Administration, last revised September 2014, Insulin Delivery section directed, in part: The forms of insulin delivery include: 3. Pens - containing insulin cartridges deliver insulin subcutaneously through a needle.The Steps in the Procedure section (Insulin Injections via Syringe) did not provide direction on the use of Pen to deliver insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, review of kitchen staff training records, and staff interviews the facility failed to prepare pureed foods under safe and sanitary conditions during 1 of 2 kitchen observations. The facility reported a census of 57 residents.Findings include:During an observation on 7/22/2025 at 8:23 AM, Staff A, [NAME] started the puree process for lunch. She stated she would make 4 servings of puree for 2 residents and wanted a pudding consistency. Staff A placed 12 ounces of turkey and turkey gravy in the machine, added additional gravy from a pan, and blended. She used a measuring cup to determine scoop size and transferred the pureed turkey into a holding pan and set it on another counter. She used a dry cloth to wipe the prep surface and the side of the puree machine. There was not a sanitizer bucket or spray on the counter or near the puree machine. Staff A did not wash her hands.At 8:30 AM, Staff A poured the peas from a holding pan into the puree canister. She wiped the counter again with the dry rag, smearing turkey from the rag back onto the counter where she wiped away a few mashed peas. When the peas were pureed, Staff A measured them and poured them into a clean holding pan and set them on the counter next to the turkey. She wiped the puree machine and food prep surface with the same dry cloth she used before. She did not sanitize the counter or wash her hands. She then wiped her right hand on the side of her shirt, picked up the rag, and wiped at the counter one more time.At 8:38 AM, Staff A reported she was done with puree because the bananas needed for lunch did not come on the truck. Staff B, Certified Dietary Manager (CDM), stated he was going to get them since she was done. When asked why she did not puree the bread on the menu, Staff A stated she was not thinking on that and forgot. She stated she should have done it with the meat. She was not able to describe what her process should be next and asked the Regional Dietary Manager (RDM) if she could add the bread to the meat. The RDM stated she could and would have to remeasure the total for a correct scoop size. Staff A said forget it. When asked what she would do if the Regional Dietary Manager and surveyor were not present, Staff A stated she would skip it (pureeing the bread). The RDM told her to puree the bread. Staff A did not wash her hands, and put gloves on to pick up the bread. She took off the gloves and did not wash her hands. She wiped the prep surface with the same dry rag used earlier to clean up spilled gravy she added to the bread, which smeared mashed peas and turkey back on to the surface. The surface was not sanitized. Staff A did not tap down the bread and gravy mixture in the measuring cup and indicated they needed a size 12 scoop. The RDM corrected Staff A and told her that the scoop should be a 16 scoop to make sure the residents had the right amount. At the end of the observation turkey, gravy, and peas were noted on the prep surface and the puree machine. The pureed food remained in the holding containers on the counter.During an interview on 7/22/25 at 8:49 AM, the CDM and RDM acknowledged Staff A did not sanitize the prep surface between foods or wash her hands properly during the puree process. The RDM indicated all staff were trained on these topics when they started. The CDM stated she should have washed her hands between food items and after removing her gloves. He reported that staff needed education, it was better to be safe than sorry, and he would start from the beginning. He stated Staff A needed to review filling and using the sanitizer bucket, keeping it near to her, sanitizing between foods prepped, how to store foods, tapping down the puree for accurate measurement, and proper use of the puree chart. A document titled Course Completion History printed 7/21/25 documented Staff A completed the following Kitchen related training:a. An Overview of Safe Eating and Drinking on 1/21/25;b. Customer Service in Dining Rooms on 1/23/25;c. Dry Storage on 1/23/25; d. Food Safety Fundamentals on 1/27/25; e. Handling Food Safely Part 1 on 1/27/25f. Handling Food Safely Part 2 on 1/27/25; g. Setting up the Steam Table on 1/27/25; h. Using a 3 Compartment Sink on 1/27/25; i. Using the Dishwasher on 1/27/25. During an interview on 7/23/25 at 9:29 AM, the CDM stated he started staff re-education. A document titled Five Minute Meeting for Employees dated 7/22/25 documented topics that included the puree process, washing hands, added bread, measuring cups, sanitizing, and temperatures.