STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165498	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhaven Community	112 West Fourth Street Boone, IA 50036

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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 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. Based on observations, staff interviews, and policy review, the facility failed to properly wear and change out gloves during meal services for 2 of 2 dining rooms observed. The facility reported a census of 59. Findings include:During a continuous observation on 4/30/26 at 12:15 PM, Staff I, Culinary Assistant, wore a glove on one hand (right) while preparing resident lunch plates in the Westown independent resident dining room. They touched the refrigerator door, cabinet door, counter top, and scoop handles with the gloved hand. The same glove was also worn as Staff I prepped and placed buns on resident plates. During a continuous observation on 4/20/26 at 12:00 PM, Staff H, Culinary Assistant, prepared resident lunch plates in the Bistro resident assist dining room. Upon the start of service, Staff H noted there were no tongs to use for the philly steak sandwich buns. Before preparing each plate, Staff H washed hands and put on new gloves. They then touched scoop handles, dietary cards, menus, and food packaging before handling the bread. Staff H delivered plates and assisted the resident with meal set-up. They touched condiment packets (from a bowl of packets), silverware, and resident arms/shoulders with the gloved hands and then touched sandwiches to cut or prepare as requested.In an interview on 4/29/26 at 1:15 PM, the Registered Dietitian (RD) noted the above observations were inappropriate glove use. Staff should not be touching other objects with gloved hands and then resident food.The policy Employee Health and Hygiene, Food and Nutrition Services (revised 1/12/24) noted the following: A. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness B. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper hand washing.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, staff and resident interviews, resident health record review, and policy review the facility failed to obtain an order for self administration of medication and allowed resident to consume her medications without observation for 1 of 5 residents reviewed. The facility reported a census of 59 residents. Findings include:The Minimum Data Set (MDS) for Resident #57, dated 1/6/26, included diagnoses of stroke, diabetes, and depression. A Brief Interview for Mental Status (BIMS) score of 12 indicated mild cognitive impairment. On 4/30/26 at 8:18 AM, observed Resident #57 sitting at the dining room (DR) table with several pills in a cup sitting on the table in front of her. On 4/30/26 at 8:22 AM, Staff D, Certified Medication Aide stated Staff A, Licensed Practical Nurse (LPN) prepared Resident #57's medications. On 4/30/26 from 8:22 AM - 8:28 AM, observed Resident #57 drinking fluids, covered her mouth and face turned red. Staff A propelled Resident #57 to her room with the pills remaining on the table. Staff D left the DR area with the cup of pills remaining on the table and no nursing staff in the DR. Staff A returned to the DR and removed the cup of pills and returned to Resident #57's room. Interview on 4/30/26 at 8:30 AM, Staff B, LPN stated Resident #57 does not have an order to self administer medications and the policy is to observe the residents take their medications. Interview on 4/30/26 at 8:40 AM, Staff A stated she prepared and placed Resident #57's medications on the table. Staff A stated the pills were the resident's morning pills and there were 13 pills in the cup. Staff A stated she does that for residents if she is in the DR passing medications and she will just keep an eye on the residents to make sure they take the pills. Staff A confirmed she left the medications on the table when she took the resident to her room due to the choking type episode. Interview at 04/30/2026 at 12:45 PM, Resident #57 stated the staff always leave her medications on the table because she doesn't want to take them until after she eats. Facility Medication Management, Oral Medications policy reviewed 9/30/25, revealed administer medications and stay with the resident until medications are swallowed unless the resident has an order to self- administer medications. Interview on 4/30/26 at 9:50 AM, the Director of Nursing stated an expectation for staff to observe the resident take the medication, not leave on the table unsupervised.

