STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	1701 West 25th Street Sioux City, IA 51103

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic health records (EHR) review, observations, staff interview, policy review and resident family interview the facility failed to provide dignity by leaving food on a residents clothing protector as well as face to 1 of 1 resident reviewed (Resident #44). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #44 had a Brief Interview for Mental Status (BIMS) of 2 indicating severe cognitive impairment. The MDS documented Resident #44 was staff dependent during personal hygiene and substantial / maximal assistance with eating. On 5/20/24 at 1:57 PM an observation of Resident #44 sitting in her bedroom revealed 2-3 tablespoons of orange food present on clothing protector and dry orange food present on chin as well. Review of document titled, facility name SS 2024 (menu) for lunch meal on 5/20/24 revealed baked yam. On 5/20/24 at 2:10 PM Staff A, MDS coordinator stated lunch was over at 12:45 PM - 12:50 PM. On 5/22/24 at 9:39 AM Resident #44 ' s family member stated that the debris on Resident #44's clothing protector was from lunch and he cleaned it up when he got up to Resident #44 ' s room. Resident #44 ' s family member stated he had a doctor's appointment and he cleaned it off of Resident #44 ' s face and changed her clothing protector at 3:00 PM or 3:30 PM. Resident #44 ' s family member stated that was the first time that had happened. Review of policy titled, Quality of Life - Dignity revised 2/20 provided by the DON documented each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents were treated with dignity and respect at all times. On 5/21/24 at 3:29 PM the DON stated she would expect that the clothing protector would be changed if food was present. The DON stated food should have been cleansed from resident #44's face prior to returning to the bedroom.

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on personnel file reviews, staff interviews, and facility policy review, the facility failed to ensure all employees had an Iowa Criminal Background check and dependent adult/child abuse registry check completed prior to working in the facility for 1 out of 5 employees reviewed (Staff N). The facility reported a census of 63 residents. Findings include: Review of untitled payroll information provided by the Human Resource Generalist, Employee N, Certified Nurses Assistant (CNA) date of hire recorded as 2/4/24. The date of birth revealed Staff N to be [AGE] years old at the date of hire. The personnel file for Staff N revealed the file lacked documentation of the Iowa Criminal Background Check. Review of facility provided undated policy titled Employee/Volunteer Background checks instruct high school students age 18 and older who seek employment or who seek employment to volunteer for positions in which they will be working with minor children, are considered adults and will be bound by the same safe environment policies as all other adult volunteers and employees. In an interview on 5/21/24 at 2:13 PM, the Human Resource Generalist revealed per facility policy background checks are not required for staff under [AGE] years of age. In an interview on 5/28/24 at 3:35 PM, the Administrator reported knowledge of federal regulations that all employees are required to have background checks regardless of age. The Administrator is new to the facility and unaware of the facility policy.

