STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165442	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Terrace	1922 Fifth Avenue NW Waverly, IA 50677

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, staff interview, and policy review the facility failed to provide notice of Bed-Hold policy and return prior to 1 of 1 hospitalization s reviewed (Resident #39). The facility reported a census of 86 residents. Findings include: Record review of Resident #39 Census in the Electronic Health Record (EHR) documented she discharged to the hospital on 3/23/25 and returned to the facility on [DATE]. She discharged to the hospital again on 3/29/25 and returned to the facility on [DATE]. Record review of Resident #39 Progress Notes lacked documentation her or her Power of Attorney (POA) were notified of the facilities Bed Hold policy. During an interview on 5/07/25 at 12:25 PM Staff J, Social Services reports the facility failed to do a Bed Hold for Resident #39 transfers to the hospital. She reports staff normally ask the resident and have them sign it if able. If they don't ask the resident then they contact the family to see if they want the bed to be held. Review of the facility policy titled Bed Hold Prior and Upon Transfer with a revised date of 4/08/25 directed staff that upon transfer to the hospital the facility will give notice to the resident or resident representative. It further documents that within 24 hours of hospitalization , the social services will contact the resident representative to verify a Bed Hold, review cost, effective date, and document in the EHR.

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50874 Based on Electronic Health Record (EHR) review, the Centers for Medicare and Medicaid Services (CMS) Long term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interviews the facility failed to accurately code 1 of 1 residents (Resident #38) Minimum Data Set (MDS) assessment for an indwelling catheter during the look back period. The facility reported a census of 86. Findings include: The MDS with a target date of 2/6/2025 documented Resident #38 had no indwelling catheter, external catheter, ostomy or intermittent catheterization. The MDS documented diagnoses of benign prostatic hyperplasia (a condition where the prostate gland, located below the bladder in men, enlarges over time), obstructive uropathy (a blockage or hindrance in the flow of urine from kidneys through the ureters and into the bladder, and then out through the urethra) and renal insufficiency (a condition where the kidneys are not functioning at their full capacity). Staff D, MDS Coordinator electronically signed the MDS on 2/10/25 verifying assessment completion. A review of the EHR Orders tab revealed the following: * Change catheter monthly and as needed with 16FR 10CC balloon * Change catheter bag and graduate weekly * Irrigate catheter with 30 milliliters of sterile water as needed * Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce the transmission of multidrug- resistant organisms in nursing homes). The EBP directed facility staff to don gown and gloves when performing high contact cares for Resident #38 due to indwelling urinary catheter. * Record Foley output every shift The physician Order Audit Report revealed the physician reviewed and electronically signed catheter orders on 12/02/24 and most recently on 2/24/25. The Care Plan initiated on 5/26/20, identified Resident #38 had a catheter placed due to obstructive uropathy and prostate disorder. During an interview on 5/5/25 at 4:25 PM with Staff A, Certified Nursing Assistant (CNA) acknowledged Resident #38 had a Foley catheter. Staff A, CNA revealed Resident #38 had a leg bag on during the day and a larger bag during the night. During an interview on 5/5/25 at 4:26 PM, with Staff B, Registered Nurse (RN) acknowledged Resident #38 had a Foley catheter. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/7/25 at 5:07 PM, Staff C, CNA acknowledged Resident #38 had a Foley catheter and at no time had the catheter been removed while she had been employed. During an interview on 5/7/25 at 3:18 PM, Staff D, MDS Coordinator revealed he had been responsible for completing the annual MDS assessment for Resident #38. Staff D, acknowledged Resident #38 had an indwelling catheter for the last five years. Staff D, MDS Coordinator acknowledged he failed to code the indwelling catheter on the annual MDS assessment. Staff D, MDS Coordinator acknowledged he follows the RAI manual when completing the MDS assessments. A review of the Centers for Medicare and Medicaid Services (CMS) Long term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual revealed the following: The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS. The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review, and staff interview, the facility failed to administer the correct dosage of medication as physician