STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175337	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Botkin Care and Rehab	102 W Botkin Street Wellington, KS 67152

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34056 The facility reported a census of 40 residents with 14 residents included in the sample. Based on observation, record review and interview, the facility failed to review and revise the care plans for five of the Resident's sampled, including R9, R30 and R17, regarding failure to review and revise the care plan to include Enhanced Barrier Precautions (EBP-a set of infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs), R17, regarding the use of antianxiety medication (medication used to calm and relax people) and R18, regarding the use of footrests on the resident's wheelchair. Findings included: - Review of Resident (R)9's electronic medical record (EMR) revealed a diagnosis of urinary retention (the inability to pass urine). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Functional Abilities Care Area Assessment (CAA), dated 09/26/24, documented the resident required staff assistance with emptying his indwelling urinary catheter. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine, indicating moderately impaired cognition. He had a indwelling urinary catheter. The care plan, revised 01/28/25, lacked staff instruction regarding Enhanced Barrier Precautions (EBP-a set of infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) for the use of his indwelling urinary catheter. On 02/24/25 at 11:05 AM, the resident's room door lacked signage indicating the resident was on EBP due to the indwelling urinary catheter. On 02/26/25 at 08:04 AM, Administrative Nurse D stated the resident's care plan had not been reviewed and revised to include EBP related to his indwelling urinary catheter. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Botkin Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 102 W Botkin Street Wellington, KS 67152	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Comprehensive Care Plans, revised 08/22, included: The Interdisciplinary Team (IDT) shall be responsible for the periodic review and updating of the resident care plans. The facility failed to review and revise this resident's care plan to include EBP related to his indwelling urinary catheter. - Review of Resident (R)17's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe impairment. She did not receive antianxiety medication (medication that helps to calm and relax people) during the assessment period and had an unhealed stage III pressure ulcer (PU-a full-thickness tissue loss where subcutaneous fat is visible), not pressent on admission. The Psychotropic Drugs Care Area Assessment (CAA), dated 02/08/25, documented the resident's psychotropic medications were discontinued during the assessment period due to the resident's inability to take medications and being put on comfort care. The Pressure Ulcer CAA, dated 02/08/25, documented the residen was at high risk for the development of PUs. The Significant Change MDS, dated [DATE], documented the staff assessment for cognition revealed severe impairment. The resident did not receive antianxiety medication during the assessment period and had a stage III PU, not present on admission. The care plan, revised 01/24/25, lacked staff instruction on the use of the antianxiety medication and the need for EBP due to the resident's PU. Review of the resident's EMR revealed the following physician's order: Lorazepam (an antianxiety medication), 0.5 milligrams (mg), by mouth (po) or sublingual (sl), every (Q) four hours, as needed (PRN), for anxiety, ordered 02/07/25. Review of the resident's Medication Administration Record (MAR) for February 2025, revealed the resident had received the medication on three occasions with effective results. Review of the resident's EMR revealed the resident had a stage III PU to her right heel with treatments ordered twice weekly. On 02/24/25 at 01:19 PM, the resident's room door lacked signage indicating the need for EBP related to the resident having a PU. On 02/26/25 at 08:04 AM, Administrative Nurse D stated the resident's care plan had not been reviewed and revised to include EBP related to her PU and had not been reviewed and revised to include staff instruction regarding the use of the antianxiety medication. The facility policy for Comprehensive Care Plans, revised 08/22, included: The Interdisciplinary Team (IDT) shall be responsible for the periodic review and updating of the resident care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to review and revise the resident's care plan to include EBP related to her PU and failed to review and revise the resident's care plan related to the use of the antianxiety medication. - Review of Resident (R)18's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. She used a wheelchair for mobility with substantial to maximal staff assistance for distances for 150 feet. The Functional Abilities Care Area Assessment (CAA), dated 10/08/24, documented the resident self-propelled her wheelchair for short distances. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She used a wheelchair for mobility with partial to moderate staff assistance for distances for 150 feet. The care plan, revised 10/31/24, lacked staff instruction regarding the resident's need for staff assistance with propelling her wheelchair and the use of foot pedals while staff propel her in her wheelchair. Review of the resident's EMR, from 01/28/25 through 02/25/25, revealed she used a wheelchair for mobility throughout the facility. On 02/26/25 at 08:04 AM, Administrative Nurse D stated the resident's care plan had not been reviewed and revised to include staff instruction to utilize footrests while propelling the resident in her wheelchair. The facility policy for Comprehensive Care Plans, revised 08/22, included: The Interdisciplinary Team (IDT) shall be responsible for the periodic review and updating of the resident care plans. The facility failed to review and revise this resident's care plan to include staff instruction to utilize footrests while propelling the resident in her wheelchair. - Review of Resident (R)30's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. He had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag). The Functional Abilities Care Area Assessment (CAA), dated 09/06/24, documented the resident was dependent on staff for activities of daily living (ADL). The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating intact cognition. He had an indwelling urinary catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, revised 01/07/25, lacked staff instruction regarding Enhanced Barrier Precautions (EBP-a set of infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) for the use of his indwelling urinary catheter. On 02/24/25 at 10:31 AM, the resident's room door lacked signage indicating the resident was on EBP due to the indwelling urinary catheter. On 02/26/25 at 08:04 AM, Administrative Nurse D stated the resident's care plan had not been reviewed and revised to include EBP related to his indwelling urinary catheter. The facility policy for Comprehensive Care Plans, revised 08/22, included: The Interdisciplinary Team (IDT) shall be responsible for the periodic review and updating of the resident care plans. The facility failed to review and revise this resident's care plan to include EBP related to his indwelling urinary catheter.

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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** 34056 The facility reported a census of 40 residents with 14 residents sampled, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide safe transportation for one dependent Resident (R)18, regarding failure to utilize footrests while transporting the resident in a wheelchair. The facility also failed to ensure care planned fall interventions were in place for R19. Findings included: - Review of Resident (R)18's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. She used a wheelchair for mobility with substantial to maximal staff assistance for distances for 150 feet. The Functional Abilities Care Area Assessment (CAA), dated 10/08/24, documented the resident self-propelled her wheelchair for short distances. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She used a wheelchair for mobility with partial to moderate staff assistance for distances for 150 feet. The care plan, revised 10/31/24, lacked staff instruction regarding the resident's need for staff assistance with propelling her wheelchair and the use of foot pedals while staff propel her in her wheelchair. Review of the resident's EMR, from 01/28/25 through 02/25/25, revealed she used a wheelchair for mobility throughout the facility. On 02/24/25 at 11:51 AM, Certified Medication Aide (CMA) S propelled the resident in her wheelchair from her room to the dining room for lunch. The resident wore non-skid socks which skimmed the floor during transport. The wheelchair lacked footrests. On 02/25/25 at 08:27 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from her room to the dining room for lunch. The resident wore non-skid socks which skimmed the floor during transport. The wheelchair lacked footrests. On 02/24/25 at 11:551 AM, CMA S stated the staff did not use footrests on the resident's wheelchair because the resident was able to propel herself for short distances at times and the footrests would prevent her from being