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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** 44420 Based on clinical record review and staff interview, the facility failed to refer one resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 residents (Resident #48) reviewed for PASRR requirements. The facility reported a census of 63 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #48 documented diagnosis of anxiety disorder, depression and psychotic disorder. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 1/30/23 revealed the PASRR level 1 screen remains valid for your stay at the nursing facility and should be transferred with you if you relocate. No further level 1 screening is required unless you are known to have or are suspected of having a major mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. Further review revealed the following questions indicated the following: a. Mental health conditions diagnosed or suspected included: anxiety disorder b. Mental health medications listed: buspirone, donepezil, sertraline Review of the Care Plan last revised on 2/13/24 revealed Resident #48 used antidepressant medication, anti-anxiety medication and psychotropic medications (a drug that affects a person's mental state). Review of the Medical Diagnosis revealed Resident #48 with the following diagnosis: a. Major depressive disorder dated 2/24/23 b. Psychotic disorder with hallucinations dated 2/24/23 Review of the Psycholosical Note dated 5/10/24 at for Resident #48 showed diagnosis of depression, psychotic disorder, and anxiety. Review of Resident #48s chart on 5/21/24 showed the facility lacked a follow-up and resubmission of a PASRR with the additional diagnosis of major depressive disorder and psychotic disorder. The Behavioral Assessment, Intervention and Monitoring policy last revised in March 2019 identified when onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASRR Level II evaluation. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/24 at 2:13 AM, the Director of Nursing (DON) stated that would have expected the social worker to resubmit the PASRR for a Level II screening when new major mental health illnesses are diagnosed .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, observations and staff interview the facility failed to follow a care plan to provide supervision while the resident sat in a wheelchair located in his room for 1 of 21 sampled residents reviewed for comprehensive care plans (Resident #33). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #33 documented diagnoses of depression, muscle weakness and history of a left fracture. The MDS showed the Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Review of Resident #33 ' s Care Plan last revised on 5/20/24 showed on 4/2/24 the facility initiated a fall intervention for Resident #33 instructing staff not to leave Resident #33 unattended in a wheelchair while in his room. The intervention was resolved during the survey on 5/20/24. A Health Status Note dated 5/22/24 at 9:53 PM for Resident #33 documented the following: Resident #33 is high risk for fall, this nurse found the resident while he was sitting on the edge of the bed and struggling. This nurse called for help and to get the resident up in bed x2 assist. The Certified Nursing Assistant (CNA) changed his brief and lowered the bed down. Resident is resting in bed at this time. Educated CNA do not leave resident alone in his room. Resident #33 needs supervision while in a wheelchair at all times. Observation on 5/19/24 at 1:12 PM showed Resident #33 propelling himself down the hall in a wheelchair while unattended by staff. Observation on 5/19/24 at 1:40 PM showed Resident #33 seated in a wheelchair located in his room. The resident leaned forward in the wheelchair while looking through his closet unattended by staff. Observation on 5/19/24 at 3:10 PM showed Resident #33 seated in a wheelchair located in his room watching TV unattended by staff. In an interview on 5/21/24 at 12:40 PM, Staff E, Licensed Practical Nurse (LPN) asked where the Resident #33 spent most of his time, Staff E replied, The resident spends most of his time in his room or out in the halls. When asked if Resident #33 recently required supervision while in his room if seated in a wheelchair, Staff E replied, No he can call us if he needs to. In an interview on 5/21/24 at 1:43 PM, Staff M, LPN reported Resident #33 did not require supervision in his room while in a wheelchair at this time, or anytime recently. When asked where information about Resident #33 ' s supervision needs could be found, Staff M stated, it would be on his care plan. In an interview on 5/21/24 at 1:59 PM, Staff K, CNA reported Resident #33 has not required supervision while out of bed and could not recall prior supervision needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plans, Comprehensive Person Centered policy last revised September 2013 identified a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Interview on 5/22/24 at 2:49 PM, the Director of Nursing, (DON) reported no prior knowledge of supervision needed for Resident #33. The DON noted the current care plan failed to reflect a need for supervision. After reviewing the chart the DON reported on 5/19/24 Resident #33 required supervision in his room and in a wheelchair.