ordered resulting in a 7.69 percent (%) medication error rate affecting 2 of 8 residents sampled (Residents #2 and #29). The facility reported a census of 86 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 2 out 15 indicating a severe cognitive loss. The MDS documented Resident #2 with complaints of difficulty or pain when swallowing and a diagnosis of cancer of the oropharynx (middle part of the throat), unspecified. Resident #2's Physician Order electronically signed by the Provider on 4/11/25 directed to give Atropine Sulfate Ophthalmic Solution 0.01 % give 1 drop by mouth as needed for secretions four times a day as needed for secretions. On 5/06/25 at 7:49 AM Staff N, Certified Medication Aide (CMA) reported she planned to give Resident #2 Atropine 2-3 drops. Observation at this time revealed Staff N opened the medication cart and removed a bottle of Atropine, reviewed the resident's Electronic Medication Administration Record (EMAR) with the listed Atropine order, then proceeded to place 3 drops of the atropine on a spoon and prompted Resident #2 to take the medication. Staff N failed to administer the correct dosage of the medication. During an interview on 5/06/25 at 2:42 PM Staff O, Registered Nurse (RN) reported the nurses follow the five medication rights - right resident, right medication, right dose, right time, and right route when administering the medication. During an interview on 5/06/25 at 3:21 PM Staff K, Co-Director of Nursing (CDON) explained nurses are to follow the five right of medication administration. She expects the medication cards and the medication orders on the IPADS to be checked and match prior to medication administration. The Medication Administration Policy revised 10/30/19 documented a purpose to establish authorization and acceptable standards for personnel in the administration of drugs and biologicals. The Policy directed medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state as ordered by the physician and in accordance with professional standards of practice. The Policy Standards directed drugs would be administered in accordance with orders of licensed medical practitioners in the State of Iowa. All licensed nurses utilized and assigned the responsibility of administering and recording of medications must meet the requirements of the Iowa State Board of Nursing. The Policy failed to define the acceptable standards for personnel to follow in the administration of medications. 2. Resident #29's MDS dated [DATE] showed a BIMS score of 14 out of 15 indicating intact cognition. The resident required set up and clean up assistance for eating. The MDS listed diagnoses of other fracture and Non-Alzheimer's Dementia. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An E-Script signed by Resident #29 Provider on 3/13/25 listed a physician order for Calcium 600 Milligrams (MG) plus Vitamin D 800 Units (U), take one tablet by mouth twice a day AM/PM. Observation on 5/06/25 at 7:32 AM revealed Staff P, RN opened Resident #29 Electronic Medication Administration Record (EMAR) which listed a physician order for Caltrate 600 Plus D Minerals Oral Tablet 600-800 MG-U, give one tablet by mouth two times a day. Staff P then removed Resident #29 medication card from the medication cart with a label that read Calcium 600 MG - Vitamin D3 400 U, take one tablet by mouth twice a day, and proceeded to administer the calcium medication to Resident #29. Staff P failed to administer the correct medication dosage to Resident #29. Further review of Resident #29 Calcium 600 MG - Vitamin D3 400 U medication cards on 5/06/25 at 2:41 PM revealed 21 doses had been administered from the morning card and 20 doses had been administered from the Evening card. During an interview on 5/06/25 at 2:42 PM Staff O, explained the facility has a double note system which requires two nurses to review the physician orders to ensure the physician orders are correct. The nurses check the medications when delivered by the pharmacy to ensure the correct medication, in the correct dose and amount is received by the facility. Interview on 5/06/25 at 3:08 PM with the local Pharmacy Technician explained Resident #29 physician ordered e-script for the Calcium 600 MG - 800 U had been filled in error by the pharmacy during the last fill on 4/16/25 with Calcium 600 MG - Vitamin D3 400 U. The facility Caltrate plus with minerals E-script order was for 600 MG - 800 MG, but the pharmacy filled and sent out Calcium 600 MG - 400 U in error. The two medications look almost identical. The pharmacy sent the medication out to the facility for administration on 4/16/25 and would have been used since that time. During an interview on 5/06/25 at 3:21 PM Staff K reported the nurses do a changeover of medication from pharmacy on the 15th of the month. She expects the nurses to check the medication cards with the Medication Administration records (MARs).

