STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175507	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Association	321 N Chestnut Street Lindsborg, KS 67456

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 70 residents. The sample included 18 residents with four reviewed for urinary catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, interview, and record review the facility failed to provide adequate catheter care per standards of practice for Resident (R)36's urinary catheter. This deficient practice placed R36 at risk for urinary tract infections (UTI- an infection in any part of the urinary system) and other catheter-related complications. Findings included: - R36's Electronic Medical Record (EMR) documented diagnoses of bladder-neck obstruction and retention of urine (inability to empty the bladder completely). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R36 was independent with eating and required staff assistance for toileting hygiene and transfers. The MDS documented R36 had a urinary catheter. R36's Care Plan, dated [DATE], documented R36 had a urinary catheter and directed staff to administer antibiotics for a UTI when ordered by the physician, monitor for changes in mood, urine odor or color as well as pain, and general feelings of malaise (vague uneasy feeling of body weakness, distress or discomfort). The plan directed to change the catheter every two weeks and as needed and monitor intake and output per facility policy. Staff was to report to the physician signs and symptoms of a UTI such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns. The plan documented the resident was able to manage his catheter, and staff were to assist and provide support as the resident requested. An intervention dated [DATE] directed staff to provide enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care) for the urinary catheter with colonized proteus mirabilis (bacteria). Staff were to provide a sign on R36's door to alert staff of the need for EBP and update the report sheet with this information. Staff would clean their hands with alcohol sanitizer or wash with soap and water, then don the required personal protective equipment (PPE) before entering the resident's room for high-contact care activities. (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: 175507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Association		STREET ADDRESS, CITY, STATE, ZIP CODE 321 N Chestnut Street Lindsborg, KS 67456	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated [DATE] at 10:12 PM, documented R36 reported he had lower body aches and chills. Staff checked his vital signs and noted an increased temperature and increased blood pressure. The resident reported increased confusion and began talking about a UTI four years prior where he could have died if he waited until morning. The note recorded the nurse recommended that R36 go to the emergency room as he was displaying symptoms of a UTI. His charge nurse immediately called his urologist's on-call number to advise them of the situation and they recommended sending the resident to the emergency room for evaluation. R36's EMR documented an unplanned discharge to an acute hospital on [DATE] and re-admission to the facility on [DATE]. The Progress Note, dated [DATE], recorded staff discussed all R36's lab results with him and discussed that R36 was colonized with bacteria and awaiting the urine culture. The note recorded that R36 stated that unless he was symptomatic, his urologist requested he not be treated with antibiotic therapy. The Physician Order, dated [DATE], directed staff to administer cefuroxime axetil (antibiotic) 500 milligrams (mg), twice daily for seven days for a UTI. R36's Urine Culture Lab, dated [DATE], documented abnormally high values for bacteria and identified proteus mirabilis as the organism. The Progress Note, dated [DATE] at 04:27 PM, R36 reported he had chills and just did not feel right; he asked to have his vital signs taken. His vital signs were within normal limits and he refused further assessment. The note recorded the resident requested a registered nurse (RN) come to see him and at 04:50 PM, an RN assessed R36's vital signs and identified a low-grade temperature with elevated blood pressure and shaking. The note documented R36 reported he had chills for the past ,d+[DATE] minutes and brain fog. The Progress Note, dated [DATE] at 10:55 AM, documented R36 returned to the facility from the hospital with a diagnosis of urosepsis (a condition where a urinary tract infection leads to a systemic infection that spreads throughout the body). The Progress Note, dated [DATE] at 10:55 AM, documented the physician called the facility and stated that R36's cultures grew back and because of his history he will have intravenous (IV-administered directly into the bloodstream via a vein) antibiotics every 12 hours for 10 days. The note directed to keep R36's catheter bag below the suprapubic line (insertion site on the abdomen) to prevent backflow and to not allow R36 to get in a whirlpool tub as this could cause infection. The Urologist Note, dated [DATE], documented R36 had two UTIs over the past few months and staff were to change the catheter every four weeks. The Physician Order, dated [DATE], directed staff to change the suprapubic catheter and replace the drainage bag with each catheter change. The urinal is to be replaced and dated with each catheter change. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 02:50 PM, R36 sat in his recliner in his room and stated his catheter bag was hung on the chair below bladder level. He stated staff emptied the bag usually at 06:00 AM and also around lunchtime. R36 stated he had a UTI in February and April this year and said he was able to tell when he needed to have that checked as he went from UTI to sepsis (systemic infection) very fast. On [DATE] at 01:40 PM, observation revealed R36 sat in his recliner with the catheter drainage bag hung on the inside of the trash can with several used tissues. Certified Nurse Aide (CNA) N washed her hands and gloved but did not don a gown. CNA N then set the urinal canister inside the trash can on top of the used tissues. She held the catheter drainage bag over the canister and emptied it. She wiped the port with a moist wipe and then an alcohol pad. She collected 1400 milliliters of clear yellow urine which she dumped in the toilet. CNA N rinsed the urinal canister with water and stored it in a cabinet. When asked, CNA N stated she had never been told to wear a protective gown while emptying the catheter bag. On [DATE] at 01:52 PM, Administrative Nurse E verified staff were to wear PPE including gowns to provide catheter care and emptying of the catheter bag. She agreed it was not the best practice to set the catheter bag inside a trash can with soiled tissues. On [DATE] at 09:50 AM, Administrative Nurse D verified staff were to wear PPE consisting of a gown and gloves while performing catheter care. The facility's Indwelling Urinary Catheter Care policy, undated, lacked guidance for emptying the drainage bag. The facility failed to provide adequate catheter care for R36's urinary catheter. This placed R36 at risk for further UTI and catheter-related complications.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 12 received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization. This placed the resident at risk for unmet mental healthcare needs and impaired psychosocial well-being. Finding included: - R12's Electronic Medical Record (EMR) included diagnoses of post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness) urinary retention, and cardiac murmur. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. R12 was independent with most functional abilities and mobility. The MDS recorded an active diagnosis of PTSD, depression, and anxiety disorder. R12 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), and diuretic (medication to promote the formation and excretion of urine). The antipsychotic was received on a routine basis only; there was a gradual dose reduction (GDR) on 07/09/24 and no physician documented contraindication for GDR. The Psychotropic Care Area Assessment(CAA), dated 10/24/23, documented R12 received an antipsychotic and antidepressant for diagnoses of major depressive disorder and PTSD. R12 was seen routinely by a mental health practitioner. R12's Care Plan, dated 06/17/24, documented R12 had a mood problem related to a history of depression, PTSD, and generalized anxiety disorder. The care plan directed staff to administer medications as ordered, monitor and document for side effects and effectiveness, and assist the resident, family, and caregivers to identify strengths and positive coping skills, and to reinforce them. The Physician Order, dated 11/22/22, directed staff to administer clonazepam (antianxiety) 0.5 milligrams (mg) in the afternoon and at bedtime for verbal expressions of anxiety, religious doubts, and isolation related to PTSD. The Mental Health Medication Management note, dated 07/19/24, documented R12's PTSD was stable and a chronic condition, and clonazepam doses had not changed. On 08/13/24 at 01:31 PM observation revealed R12 sat in her recliner with her eyes closed. She was dressed and groomed for the day. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 02:58 PM, Certified Nurse Aide (CNA) M reported she was not aware of R12's PTSD diagnosis or was not aware of what R12's triggers were. On 08/13/24 at 04:21 PM, Licensed Nurse (LN) G reported she thought R12 had a diagnosis of PTSD but was not aware of R12's triggers. On 08/14/24 at 09:29 AM Social Service X reported the Trauma Informed Care Assessment had been done by social services staff. Social Service X reported knowledge of R12's PTSD diagnosis, which stemmed from when the resident was young. Social Service X reported R12's Care Plan lacked trauma triggers. On 08/14/24 at 10:26 AM, Administrative Nurse D reported R12's PTSD occurred many years back and the care plan is where that information including triggers for prevention of re-traumatization should be recorded. The facility's undated Standard of Practice for Trauma Informed Care policy, documented the facility would ensure the residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for each resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The facility failed to ensure R12 received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization. This placed the resident at risk for unmet mental healthcare needs.