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47673 Based on electronic health records review (EHR), staff interview, and observation the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by not accurately measuring supplemental formula according to physician ' s order and pushing medications with a piston syringe into feeding tube for 1 of 1 residents (Resident #24). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #24, dated 3/18/2024 documented a Brief Interview for Mental Status of 13 which indicated no cognitive impairment. The MDS documented a feeding tube present while a resident. Review of Resident #24 ' s Medication Administration Record (MAR) documented 330 mL of supplemental formula to be administered per PEG tube (enteral tube) three times daily at 8:00 AM, 2:00 PM, and 8:00 PM. On 5/21/24 at 7:52 AM an observation of Staff E revealed no hand hygiene prior to entering Resident #24 ' s room. Staff E entered the bathroom, obtained gloves, and applied gloves. 10cc water auscultated for enteral tube placement. Medications pushed with a piston syringe, did not flow by gravity. Enteral supplemental formula measured in the hanging bag just over the 300 mL line. No measurement of 330 mL observed on hanging enteral formula bag. Enteral feeding hanging bag connected to the enteral feeding tube. On 5/21/24 at 8:05 AM Staff E stated she just eyed the formula hanging in the bag. Staff E stated she fills the formula bag until it measures it just above the 300 mL line. Staff E stated that was how she was trained to measure the formula. On 5/21/24 at 1:05 PM an observation of 2nd enteral feeding administration revealed that after 2nd enteral feeding 175 mL remained in the formula carton. A total of 660 mL would be ordered over 2 feedings. A total of 711 mL total for 3 cartons of formula that were required to meet the 660mL ordered A total of 51 mL should be left in the last carton. Amount left in was about 175 mL. Total was 124 mL more than should have been. On 5/21/24 at 1:43 PM the Director of Nursing (DON) stated the facility's expectation was that nurses would measure the supplemental formula in a graduated cylinder. The DON stated the facility's expectation was that the medications would have been administered with gravity flow and not pushed with a piston syringe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44474 Based on observations, staff interviews, and policy review, the facility to properly store medications in a locked storage area for 1 or 1 resident observed (Resident #63). The facility reported a census of 63 residents. Findings include: 1. Observation on 5/19/24 at 2:15 p.m., revealed a bottle of Tums sitting by the sink in Resident #63 ' s room. 2. Observation on 5/20/24 at 11:05 a.m., revealed a bottle of Tums sitting by the sink in Resident #63 ' s room. Review of Resident #63 ' s clinical record lacked documentation of an assessment for Resident #63 to self administer medications. Review of the facility policy titled Conformity with Laws and Professional Standards with a revision date of April 2007 revealed the facilities policies, procedures and operational practices are developed and maintained in accordance with current and accepted professional standards and principles as well as current commonly accepted health standards established by national organizations, boards and councils. Interview on 5/21/24 at 11:54 a.m., with the Director of Nursing (DON) revealed Resident #63 was not able to self administer medications and did not have any self administration assessments completed. The DON further revealed the facility staff should have caught it in the room and removed the bottle of Tums.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Record (EHR) review, observation, policy review and staff interviews the facility failed to prepare food in a form designed to meet individual needs by sending incorrect consistency for modified diet ordered for 4 of 6 residents reviewed (Resident #33, #35, #39, and #44). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #33 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS revealed Resident #33 was on a mechanically altered diet. Review of Resident #33 ' s diet order documented a general diet with mechanical soft texture. 2. The MDS dated [DATE] documented Resident #35 had a BIMS of 13 indicating no cognitive impairment. The MDS revealed a diagnosis of dysphagia. Review of Resident #35 ' s diet order documented a low concentrated sweets diet with mechanical soft texture. 3. The MDS dated [DATE] documented Resident #39 was rarely / never understood, indicating severe cognitive impairment. The MDS revealed a diagnosis of dysphagia. Review of Resident #39 ' s diet order documented a general diet with mechanical soft texture. 