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interview, facility policy review and review of the Summary Statement of Deficiencies of previous surveys, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. The facility reported s census of 57 residents.Review of the Statement of Deficiencies for a Recertification and Complaint Survey completed on 7/15/24, revealed the deficiencies identified included F657 (Care Plan Timing and Revision), F725 (Sufficient Nursing Staff), F812 (Food Procurement, Store/Prepare/ Serve-Sanitary), and F880 (Infection Control). The Recertification and Complaint Survey completed on 7/30/25, identified repeat deficient practices for: F657, F725, F812, and F880. During an interview on 07/30/2025 at 11:03 AM, the Administrator reported the facility worked on all the previously cited deficiencies in the Quality Assurance Performance Improvement (QAPI).The Facility provided a policy titled Quality Assurance and Performance Improvement (QAPI) Program dated march 2020, included the responsibilities of the QAPI Committee are to:a. Collect and analyze performance indicator data and other information;b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services;c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process;d. Utilize root cause analysis to help identify where identified problems point to underlying systematic problems;e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care;f. Establish benchmarks and goals by which to measure performance improvement;g. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; andh. Communicate all phases of the QAPI process to the Administrator and governing body through sharing meeting minutes, committee activities and results of QAPI activities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview and facility document review the facility failed to use enhanced barrier precaution (EBP) and keep resident catheter tubing off the floor for 1 out of 2 residents reviewed (Resident #2). The Facility reported a census of 57 residents.Finding include:Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a list of diagnosis for Resident #2 which included neurogenic bladder (loss of control due to nerve damage) heart failure, and anxiety disorder. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated cognition intact. The MDS identified Resident #2 dependent for transfers to bed and chair, and dependent with toileting hygiene. Review of the Care Plan, dated 9/8/22, revealed a Focus area for Resident #2 to address the use of a urostomy (a specific type of urinary system to collect urine outside of the body through tubing to a collection bag, may be referred to in general terms as a urinary catheter) due to bladder dysfunction with a goal to remain free of infection. Interventions included, in part: Use of enhanced barrier precautions. During an observation on 7/21/25 at 2:50 PM, a sign noted to be placed on Resident #2's bedroom door. The sign directed the use of Enhanced Barrier Precautions, which included: Everyone must: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressingDuring an observation on 07/22/2025 at 10:40 AM, after a group activity, Resident #2 wheeled herself through the facility while approximately 2 inches of her urostomy tubing drug on the floor under her wheelchair.During an interview on 07/24/2025 10:58 AM, Staff J, Certified Nurse Aid (CNA) said they needed to empty Resident #2's catheter (urostomy collection bag for urine) bag. Both CNA's put on the gowns, and gloves (EBP) transferred Resident #2 from her wheelchair and placed her in the bed. Staff J, removed her gloves and gown, completed hand hygiene applied gloves, gathered the supplies to empty the urinary drainage bag. Staff J, placed a plastic barrier on the floor, she set the graduate on top of the plastic barrier, unhooked the drain spout to empty the urine drainage bag in the graduate used the alcohol swab to clean the tip. The urine filled to the top of the graduate 1000 cubic centimeters (cc). Staff J, dumped the urine into the toilet and rinsed out the graduate. Staff J, failed to wear the gown during the high contact care.During an interview on 07/24/2025 at 11:07 AM, Staff J, CNA reported the EBP were needed because of the catheter (urostomy) and the wounds. During an interview on 07/29/2025 at 10:49 AM, the Director of Nursing (DON) reported staff needed the EBP if a resident required a tube feeding, a port, dialysis, a chronic wound and catheters. The DON reported she expected urinary catheter tubing kept off the floor. During an interview on 7/30/25 at 9:22 AM Staff L, CNA reported if nursing staff see catheter tubing on the floor they are expected to pick it up and adjust the tubing so it doesn't touch the floor.Review of the facility policy titled Enhanced Barrier Precautions dated 3/28/24, revealed it is the policy of this facility to implement Enhanced Barrier Precautions for the prevention of transmission of multidrug-resistant organisms.EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.An order for EBP (in accordance with physician-approved standing orders) will be initiated for residents with any of the following:Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.Review of the facility policy titled Infection Prevention and Control Program dated 10/2018, revealed an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policies and procedures reflect the current infection prevention and control standards of practice.