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 70 residents. The sample included 18 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to ensure an approved indication for use or the required physician documentation as well as ongoing monitoring for effectiveness and the ongoing necessity for the use of antipsychotic drugs (class of medications used to treat psychosis and other mental-emotional conditions) and psychotropic (alters mood or thought) drugs for Resident (R)121 and failed to ensure a stop date for as needed (PRN) lorazepam (antianxiety drug) for R41. This deficient practice placed R41 and R121 at risk for unnecessary antipsychotic and psychotropic drugs and related side effects. Findings included: - R121's Electronic Medical Record (EMR) documented diagnoses including vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) without psychosis (any major mental disorder characterized by a gross impairment in reality perception). The Admission Minimum Data Set (MDS) was in process. R121's Care Plan, dated 8/14/24, directed staff to obtain periodic gradual dose reduction (GDR) evaluations by a pharmacist or the physician per Center for Medicare and Medicaid Services (CMS) guidelines. The Physician Order, dated 08/01/24, directed staff to administer quetiapine (antipsychotic) 25 milligrams (mg) at bedtime, and stated the diagnosis was pending. The Physician Order, dated 08/02/24, directed staff to administer sertraline (antidepressant) 50 mg, in the morning, and stated the diagnosis was pending. The Progress Note, dated 08/04/24 at 01:57 AM, documented R121 was slightly upset at being left here. Staff talked with R121 about her being a bus driver and was able to redirect her. The resident asked if she had to stay here forever now. R121 visited with another resident next door and then went to bed for the night. The Social Services Note, dated 08/06/24 at 01:43 PM, documented that R121 was upset at the time and confused as to why she was here and not at the other place. She became a bit angry, demanding answers as to what is going on. She was easily redirectable with assurances provided. She had very limited memory recall and was only oriented to person. She had difficulty tracking the entirety of the conversation. R121 stated that she becomes depressed and angry sometimes and felt lonely often. She had frequent visitors and interacted with other residents often. The Progress Note, dated 08/12/24 at 01:06 PM, documented that staff contacted the physician to report an increase in anxiety and tearfulness and were awaiting a return call. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R121's progress notes and physician notes lacked notation of behaviors other than anxiety and depression. R121's behavior monitoring lacked a specific targeted behavior for the use of quetiapine and sertraline and documented no behaviors observed since admission. On 08/12/24 at 01:31 PM, observation revealed R121 independently ambulated out of her room with a walker and steady steps. R121 wore walking shoes, walked to the small commons area by a side exit, and sat down. She stated she had one fall where she slipped out of bed and had no injury. R121 stated she had been here at the facility for two weeks. On 08/13/24 at 07:58 AM, CMA T administered medications to R121. The CMA asked the resident if she took them whole or crushed and the resident reached out, took the medication cup, and took them whole, all at one time with water to follow. On 08/14/24 at 10:05 AM, Administrative Nurse D verified the physician had not given a diagnosis for the prescription for quetiapine and sertraline. She stated they had trouble getting answers back from her physician. During the interview, Administrative Nurse D received communication from the physician's office of the diagnoses: quetiapine for vascular dementia with psychosis and sertraline for depression. The facility's Psychotropic Medication Monitoring, policy, dated 06/07/2018, stated the facility would use and administer psychotropic medications appropriately to ensure the appropriate use, evaluation, and monitoring. Physician responsibilities included orders for psychotropic medication only for the treatment of specific medical or psychiatric conditions when the medication meets the needs of the resident to alleviate significant distress not met using non-pharmacological approaches. The physician would document the rationale and diagnosis for use and identify target symptoms. The policy stated upon admission of a resident with ordered psychoactive medication and a diagnosis of dementia, the nursing staff would obtain from the physician an approved diagnosis for the antipsychotic medications and a specific behavior for its use. The facility failed to ensure R121 had a CMS-approved indication for the use of quetiapine, or the required physician documentation and failed to monitor for targeted behaviors to determine the effectiveness and ongoing necessity of psychoactive medications. This placed the resident at risk of receiving unnecessary antipsychotic and psychotropic drugs. 