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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, family interview, resident interview, staff interview, and policy review, the facility failed to offer or hold an admission care conference for 2 of 17 residents (Residents #1 and #30) reviewed for Care Plans. The facility reported a census of 59. Findings include:1.The Minimum Data Set (MDS) Assessment completed on 2/3/26 revealed Resident #1 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The Clinical Census section of the electronic health record (EHR) showed Resident #1 was admitted to the facility on [DATE]. The clinical record lacked documentation that a care conference was offered or held after the admission comprehensive assessments were completed. The first care conference documented was held on 2/11/26. This coincided with the quarterly comprehensive assessments completed by 2/3/26. The Care Plan Conference Summary sheet, dated 2/11/26, lacked documentation if Resident #1 attended the conference or if they declined to attend. During an interview on 4/30/26 at 11:00 AM, Resident #1 was unable to recall either way if they participated in a Care Plan meeting or not since admission.2. The MDS Assessment completed on 2/28/26 revealed Resident #30 with a BIMS score of 6, indicating severe cognitive impairment. The Clinical Census section of the EHR showed Resident #30 was admitted to the facility on [DATE] and discharged on 11/11/25. Resident #30 was readmitted on [DATE]. The MDS Assessment tab of the EHR showed an admission assessment was completed on 9/19/25 and 12/24/25. A quarterly assessment was completed 1/26/26. Review of the clinical record showed a care plan conference was held in September 2025 coinciding with Resident #30's previous admission. No documentation identified which indicate a care conference had been held or offered since the resident's readmission on [DATE].During an interview on 4/27/26 at 1:30 PM, Resident #30's family indicated they have not attended nor been invited to a care conference since December's readmission. During an interview on 4/29/26 at 8:15 AM, the MDS Coordinator acknowledged the lack of documented care conferences for Resident #30 since the December 2025 readmission. With no documentation, the MDS Coordinator noted a care conference was most likely not held. With regards to Resident #1, the MDS Coordinator reported an admission care conference was most likely not held as there is no documentation. The MDS Coordinator explained a resident's first care conference is typically held when the first quarterly assessments are completed and not with admission assessments. If a resident and/or resident representative is present, the Care Plan Conference Summary sheet is signed by them. However if the the resident declines to attend and a resident representative is not present, no further documentation is noted on the Care Plan Conference Summary sheet to reflect the non-attendance. The policy Care Plan and Baseline Care Plan, revised 10/14/22, outlined the following: a. A comprehensive care plan will be in the EHR by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. b. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other scheduled MDS assessments. c. The resident and their representative have the right to participate in the care planning process, including the right to be informed, in advance, of the care to be furnished. The resident also has the right to request meetings and the right to request revisions to the person-centered plan of care. If it is determined that the participation of the resident and their representative is not practical for the development of the care plan, this will be explained in the EHR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 promote the healing of a pressure injury and prevent futher deterioration of the pressure injury for 1 of 1 residents reviewed (Resident #2). The resident had a documented risk for pressure ulcers/injuries without interventions listed on the care plan, assessments were not complete and the treatments were not signed as complete. The facility reported a census of 59 residents. Findings include:The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.Unstageable Ulcer: inability to see the wound bed.Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Minimum Data Set (MDS) assessment dated [DATE], for Resident #2 documented diagnoses that included depression, diabetes mellitus, and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified the resident as at risk for pressure ulcers. The MDS also identified the facility had placed a pressure reducing device in the Resident #2's chair and bed. The MDS identified Resident #2 is partial/moderate assistance, (helper does less than half the effort. Helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort.) with rolling left and right in bed, sitting to lying on the bed and lying to sitting on the side of the bed, sit to stand, and with transfers. Resident #2's care plan with date initiated on 11/11/25 contained the following information:Resident #2 states I have skin problems, the care plan revealed:Will see foot doctor for routine diabetic foot careWeekly diabetic skin checksTreatments as orderedSkin protective