able to propel the wheelchair with her feet. On 02/26/25 at 07:21 AM, CNA O stated staff used the footrests on the resident's wheelchair when she felt weak and would not be able to hold her feet up while staff propelled her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 07:41 AM, CNA N stated the resident was able to propel her wheelchair using her feet at times, otherwise staff would propel her wheelchair. Staff did not use footrests for her wheelchair. On 02/26/25 at 09:19 AM, Administrative Nurse D stated it was the expectation for staff to utilize footrests while propelling residents in their wheelchairs. The facility policy for Ambulation Assistance, revised 01/23, included: While propelling a resident in their wheelchair, ensure the footrests are down and the resident's feet are properly placed on the footrests to avoid getting their feet caught under the wheelchair as they are being propelled. The facility failed to provide safe transportation for this dependent resident by failing to utilize footrests while being propelled in her wheelchair. 51334 - The Electronic Health Records (EHR) documented R19 had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment in reality perception), a history of falling, and chronic pain. The 06/20/24 Significant Change Minimum Data Set (MDS) documented R19 had impaired short term and long-term memory and severely impaired decisions making skills. Staff interview documented for that R19 was not understood by others or able to understand others. It documented R19 did not know staff, where her room was, the season, or that she was in a nursing home. Staff interview for mood documented a Total severity score of eight which indicated mild depression. R19 had delusions. She was dependent on staff for wheelchair mobility. She required partial to moderate assistance from staff for toileting, bathing, lower body dressing and footwear. She required supervision or touching assistance for transfers and walking with a walker. R19 had two or more falls from 03/29/24 to 06/20/24. The 06/20/24 Falls Care Area Assessment (CAA) documented R19 was at risk for falling and has a history of falling. All previous fall interventions to remain in place unless otherwise indicated. The 06/20/24 Cognitive Loss / Dementia: CAA documented R19 received hospice services for overall decline in health related to senile degeneration of the brain. The 11/29/24 Quarterly MDS documented R19 had impaired short term and long-term memory and severely impaired decisions making skills regarding tasks of daily life. Staff interview documented for that R19 was not understood by others and not able to understand others. It documented R19 did not know staff, where her room was, the season, or that she was in a nursing home. Staff interview for mood documented a Total severity score of eight which indicated mild depression. R19 had delusions. She was dependent on staff for wheelchair mobility. She required partial to moderate assistance from staff for toileting, bathing, lower body dressing and footwear. She required supervision or touching assistance for transfers and walking with a walker. R19 had two or more noninjury falls and no injury falls between 08/29/24 and 11/29/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan on 02/24/25 documented R19 was at risk for falls related to macular degeneration and dementia. She also had an unsteady gait and at times would walk without her walker. The 02/24/25 Care Plan documented the following fall prevention interventions: Initiated on 06/14/20: Non-slip strips put in front of chair and bed. Initiated on 12/27/20: Ensure R19 had on nonskid socks or appropriate shoes. Initiated on 07/15/21: Provide R19 her walker when she attempts to leave her room without it Initiated on 05/12/24: Staff to assist R19 to put on nonskid socks before bed, and remove boots before sleeping. Initiated on 10/04/24: Fall mat next to bed. Initiated on 10/06/24: Pick floor mat off floor when R19 was not in bed. The 02/24/25 Care Plan lacked mention of a wheelchair R19 used when she had pain or weakness. The Fall Risk Evaluation for R19, documented the following: On 06/03/24 a score of six, which indicated a low risk for falls. On 07/02/24 a score of 12, which indicated a high risk for falls. On 08/30/24 a score of 12, which indicated a high risk for falls. On 12/01/24 a score of 14, which indicated a high risk for falls. Review of the Progress Notes indicated the following: The Nursing Note on 07/30/24 at 08:56 AM, documented an unwitnessed fall. R19 was on the floor in her bathroom without her walker. The IDT Note: Patient at Risk on 07/31/24 at 01:43 PM documented R19 had a non-injury fall on 07/30/24. Resident was found in her bathroom on the floor between the