27168 - R41's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia (progressive mental disorder characterized by failing memory, and confusion). R41's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R41 had severely impaired cognition. The MDS recorded R41 was dependent for most activities of daily living (ADL) and required extensive staff assistance. The MDS recorded R41 received an antianxiety and antidepressant medication during the observation period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's Care Plan, dated 06/11/24 recorded R41 received the antianxiety medication lorazepam (antianxiety medication) per physician order. The care plan documented the staff would monitor, document, and report as needed any adverse side effects to the medication such as drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion, impaired thinking and judgment, memory loss, forgetfulness, nausea, slurred speech, and double vision. The Physician's Order, dated 06/22/24, directed the staff to administer lorazepam oral concentrate 1 milligram (mg)/milliliter (ml), Give 1.0 ml every two hours as needed for anxiety. The order lacked a stop date. R41's EMR lacked evidence of s specified duration which included a physician's rationale for the extended use. R41's Consultant Pharmacist monthly review completed on 07/17/24 documented that the pharmacist identified the PRN lorazepam with no stop date. The recommendation lacked a response. On 08/12/24 at 01:45 PM, observation revealed R41 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) in the living room area on the [NAME] Hall dressed in street clothes. R41's eyes were closed, and the resident held a stuffed dog. Continued observation revealed Certified Medication Aide (CMA) R administered the resident's morning medications. On 08/14/24 at 08:40 AM, Administrative Nurse D verified the resident received lorazepam PRN that lacked a stop date. The facility's Use of Psychotropic Drug Use policy, undated, documented the facility would make every effort to comply with State and Federal regulations related to the use of psychopharmacological medications in the facility to include regular review for continued need, appropriate dosage, side effects, risk and/or benefits. The facility supports the appropriate use of psychopharmacological medications that are therapeutic and enabling for residents suffering from mental illness while recognizing that the use of psychopharmacological medications for dementia-related behaviors is inappropriate in most cases but rather the use of non-pharmacological interventions based on individual resident needs, preferences and routines is the most appropriate and first-line treatment for dementia-related behaviors. The facility failed to ensure R41's lorazepam had a 14-day stop date or specified duration placing R41 at risk for adverse side effects.

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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** 27168 The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella) and other waterborne pathogens. The facility further failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing high-contact care to Resident (R) 36. This placed the residents in the facility at risk for infectious disease. Findings Included: - On 08/13/24 at 03:00 PM, Maintenance Staff U verified he was not aware of any routine facility water management checks and verified the facility had some rooms presently unoccupied. Maintenance Staff U stated staff do not flush water in the unoccupied rooms. On 08/14/24 at 08:00 AM, Administrative Nurse D verified the facility lacked a system to check regarding standing water and potential growth inside the facility and lacked a system to mitigate the risk of Legionella. The facility's Legionella Water Management Procedure policy, dated 05/01/24, documented the purpose of the policy was to ensure as far as possible, all users of the facility are protected from the incidence of Legionnaire's disease. The Director of Environmental Services is responsible for all relevant details regarding roles and responsibilities and testing regimens contained in the policy and procedure. It is the policy of the facility to ensure that appropriate precautions for the control of Legionella bacteria are identified through the Legionella risk assessment process and appropriate control measures implemented to ensure, so far as is reasonably practicable, the health, safety, and welfare of residents, visitors, staff members, and volunteers. The minimum standards to be met included but not limited to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Carrying out suitable and sufficient Legionella assessments. Description of building water systems. Identification of areas where Legionella could grow and spread. Preparation of an action plan or written scheme for preventing or controlling the risk, where appropriate. (Inclusion in the plan