mattress on bedSkin protective cushion in chairReport changes as neededEncourage good nutrition and hydration in order to promote healthier skinDiscourage scratching if notedCheck skin with cares and report changes as neededThe care plan lacked preventative interventions to prevent pressure areas The pocket care plan dated 2/24/26 lacked preventative interventions to prevent pressure areas. The facility provided Braden Scale dated 2/11/26 was incomplete.The facility provided Braden Scale dated 1/26/26 score was 18, which indicated at risk for pressure ulcers. Review of Resident #2's Progress Notes revealed the following:On 2/27/26 at 6:00 a.m. Resident #2 reported to staff his right heel was hurting, staff noted an area measuring 4.2 centimeters(cm) x 4.4cm area of redness that was blanchable. In the center of the red area was an area of black eschar and dried skin. Eschar measured 1.7cm x 1.3cm. New intervention was to apply a heel bonnet to the right foot at all times. According to the skin tear investigation the resident stated someone ran over his heel with the wheelchair leg. On 2/27/26 at 2:09 p.m. Advanced Registered Nurse Practitioner (ARNP) here to see resident: new order to paint area to right heel with betadine twice a day and leave open to air. Have a Physicians Assistant (PA-C) see next week. Area could be from trauma from bumping/rubbing with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair wheel or could be pressure but unstageable at this time.On 3/3/26 at 5:52 p.m. Per PA-C, continue to the right heel with betadine and leave open to air, continue heel bonnet. The goal is to dry out so eschar comes off on its own. On 3/10/26 at 4:51 p.m. seen by PA-C with diagnosis unstageable heel injury. Continue current orders and hold compression socks until wound healed. Review of the Non-Pressure Skin Condition Report revealed measurements on the right heel: 2/27/26 - 4.2cm x 4.4cm redness with 1.7cm x 1.3cm eschar3/3/26 - 2.4cm x 2.0cm 100% eschar3/7/26 - 2.3cm x 3cm eschar - no change in progressReview of the wound/skin healing record revealed measurements on the right heel:3/10/26 - 2cm x 2cm unstageable eschar3/13/26 - 2.4cm x 2cm unstageable eschar3/21/26 - 2.4cm x 2cm unstageable eschar, deep tissue injury3/25/26 - 5.0cm x 4.9cm unstageable eschar3/28/26 - 5.0cm x 4.9cm unstageable eschar4/1/26 - 3.6cm x 4.0cm - nothing else completed on assessment4/15/26 - 3.6cm x 2.9cm - nothing else completed on assessment4/25/26 - 5.0cm x 4.0cm - escharReview of the March and April 2026 Treatment sheets revealed the order to paint betadine to the right heel twice a day and leave it open to air; the treatment sheets lacked many signatures indicating treatment was not completed. The facility provided a policy named Skin integrity and wound management with a date revised 3/3/26 revealed residents admitted without pressure injuries will remain free of pressure injuries unless clinically unavoidable. Care and services will align with professional standards of practice to prevent the development of new pressure injuries, promote healing of existing wounds, and prevent further deterioration. The facility recognizes that despite vigilant care, certain residents may develop or experience worsening skin injuries due to their medical condition. In these cases, the focus will be on risk reduction, prevention strategies, and effective wound management. Develop and implement individualized care plans and interventions based on current skin impairments and potential risk areas. Interventions will be communicated to certified nursing assistants (CNA) via assignment sheets or profiles. CNA's inspect the skin during care and report any new concerns immediately to the licensed nurse. Licensed nurses conduct visual body inspections, observation and document findings. Interview on 4/30/26 at 11:00 a.m. with the DON revealed that they go by the braden scale and anyone that scores an 18 they will put the interventions in place. DON stated it is an expectation that staff sign off when treatments are completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review the facility failed to provide adequate supervision in the dining room at meal times for a resident with recommendations for full supervision during meals for 1 of 1 residents reviewed (Resident #57). The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) for Resident # 57, dated 1/6/26, included diagnoses of stroke, diabetes, and depression. A Brief Interview for Mental Status (BIMS) score of 12 indicated mild cognitive impairment. On 4/27/26 with continuous observation from 12:00 PM - 12:31 PM, observed 1 dietary staff and 19 residents in the Westown dining room (DR), with no nursing staff present in the DR. Resident #57 in the DR eating lunch with sign at table in front of her with documentation of Please chew and swallow food before taking a drink. Observation on 4/28/26 at 8:30 AM, Resident #57 in DR eating breakfast with no nursing staff present. Resident #57's Progress Notes revealed the following:a. 1/18/26 at 12:30PM - Dietary aide approached the nurse station to report that the resident seemed to be choking. Upon assessment, the resident was noted to be coughing, red in the face, was able to catch her breath but began