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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. 42133 Based on observation, policy review and staff interviews, the facility failed to properly store medications and remove expired medications per the manufacturer's recommendations for use from 1 of 3 medication carts inspected. The facility identified a census of 86 residents. Findings include: Medication cart inspection of the Evergreen Arbor medication cart on 5/08/25 at approximately 8:47 AM revealed the following expired medications: a. One bottle stock Melatonin 1 Milligram (MG), 90 tablet count with 31 tablets left in the bottle, best by date 3/25. b. One bottle stock docusate sodium 100 MG, open date 12/21/24, bottle 2/3 full expired 4/25. c. Resident #16 one bottle Latanoprost 0.005% eye drop, instill one drop in each eye daily at bedtime, open date 3/4/25, expiration date 4/25, documented on the medication bag by Staff B, Registered Nurse (RN). d. Resident #58 one bottle Latanoprost 0.005% eye drops, instill one drop in each eye daily at bedtime, open date 3/4/25, expiration date 4/25, documented on the medication bag by Staff B. e. Resident #74 one Lantus Solostar KwikPen 100 units(U)/ML inject 8 units subcutaneously (SQ) at bedtime, open date 3/19/25. No expiration date written on the outer package or on the pen label. f. One Insulin Lispro Injection KwikPen 100 U/ML with seal broke, no resident name and no open date. During an interview on 5/08/25 at 9:06 AM Staff H, Licensed Practical Nurse (LPN) reported Staff I, Staff Development Coordinator does all of the medication cart audits. Staff H didn't know how often the medication carts were audited, maybe quarterly. At 9:34 AM Staff H voiced the nurses use a Medication Expiration Date Calendar to determine expiration dates. Interview on 5/08/25 at 9:43 AM Staff E and K, Co-Directors of Nursing (CDON) explained Staff I inspects the medication carts monthly. Staff K reported the last cart inspection for Evergreen Arbor had been 4/02/25. On 5/08/25 at 9:45 AM Staff D reported they have a procedure they follow for medications. She expects nurses to place open dates on the medication when opened, and ideally the nurses/Certified Medication Aides (CMA's) should put an expiration date on the medication at that same time. Staff K stated the nurse or CMA administering the medication has the responsibility to ensure the medication is in-date when administering the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Manufacturer's Directions for use of Latanoprost under Storage and Handling specifies once a bottle is opened for use, it may be stored at room temperature for 6 weeks. The Manufacturer How to use the Lantus(R) SoloStar(R) pen under How to Store the Opened Lantus Solostar Pen directed to keep the pen at room temperature (below 86 degrees Fahrenheit) and after 28 days throw the pen away, even if it has insulin left in it. The manufacturer's Instructions for use Insulin Lispro KwikPen directs to throw away the insulin Lispro Pen after 28 days, even if the pen still has insulin left in it. The Storage of Medications Policy, revised 12/12/23 directed no discontinued, outdated, or deteriorated medications would be available for use in the facility. All such medication were to be destroyed.