toilet and the wall. Nonskid strips were added to the floor. All previous fall interventions were to remain in place unless otherwise indicated. The Nursing: Skilled Note on 10/04/24 at 02:10 AM documented an unwitnessed fall. R19 was on the floor beside her bed. R19 denied pain with no apparent injuries. The Nursing: Skilled Note on 10/04/24 at 09:50 AM documented an unwitnessed fall. R19 was laying on her left side on the floor facing towards the bathroom with a pool of blood under her head. She complained of pain on the left side of her head and left shoulder. R19 had a laceration approximately one inch long above her left eyebrow. Steri-strips (adhesive wound closures) applied to laceration. R19 was sent to the hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing: Skilled Note on 10/06/24 at 07:16 PM documented an unwitnessed fall. R19 was sitting on the floor in her room on the fall mat. R19 stated she had fallen out of bed. The Progress Note from the provider for date of service 10/09/24 documented bruising around her left eye and face from a fall on 10/04/24. The IDT Note: Patient at Risk on 10/09/24 at 01:18 PM documented R19 had a noninjury fall on 10/04/24. A new fall intervention included a fall mat on the floor next to her bed. R19 had a second fall that night while walking with no assistance. She received a laceration above her left eye and was taken to the emergency room for treatment. R19 again fell on [DATE]. The note documented that the cause of the fall was her tripping over the fall mat getting into bed not falling out of bed as she had stated. The new intervention was to keep the fall mat off the floor unless R19 was in bed. The plan was to report the fall on 10/04/24 and follow the care plan as directed. During an observation on 02/24/25 at 01:37 PM, R19 was climbing out of bed. There was no fall mat in place, and no nonskid strips were on the floor. The surveyor alerted a staff member who assisted R19. During an observation on 02/25/25 at 07:47 AM, R19 was not in her room. Her walker was at her bedside, nonskid strips were not on the floor. R19 was in the dining area in a wheelchair. During an observation on 02/25/25 at 08:49 AM, R19 was in the hallway in her wheelchair, independently and slowly propelling to her room. During an observation on 02/25/25 at 09:22 AM, R19 reported pain to her shoulders. She was in bed, with no nonskid strips by bed or chair, no fall mat, and she had her boots on. During an observation on 02/25/25 at 12:47 PM, Certified Nurse Aide (CNA) P assisted R19 to her room from the dining room. CNA P guided R19 as she walked with a walker and assisted her into bed. CNA P lowered her bed and asked her if she wanted her shoes off, but R19 did not. CNA P assured R19's call light was in reach, washed her hands, and left the room. During an interview on 02/26/25 at 10:29 AM, CNA P revealed that R19 had a wheelchair since she started hospice and sometimes used it if her legs were hurting, or if she was tired. CNA P was unaware if it was in the care plan and stated that the Director of Nursing, Administrative Nurse D, or Administrative Nurse E usually updated the care plan. CNA P stated the fall interventions were the low bed, and she used to have a fall mat, but she was unsure what happened to it. During an interview on 02/26/24 at 10:38 AM, Licensed Nurse (LN) G revealed R19 fell and interventions included nonskid socks and a fall mat. LN G said she was not sure if the fall mat was still in her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 02:12 PM, Administrative Nurse E revealed that she expected the fall interventions for R19 to be used. Administrative Nurse E said R19's room was to have nonskid strips in front of her chair, her bed, and in the bathroom. she said staff were to take her shoes off and put on nonskid socks before bed, and said sometimes she refused taking off her shoes. Administrative Nurse E said R19 had a fall mat but tripped over it, so they removed it, and she discontinued it from the care plan during the interview. Administrative Nurse E revealed R19 sometimes used a wheelchair when she was tired or in pain, and that should have been in the care plan. During an interview on 02/26/24 at 02:31 PM, Administrative Nurse D revealed it is her expectation that the care plans be accurate so the staff will know how to care for the residents and that all interventions be followed to prevent further falls. The facility policy for Comprehensive Care Plans, revised 08/2022, included: The Interdisciplinary Team (IDT) shall be responsible for the periodic review and updating of the resident care plans. The facility failed to ensure care planned fall interventions were in place for R19. This placed the resident at risk for continued falls.