coughing up mucus and had an emesis (vomit). Resident reports she has been having increasing difficulty chewing her meat at meals. Physician notified.b. 1/19/26 at 9:02 AM - Order received for speech therapy evaluation and treatment. c. 2/16/26 at 11:45 AM - this nurse was at the nurse's station when staff yelled that resident was choking. She was coughing and spit out a moderate amount of thin clear liquid.d. 4/14/26 at 12:05 PM - Resident red in the face, nurse approached, and resident was able to start coughing which brought up a pill. Resident had a large emesis. e. 4/29/26 at 12:31 PM - 2 nurses called upon by dietary aide due to resident choking on her lunch of egg salad and toast. Resident did cough up evidence of egg salad. Resident #57's MDS Nutrition assessment dated [DATE] revealed coughing or choking during meals or when swallowing medications in the past 7 days. Resident #57's Clinical Nutrition assessment dated [DATE] revealed resident is eating in the Westown DR or her room per her request. She is eating independently with set up. Resident to not consume fluids when food present in mouth. If resident agrees, recommend assist DR for additional supervision and encouragement during meals. Resident #57's physician notification form dated 4/14/26 revealed an episode of choking while taking pills with a new order written for speech therapy to evaluate and treat if needed. The Speech Therapy (ST) Evaluation and Plan of Treatment dated 4/20/26 documented resident presents with suspected esophageal dysphagia (difficulty swallowing) by reported episodes of emesis following intakes, complaints of heartburn, and sensation of food sticking. Recommendations for full supervision during meals. Interview on 4/30/26 at 9:25 AM, the Director of Rehab stated on 4/21/26 she sent an email to the Dietician, Director of Nursing, and MDS Coordinator for Resident #57 with the recommendations from the ST evaluation for supervision. Interview on 4/30/26 at 11:35 AM, the Dietician stated she received the email from the Director of Rehab for Resident #57 and the recommendations from the ST eval for supervision during meals. The Dietician stated she had completed an assessment herself prior and had recommended the assisted DR for additional supervision and those recommendations were provided in her weekly consultant report to the DON. Interview on 4/30/26 at 9:45 AM, the MDS Coordinator stated she didn't recall receiving recommendations from therapy from the ST evaluation for Resident #57. The MDS Coordinator stated her process is to put the recommendations on the care plan and then direct therapy who else they need to advise of recommendations. The MDS Coordinator proceeded to review her emails and found an email from the Director of Rehab in her deleted folder and confirmed she had not addressed the recommendations. Interview on 4/30/26 at 12:40 PM, Staff C, Dietary Aide stated nursing staff are only in the Westown DR during meals times when they are passing medications. Staff C stated nursing staff do not stay in the DR the whole time the residents are eating, only in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted DR. Staff C stated she tries to keep an eye on the residents and if a resident starts coughing, she goes and checks on them and would go find a nursing staff if needed to. Interview on 4/30/26 at 11:40 AM, the DON stated Resident #57 doesn't want to go to the assisted DR and in a choking/coughing situation the Dietary Aide is to alert the nurse. The DON stated they have attempted to move Resident #57 to the assisted DR and she refused. Quiered about providing recommended supervision to Resident #57 during meal times and the DON stated she didn't have enough staff to sit 1:1 with the residents in the independent DR and residents are to go the assisted DR if need supervision/assistance. Interview on 4/30/26 at 12:45 PM, Resident #57 stated she is having choking and coughing problems, feels it is more in the morning when she is dry and then starts drinking at breakfast. The resident stated she had an episode this morning at breakfast and yesterday at lunch. The resident further stated no staff had spoken with her about going to the assisted DR to be supervised and that she was willing to try it because she gets worried about the choking. The Facility Dining Room Service policy revised 11/24/25 revealed staff will provide appropriate supervision in the DR to help ensure a safe and supportive mealtime environment for all residents. Interview on 4/30/26 at 2 PM - the Administrator stated expectation to follow recommendations from therapy.