4. The MDS dated [DATE] documented Resident #44 had a BIMS of 2 indicating severe cognitive impairment. The MDS documented Resident #44 maximal assistance with eating. Review of Resident #44 ' s diet order documented a general diet with mechanical soft texture. On 5/21/24 at 11:50 AM -12:35 PM an observation of lunch service on the 2nd floor revealed Staff F, Dietary Aide / Cleaner served coleslaw to 4 of 6 residents who required mechanical soft diets. Two residents who had orders for a mechanical soft diet wanted the cooked cabbage and stated they could not eat the coleslaw, the cooked cabbage was served to them. Observation revealed none of the residents on mechanical soft diets ate the coleslaw. Review document titled (facility name) SS 2024 (menu) revealed that on 5/21/24 residents on a mechanical soft diet were to be served steamed cabbage. On 5/21/24 at 12:40 PM Staff F stated the menu for 5/21/24 documented that residents on a mechanical soft diet were supposed to have steamed cabbage instead of the coleslaw. Staff F stated he forgot to serve the cabbage to the residents who were on mechanical soft diets. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled, Accuracy and Quality of Tray Line Services dated 2021 documented the meal would be checked against the therapeutic diet spreadsheet to assure the food were served as listed on the menu. On 5/21/24 at 1:00 PM Staff G Certified Dietary Manager stated the facility's expectation was that the menu and modified diets of the residents would have been followed. On 5/21/24 at 1:05 PM Staff H Registered Dietitian stated Staff F should have followed the menu for modified diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47673 Based on observation, staff interview, and policy review the facility failed to store food and follow proper sanitation to prevent spread of illness in accordance with professional standards for 61 of 63 residents. The facility reported a census of 63 residents. Findings include: On 5/21/24 at 11:50 AM -12:35 PM an observation of lunch service on the 2nd floor revealed Staff F completed hand hygiene. Staff F, dietary aide picked up the tongs, removed a hamburger bun from steam table pan, placed the bun on the plate, used left hand to separate the bun, picked up the bottom of the bun in left hand, used tongs to place a hamburger patty on the bun, placed the bun and patty back on the place, placed the top bun on top of the hamburger patty with left hand, obtained small bowl with left hand, picked up scoop with right hand, scooped coleslaw into the small bowl, used right hand with tongs to pick up french fries, picked up plate with the food on it, handed it to staff in the dining room, and obtained a new plate from top of steam table. This was repeated for all plates served with no hand hygiene during the observation after the initial. Review of policy titled, Hand Washing dated 2021 documented hand hygiene should have been completed as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks. Also hand hygiene should be completed after engaging in other activities that contaminate hands. On 5/21/24 at 1:00 PM Staff G, Certified Dietary Manager stated Staff F should not have touched the hamburger buns with his hands. Staff G stated Staff F should have used tongs to open the buns.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Records (EHR) review, observations, staff interview, and policy review the facility failed to provide complete and accurately documented electronic health records for 1 of 5 resident reviewed (Resident #5). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #5 had a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. On 5/20/24 at 9:13 AM an observation was made of resident #5 wearing oxygen in his bedroom. On 5/20/24 at 9:14 AM Resident #5 stated he had been wearing oxygen almost daily for a couple years. Resident #5 stated the staff check his oxygen saturation a couple of times a day. Review of Resident #5 ' s Care Plan documented oxygen therapy related to shortness of breath and diagnosis of COPD. Review of Resident #5 ' s Physician Orders documented the most recent oxygen order was discontinued on 1/11/23. On 5/21/24 at 3:54 PM Staff I, Licensed Practical Nurse (LPN) stated she thought Resident #5 had a PRN order for oxygen to keep him above 90% saturation. Staff I stated during a review of orders there was no current order for oxygen. Review of Resident #5 ' s Medication Administration Records (MAR) and Treatment Administration Records (TAR) for the month of May revealed no current order for oxygen. On 5/21/24 at 5:04 PM the Director of Nursing (DON) stated the facility's expectation was the current order for oxygen use would be on Resident #5's Medication Administration Records. The DON stated the oxygen order was not present on the residents current MAR. The DON stated the order must have been d/c when Resident #5 was at the hospital and not added back to EHR upon return. On 5/22/24 at 9:23 AM Review of procedure titled, Noting a physician's order documented to confirm order in PCC once pushed through by pharmacy after ordered by physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, record review, document review, and staff interview the facility failed to provide appropriate infection prevention practices by not completing appropriate hand hygiene, failed to develop policies related to COVID-19 vaccinations, and not following guidelines for enhanced barrier precautions for 