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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. 51334 The facility reported a census of 40 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to failing to clean the vent on the oxygen concentrator for resident (R)30 and R18, and failed to follow enhanced barrier precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) R19 and R30. This deficient practice had the potential to spread possible infections to the residents in the facility. Findings included: - During an observation on 02/24/25 at 10:31 AM, R30 rested in bed with eyes closed. R30's nebulizer was not put away properly, with the face mask and medication barrel still attached. R30's face mask had dried debris on the inside, and it rested on top of the dresser and lacked a cover. During an interview on 02/24/25 at 01:30 PM, R30 stated that he had been to the hospital twice a few months back for pneumonia, but was feeling better now. R30 stated he gets four breathing treatments per day. During an observation on 02/25/25 at 08:23 AM, R30 sat on the side of the bed. The nebulizer face mask remained in the same location on R30's dresser. The oxygen concentrator had a heavy build-up of dust and debris covering the vent on the back of the machine. During an interview on 02/26/24 at 09:19 AM, Administrative Nurse D stated that nebulizers are cleaned with soap and water and put on a paper towel to dry after each use. Administrative Nurse D stated that oxygen concentrators should be cleaned between use of residents, and staff changed and dated the tubing weekly. Administrative Nurse D stated staff cleaned the filters as needed and staff were to ensure there was a bag for storage of the tubing. During an observation on 02/25/25 at 01:20 PM, CNA P and CMA S went into R30's room to empty the urinary catheter. CNA P and CMA S wore gloves, performed proper hand hygiene, but failed to wear the gown required for the EBP for R30. During an interview on 02/25/25 at 01:05 PM, Administrative Nurse D stated she did not know why the pump was on the floor. She would expect it to be hanging on the bed or have some type of barrier rather than rest directly on the floor. During an observation on 02/24/25 at 01:19 PM, R19 was resting in his bed, with pillows to float the right heel. R19 had a pressure ulcer currently. The door to R19's room lacked EBP instructions for staff. During an interview on 02/26/25 at 07:21 AM, CNA O was unsure about EBP. She would have to ask someone about that. (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	During an observation on 02/24/25 at 02:37 PM, R18's oxygen concentrator filter was filled with dust. The distilled water for the oxygen humidifier rested directly on the floor. During an observation on 02/25/25 at 08:17 AM, R18 rested in bed with eyes closed wearing oxygen. Bottle of water for humidifier sat between the foot of the bed and the wall, rested directly on the floor. The filter on the oxygen concentrator was heavily soiled and discolored from dust and debris. During an interview on 02/26/25 at 07:21 AM, CNA O revealed R18 always used oxygen. The nurses were responsible for changing tubing, usually, but sometimes the CNAs did it. During an interview on 02/26/25 at 07:41 AM, CNA N stated R18 used the oxygen at night while in bed. The night nurse was responsible for changing the tubing and cleaning the filters of the concentrator. During an interview on 02/26/25 at 07:41 AM, CNA N stated that EBP was something new the facility was doing. Staff were to put on PPE when going into residents' rooms who have a catheter or a wound. CNA N stated they had not done that, until the day before. During an interview on 02/26/25 at 07:57 AM, CMA R reported staff needed to gown and glove when going into a resident's room who had a wound or a pressure ulcer. CMA R said this was new and they had not always done that. During an interview on 02/26/25 at 07:37 AM, Licensed Nurse (LN) G stated the facility practiced EBP for residents with a catheter or wound care. During an interview on 02/26/25 at 08:04 AM, Administrative Nurse D stated EBP applied to the residents with chronic wounds or an indwelling catheter of some type. They were to wear gowns and gloves to give high contact care. This included toileting, bathing, high contact care. This was not being done before yesterday. During the infection control interview on 02/26/25 at 01:05 PM, Administrative Nurse D confirmed that the facility had not been following the EBP but is now following the policy for all residents that had an open wound or a catheter, etc. Also confirmed that the dirty oxygen filters were an infection control issue and have been changed out. It was her expectation that the catheter bag and tubing would be covered and not dragging on the ground. Administrative Nurse D confirmed that the air bed hose should not have been on the floor. The facility lacked a policy for the care and upkeep of oxygen concentrators. The facility policy for Enhanced Barrier Precautions, revised 03/24, included: The use of gown and gloves for high-contact resident care activities was indicated, when Contact Precautions did not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDROR colonization as well as for residents with MDRO infection or colonization. The facility failed to maintain an effective infection control program related to improper infection control practices which included failed to wear the proper PPE when staff cared for residents on EBP to prevent cross contamination in the facility.