of any area where medical procedures may expose residents to water mists including hydrotherapy and respiratory therapy services) Implementation. Management monitoring and recording of precautions to include regular inspection, microbiological monitoring, temperature checks, and flushing where appropriate. Plans to intervene when control limits are not met. Continuous monitoring of program compliance. Documentation of all monitoring. Seeking suitable advice and assistance from competent persons and Specialist consultants, where appropriate. Appointment of a person or persons to be managerially responsible for the water system at each premise. To otherwise meet the requirements of CMS Center for Clinical Standards and Quality/Survey and Certification Group, Survey and Certification letter 17-30, dated 02/2017 related to the requirement to reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease. The facility has established and maintained, an infection prevention and control group designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy further documented the requirements will be met by the following: inspection of water storage tanks, water would be measured at 86 degrees or below after two minutes of running, and hot water storage or distribution would be measured at 122 degrees at outlets after one minute of running. All cases of Legionella would be reported to the local health department and the State health departments. The facility failed to implement a water management program to test and manage waterborne pathogens placing the residents who resided in the facility at risk of contracting Legionella disease. 26768 - R36's Electronic Medical Record (EMR) documented diagnoses of bladder-neck obstruction and retention of urine (inability to empty the bladder completely). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R36 was independent with eating and required staff assistance for toileting hygiene and transfers. The MDS documented R36 had a urinary catheter. (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 - Many	R36's Care Plan, dated 05/30/24, documented R36 had a urinary catheter and directed staff to administer antibiotics for a UTI when ordered by the physician, monitor for changes in mood, urine odor or color as well as pain, and general feelings of malaise (vague uneasy feeling of body weakness, distress or discomfort). The plan directed to change the catheter every two weeks and as needed and monitor intake and output per facility policy. Staff was to report to the physician signs and symptoms of a UTI such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns. The plan documented the resident was able to manage his catheter, and staff were to assist and provide support as the resident requested. An intervention dated 03/28/24 directed staff to provide enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care) for the urinary catheter with colonized proteus mirabilis (bacteria). Staff were to provide a sign on R36's door to alert staff of the need for EBP and update the report sheet with this information. Staff would clean their hands with alcohol sanitizer or wash with soap and water, then don the required personal protective equipment (PPE) before entering the resident's room for high-contact care activities. On 08/13/24 at 01:40 PM, observation revealed R36 sat in his recliner with the catheter drainage bag hung on the inside of the trash can with several used tissues. Certified Nurse Aide (CNA) N washed her hands and gloved but did not don a gown. CNA N then set the urinal canister inside the trash can on top of the used tissues. She held the catheter drainage bag over the canister and emptied it. She wiped the port with a moist wipe and then an alcohol pad. She collected 1400 milliliters of clear yellow urine which she dumped in the toilet. CNA N rinsed the urinal canister with water and stored it in a cabinet. When asked, CNA N stated she had never been told to wear a protective gown while emptying the catheter bag. On 08/13/24 at 01:52 PM, Administrative Nurse E verified staff were to wear PPE including gowns to provide catheter care and emptying of the catheter bag. She agreed it was not best practice to set the catheter bag inside a trash can with soiled tissues. On 08/14/24 at 09:50 AM, Administrative Nurse D verified staff were to wear PPE of gown and gloves while performing catheter cares. The facility's Enhance Barrier Precautions policy, undated, stated EBP would be implemented in addition to standard precautions when standard precautions do not prevent pathogen (any organism or agent that can produce disease) transmission. Clear signage would be placed on the door outside the resident room as well as inside the resident's room to identify the type of precautions and PPE to be used: gown and gloves during high contact care. The Infection Prevention Nurse would update the care plan, educate facility workers, resident, their representative, and their visitors PPE use and disposal. The facility failed to provide adequate infection prevention during care for R36's urinary catheter. This placed R36 at risk for infection.