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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. 48003 Based on observations, staff interviews, and policy review the facility failed to maintain a sanitary kitchen; failed to serve and prepare food in accordance with professional standards for food safety to reduce the risk of cross contamination and food borne illness. The facility reported a census of 86 residents. Findings include: During a continuous observation on 5/05/25 from 11:15 AM to 12:44 PM of meal service on second floor, Staff L, dietary, handling hamburger buns with her bare hands after touching her face and adjusting her shirt without performing hand hygiene for eight residents. At 11:43 AM after adjusting her glasses and not doing hand hygiene used her bare hands to slide food from one plate to another touching the food with her hands then serving it to a resident. At 11:57 AM Staff L rubbed her nose then went to the hand washing station, got soap on her hands and washed her hand for 5 seconds. She then got a tong and put it with the hamburger buns. Observation on 5/05/25 at 1:00 PM the kitchen floor on the second floor being very dirty with a bowl in the corner by the steam table. Observation on 5/05/25 at 3:00 PM the kitchen floor on the second floor under the metal counters and around the steam table are noted the dried foods and dirty floors remained. Dirty bowl noted still in the corner. Observation 5/06/25 12:07 PM Kitchen floor on second floor still dirty with dried food. The bowl remains in the same spot on the floor in the corner by the steam table. During an interview on 5/07/25 at 1:41 PM the Dietary Manager reported staff are to use tongs or gloves to handle the buns. She reported staff are to wash their hands if they touch anything contaminated or if they touch clothing. She verbalized housekeeping is in charge of cleaning the floors. During an interview on 5/07/25 at 2:12 PM the Housekeeping Manager reported housekeeping is to sweep and mop the dining room and kitchen areas second floor after each meal. Facility policy titled Hand Washing - Dining Service with a revised date of 4/24/25 directs staff to wash their hands after engaging in other activities that contaminate the hands. The policy further documents when washing hands staff are to wash their hands for 20 seconds. Facility policy titled Single Use Glove and Utensil Usage with a revised date of 8/22/20 directs staff that single use gloves or utensils are to be used when handling ready to eat foods. 50874 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During continuous observation on 5/7/25 at 6:48 AM, Staff F, Dietary [NAME] failed to perform hand hygiene prior to preparing pureed meals for 9 residents with physician orders for a pureed diet. Staff F placed ground rib meat from a stainless-steel bowl into a robot coupe food processor using a rubber spatula. The stainless-steel bowl had been placed on the counter with the rubber spatula placed in the bowl. The handle of the rubber spatula fell into the 14 ounces of ground meat that remained in the bowl to be pureed. Staff F reached in with her bare left hand and grabbed the handle of the rubber spatula with her index finger and thumb. When all the ground meat had been pureed, Staff F placed the dirty stainless-steel bowls and rubber spatula in the sink leaving the bowl of the robot coupe on the base. Staff F failed to perform hand hygiene prior to pureeing the next food item. Staff F, grabbed a blender, opened a #10 can of cream corn, turned to the counter where the robot coupe contained the dirty robot coupe bowl used to puree the meat and removed it from the base placing it off to the side. Staff F walked over to a hanging rack that held various size scoops. Staff F grabbed a 4-ounce scoop with her bare left hand by the scoop versus the green handle. Staff F proceeded to rub the inside of the scoop with her left thumb with her fingers around the outside of the scoop. Staff F held the handle of the scoop to portion out creamed corn to be pureed for 9 residents. Staff F walked into the freezer, carried a box of frozen dinner rolls out and placed the box on a counter. Staff F washed her hands, donned gloves and opened the box of dinner rolls. Staff F opened the plastic bag and used her right gloved hand to remove 6 dinner rolls. Staff F failed to don clean gloves or use tongs to remove the frozen dinner rolls. The dinner rolls were heated prior to being pureed. Staff F moved the dirty robot coupe bowl and the dirty blender to the dishwashing area. Staff F wiped of the counter. Staff F failed to wash her hands. Staff F grabbed a blender and placed a rubber spatula directly on the counter. Staff F placed the warmed dinner rolls in the blender with tongs. Milk was added and then blended to proper consistency. Staff F used the rubber spatula to scrape the sides of the blender. Staff F failed to use a barrier between the counter and the rubber spatula. During an interview on 5/7/25 at 7:31 AM, Staff F, Dietary [NAME] acknowledged she had been trained on proper food handling procedures. Staff F acknowledged the handle of the rubber spatula had direct contact with the ground meat when she reached in to remove it. Staff F acknowledged she did not wash her hands enough and should have washed her hands more frequently throughout the process. A review of the facility policy dated April 24, 2025 for Hand Washing-Dining Services revealed the following: * Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures. * Hands and exposed portions of arms should be washed immediately before engaging in food preparation * Staff are directed to wash hands o When entering the kitchen at the start of a shift o After handling soiled equipment or utensils o During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Before donning disposable gloves for working with food and after gloves are removed. o After engaging in other activities that contaminate the hands