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on facility document and menu review, observations, and staff interview, the facility failed to ensure appropriate serving sizes for 5 of 6 residents receiving the puree lunch served on 4/29/26. The facility reported a census of 59. Findings include:Observation on 4/29/26 revealed the puree hot lunch items for the meal served consisted of a philly steak sandwich with peppers and onions and a hot dog on bun as the alternative. Beets were offered instead of baked beans as the beans were not available. On 4/29/26 at 9:00 AM, Staff E, Cook, prepped the puree hot lunch items. Four servings of puree philly steak sandwich (which measured out to 4 cups) and three servings of puree hot dog with bun (which measured out to 2.5 cups) were prepared to the correct consistency and set aside in separate measuring cups. Six servings of puree canned beets (measured out to 3 cups) were also prepared to the correct consistency and set aside in separate measuring cup.After preparing the puree items, Staff E referred to the Pureed Diet Portion Sizes/Scoops chart to determine scoop serving sizes. The puree philly steak sandwiches were remeasured and voiced at 4.5 cups, requiring a grey and a black scoop. Staff E transferred to entree to a serving pan, covered with foil and labeled it with #12 and blackThe pureed hot dogs with bun were initially remeasured as 3.5 cups. The process was stopped and Staff E was asked to verify the measurement. Staff E corrected it to 2.5 cups, voiced it required a #12 and #16. Staff E transferred the entree to a serving pan, covered with foil, and labeled it with grey and green. The pureed beets were remeasured at 3 cups, requiring a grey scoop. Staff E transferred the vegetable to a serving pan, covered with foil, and labeled with #12. On 4/29/26 at 11:30 AM, Staff E removed the pureed items from the oven and prepared them for delivery to the Central Bistro Dining Room. It was observed that the pan of philly steak sandwiches lacked the scoop size on the foil. Upon arrival to the dining room, Staff E placed the pureed items on the steam table with the following serving scoops on top of the lidded pans: Philly steak sandwiches a grey #8Hot dog with bun a grey #8 and green #12 Beets a grey #8 and black #30 During the lunch service, Staff H, Culinary Assistant, dished out the puree items, per resident choice, using the above scoop sizes for 5 of the 6 residents on a puree diet. For the items with two scoops, Staff H used both (1 serving from each scoop) for the plate. The Pureed Diet Portion Sizes/Scoops chart listed the following serving scoop sizes:Philly steak sandwiches: Total volume 4 cups for 4 servings would need 2 scoops from a grey #8 and 1 scoop from a black #30Hot dog on bun: Total volume 2.5 cups for 3 servings would need 1 scoop from grey #8 and 1 scoop form a green #12Beets: Total volume 3 cups for 6 servings would need 1 scoop from a grey #8In an interview on 4/29/26 at 1:15 PM, the Registered Dietitian (RD) explained staff should correctly measure out puree food items when utilizing the volume method for determining puree serving sizes. The RD would expect dietary staff to use the scoop size and the number of scoops as outlined on the Puree Diet Portion Sizes/Scoops chart. The facility did not have a specific policy which outlined the procedure used to determine appropriate puree food portions sizes.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, document review and staff interviews the facility failed to provide appropriate infection prevention practices by not following guidelines for enhanced barrier precautions (EBP) for 1 out of 1 resident reviewed (Resident #8). The facility reported a census of 59 residents. Finding include:The Minimum Data Set (MDS) dated [DATE] for Resident #8, documented the Brief Interview for Mental Status (BIMS) scored a 14 indicating intact cognition. The MDS identified diagnosis as a renal insufficiency, urinary tract infection, diabetes mellitus. The MDS also documented that the resident has an indwelling catheter. Review of Resident #8's Care Plan with a date of 4/9/26 failed to mention Enhanced Barrier Precautions (EBP) due to an indwelling catheter. Observation completed on 4/29/26 at 12:05 pm with Staff F, Certified Nursing Assistant (CNA) and Staff G, CNA failed to wear EBPs while providing catheter care. Interview on 4/29/26 at 1:26 pm with Staff F and Staff G acknowledged that they should have worn the EBP while providing catheter care. The facility policy named Enhanced Barrier Precautions with a revised date of 9/29/25 stated If contact precautions do not otherwise apply enhanced barrier precautions are recommended for residents with any of the below criteria: Residence with an indwelling medical device, even if the resident is not known to be infected or colonized with an Multidrug-Resistant Organisms (MDRO). Examples of indwelling medical devices include but are not limited to central vascular lines, Peripherally Inserted Central Catheter (PICC) or mid-line catheters indwelling urinary catheter, nephrostomy tube, feeding tube, tracheostomy tubes. Dialysis shunts, ports that are not currently accessed, peripheral intravenous (IV) lines do not qualify as indwelling medical devices.Examples of high-contact resident care activities requiring gown and gloves used for EBP include (our goal is to keep our skin and uniform from touching the resident during high contact activities so that we can avoid potential transfer of organisms to other residents).These activities included:Bathing/showeringTransferringProviding hygieneChanging linensChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheotomy/ventilatorWound care: any skin opening requiring a dressingInterview on 4/29/26 at 1:47 pm with the Director of Nursing (DON) stated the expectation for the staff is to wear the EPB for residents catheters.