63 of 63 residents reviewed. The facility reported a census of 63 residents. Finding include: 1. The Minimum Data Set (MDS) for Resident #24, dated 3/18/2024 documented a Brief Interview for Mental Status of 13 indicating no cognitive impairment. The MDS documented a feeding tube present while a resident. On 5/21/24 at 7:52 AM an observation of Staff E Licensed Practical Nurse (LPN) revealed no hand hygiene prior to entering Resident #24 ' s room. Staff E entered Resident #24 ' s bathroom, obtained gloves, and applied gloves. Staff E pushed via 60 mL syringe 10 mL of tap water to auscultate for enteral tube placement. Staff E then pushed medications with a piston syringe. Staff E did not allow medications to flow by gravity. Staff E then removed gloves and applied new gloves without hand hygiene. Staff E poured enteral formula into the hanging bag. Staff E connected the enteral feeding bag Resident #24 ' s enteral feeding tube. Staff E removed gloves and rinsed the piston syringe. Staff E returned to the medication cart and completed hand hygiene. No enhanced barrier precautions in place during care by Staff E. No gown donned during resident care. Review of Resident #24 ' s Physician Orders revealed an order for gastrostomy tube to be changed every 6 to 9 months. Review of undated policy titled, Hand Hygiene documented situations that require hand hygiene include but are not limited to before and after direct resident contact, before and after entering isolation precautions, before and after assisting residents with personal care, before and after applying gloves, before and after coming in contact with residents intact skin, and after removing gloves, 2. The MDS dated [DATE] documented Resident #44 had a BIMS of 2 indicating severe cognitive impairment. The MDS documented Resident #44 was staff dependent during personal hygiene. On 5/22/24 at 8:06 AM an observation of catheter cares and peri cares completed on Resident #44 by Staff J, Staff K, and Staff L revealed hand hygiene was completed by all staff. Gloves applied by all staff. Staff J completed catheter cares to Resident #44 ' s suprapubic stoma site cleansing from stoma down catheter tubing. Staff J completed peri care from labia out to the groin and abdomen. Staff K helped with positioning Resident #44 from side to side during care. Staff J, Staff K, and Staff L removed gloves, hand hygiene completed by all of the staff, and new gloves applied. Resident #44 was turned to the right side buttocks cleansed from cleft to outward to hip on the left side. Resident #44 was turned to the left side and cleansed from the cleft outward to hip. Staff J, Staff K, and Staff L removed gloves, completed hand hygiene, and applied gloves. Barrier cream and brief applied to Resident #44. Staff J, Staff K, and Staff L removed gloves and hand hygiene completed. Trash and laundry removed from the room. No enhanced barrier precautions in place during care by Staff J, Staff K, or Staff L. No gowns donned during resident care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Spirit Retirement Home	1701 West 25th Street Sioux City, IA 51103

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 - Many	Review of Resident #44 ' s Physician Orders revealed size 22 french suprapubic catheter to be changed every 4 weeks and as needed. 44474 3. The MDS assessment dated [DATE] for Resident #21 documented Resident #21 had an indwelling catheter. Review of Resident #21 ' s Care Plan with revision date of 5/6/24 revealed Resident #21 had an indwelling catheter. Observation on 5/20/24 at 11:05 a.m., of Resident #21 indwelling catheter in the privacy bag hanging under the wheelchair. Observation on 5/21/24 at 2:33 p.m., of Staff D, Certified Nursing Assistant (CNA) assisted Resident #21 with catheter care. Staff D did not wear any Enhanced Barrier Precautions (EBP) during catheter care. Interview on 5/21/24 at 2:40 p.m., with Staff B, Licensed Practical Nurse (LPN) revealed there is no one in the facility on EBP in the facility at this time. Staff B revealed the facility would list it in the medication administration record and would have it listed and it would be passed on. Interview on 5/21/24 at 2:42 p.m., with Staff C, Registered Nurse (RN) revealed there is no one in the facility currently on EBP precautions in the facility at this time. Explained if someone in the facility was on EBP it would be listed in the electronic medical chart in the orders. Stated that they would use it for ulcers. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 5/21/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident ' s admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Interview on 5/21/24 at 3:45 p.m., with the Director of Nursing revealed the facility was not currently implementing any EBP at this time but will be implementing it. 4. During the entrance conference on 5/19/24 the facility was requested to provide COVID-19 policy and procedures for the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/21/24 at 1:13 p.m., with the Director of Nursing (DON) revealed the facility follows the Centers for Disease Control guidelines for COVID-19 vaccines but does not have that written anywhere.