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, Center for Disease Control and Prevention (CDC), policy review, and staff interview, the facility staff failed to wear an isolation gown and gloves during high-risk care provision of 1 of 3 residents on CDC Enhanced Barrier Precautions (EBP) (Resident# 79) and failed to prevent cross contamination when a urinary drainage bag came into contact with the floor for 1 of 2 residents sampled (Resident #79). The facility identified a census of 86 residents. Findings include: Resident #79 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 6 out of 15 indicating a severe cognitive loss. Resident #79 required substantial to maximal assistance with toileting. The MDS documented Resident #79 utilized an indwelling urinary catheter for a diagnosis of obstructive uropathy and had a urinary tract infection (UTI) with in the last 30 days. A Hospital Progress Note, History of Current hospitalization dated 4/15/25 at 8:01 AM documented Resident #79 on Zosyn Intravenous antibiotic, positive for pseudomonas and Enterococcus (opportunistic bacteria) UTI. Resident #79 to discharge to [NAME] Lutheran Home (Woodland Terrace) tomorrow. The Hospital Progress Notes further documented Resident #79 had a chronic indwelling urinary catheter. Observation on 5/05/25 at 11:37 AM revealed a CDC Enhanced Barrier Precautions Sign hanging outside Resident #79 room which directed providers and staff must wear gloves and a gown for the following activities dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and during device care which included urinary catheters. During an observation on 05/05/25 at 11:39 AM Staff M, Certified Nursing Assistant (CNA) transferred Resident #79 from the bed to the wheelchair utilizing a gait belt without wearing an isolation gown and gloves. Staff M placed Resident #79 walker by the bed with the urinary catheter hanging in a privacy bag on the walker and the tubing extending out Resident #79 pant leg. Observation on 5/05/25 at 12:10 PM revealed Resident #79 sitting at the dining room table with approximately three inches of the urinary drainage bag tubing laying in direct contact with the dining room floor under his wheelchair. Staff members sat at the dining room table assisting residents and did not address the catheter tubing on the floor. On 5/07/25 at 2:41 PM Staff O, Registered Nurse (RN) reported staff are to wear an isolation gown and gloves when there is a risk of contact/splashing of urine and when providing catheter care. If staff could come in contact with body fluids, then they may have to wear a face shield as well, but primarily they wear the Personal Protective Equipment (PPE) when there is a risk of coming into the contact with the body fluids. During an interview on 5/07/25 at 2:43 PM Staff K, Co-Director of Nursing (CDON) reiterated enhanced barrier precautions require staff to wear an isolation gown and gloves during high contact resident care activities such as dressing, toileting, transferring and when doing catheter care. (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	Observation on 5/08/25 at 8:01 AM revealed Resident #79 laying in a low bed with the lower 1 - 1.5 inches of the urinary catheter bag coming out the bottom of the privacy bag laying in direct contact with the carpeted floor. Resident #79 tubing contained yellow, cloudy urine. Interview on 5/08/25 at 9:10 AM Staff H, Licensed Practical Nurse (LPN) reported urinary drainage bags should not contact the floor. The drainage bags and tubing are to be kept up off the floor and contained in a privacy bag. Staff H explained that some of the privacy covers have clips at the bottom of the bags and as the urinary drainage bags fill up with urine the clips do not hold and the bags can come out the bottom of the privacy bag. On 5/08/25 at 9:11 AM Staff M, CNA reported regarding catheters, they are to wear PPE at any time during cares and the urinary bag should never touch the floor. Interview on 5/08/25 at 9:23 AM the Infection Preventionist explained for enhanced barrier precautions, staff wear PPE for high contact cares such as transfers, peri-cares, catheter cares and so forth. Staff are to keep the urinary drainage bag off the floor and in a privacy bag. The Enhanced Barrier Precautions Policy, revised 6/20/24, documented a purpose to prevent the transmission of multi-drug-resistant organisms. EBP would be needed for residents with indwelling medical devices including urinary catheters. PPE for EBP is only necessary when performing high-contact care activities. High-contact resident care activities include: transferring a resident. The Catheter Care Policy, revised 4/22/25 directed the staff to ensure urinary drainage bags are covered at all times and tubing is free from touching the floor.