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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225659 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/10/2024 |
| NAME OF PROVIDER OR SUPPLIER Elmhurst Healthcare (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE 743 Main Street Melrose, MA 02176 | |

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) |
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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>48990</p> <p>Based on observations, interviews, policy review, and record review the facility failed to promote and facilitate resident self-determination through support of resident choice for one Resident (#18) out of 12 total sampled residents. Specifically, the facility failed to allow Resident #18 to use a urinary catheter drainage bag instead of a urinary catheter leg bag.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Resident Rights', revised 1/2024, indicated:</p> <ul style="list-style-type: none"> - Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to self-determination. <p>Resident #18 was admitted to the facility in June 2024 with diagnoses including multiple fractures of pelvis.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 6/18/24, indicated Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #18 required an indwelling urinary catheter.</p> <p>Review of Resident #18's plan of care related to his/her suprapubic catheter, revised 7/9/24, indicated:</p> <ul style="list-style-type: none"> - Resident prefers to utilize drainage bag not leg bag. <p>The surveyor made the following observations:</p> <ul style="list-style-type: none"> - On 7/9/24 at 12:22 P.M., Resident #18 was laying in bed wearing a urinary catheter leg bag half filled with clear yellow urine. - On 7/9/24 at 1:50 P.M., Resident #18 was laying in bed wearing a urinary catheter leg bag half filled with clear yellow urine. <p>(continued on next page)</p> |

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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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- On 7/10/24 at 7:15 A.M., Resident #18 was laying in bed wearing a urinary catheter leg bag that was completely filled with clear yellow urine, and the urine continued to fill entire length of visible tubing. Resident #18 said he/she does not like this leg bag and wanted to have a larger urinary catheter drainage bag that hangs from the side of the bed, but staff told him/her he could not have one because department of public health surveyors were in the building. Resident #18 said he/she really doesn't like wearing a leg bag because it fills up to quickly and it's not comfortable.</p> <p>During an interview on 7/10/24 at 7:18 A.M., Certified Nurse Assistant (CNA) #1 said she was assigned Resident #18 during the 11:00 P.M. to 7:00 A.M. shift that night. CNA #1 said Resident #18 should not have a urinary catheter leg bag when in bed, but that the larger urinary catheter drainage bags that hang from the side of the bed were locked in the storage room that only the nurses have access to, so she expected the nurse would change it.</p> <p>During an interview on 7/10/24 at 7:25 A.M., Nurse #1 said he was assigned Resident #18 during the 11:00 P.M. to 7:00 A.M. shift that night. Nurse #1 said he assumed the 3:00 P.M. to 11:00 P.M. nurse had changed the leg bag to a side hanging drainage bag, but never checked. Nurse #1 said if Resident #18 did not want to wear a leg bag, he should have been allowed to use a urinary drainage bag that hangs from the side of the bed. Nurse #1 then asked Resident #18 if he/she wanted a urinary catheter drainage bag that hangs from the side of the bed and he/she said yes, so he changed it to as requested by Resident #18.</p> <p>During an interview on 7/10/24 at 9:30 A.M., the Administrator said she knew staff had previously been aware that Resident #18 did not want to wear a leg bag and that he/she wanted to use a side hanging urinary catheter drainage bag because they had recently inserviced the staff on this. The Administrator said this was part of Resident #18's care plan and staff should not have made him/her wear a urinary catheter leg bag since he/she did not want to wear one.</p> <p>During an interview on 7/10/24 at 10:07 A.M., the Director of Nursing (DON) said if Resident #18 did not want to wear a urinary catheter leg bag he/she should have been provided a urinary drainage bag that hangs from the side of the bed.</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>48990</p> <p>Based on observations, interviews, policy review, and record review, the facility failed maintain professional standards in the managing and caring for urinary catheter devices for one Resident (#18), out of a total sample of 12 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was maintained below level of bladder, failed to ensure the urinary catheter drainage bag was not placed directly touching the floor, and failed to ensure urinary catheter care was provided every shift as ordered by the physician.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Foley Catheter Insertion, Male Resident', revised 12/2020, indicated:</p> <ul style="list-style-type: none"> - Secure the drainage bag below the level of resident's bladder and off the floor. <p>Resident #18 was admitted to the facility in June 2024 with diagnoses including multiple fractures of pelvis.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 6/18/24, indicated Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #18 required an indwelling urinary catheter.</p> <p>Review of Resident #18's active physician's orders indicated the following orders:</p> <ul style="list-style-type: none"> - Supra Pubic Care [sic], every shift, initiated 6/12/24. - Supra Pubic [sic] 16R [sic] (french scale)/10 ML (milliliters) continuous to drainage bag, initiated 6/12/24. <p>Review of Resident #18's plan of care related to his/her suprapubic catheter, revised 7/9/24, indicated:</p> <ul style="list-style-type: none"> - Keep drainage bag below level of bladder. - Provide catheter care per policy. - Resident prefers to utilize drainage bag not leg bag. <p>On 7/9/24 at 7:57 A.M., the surveyor observed Resident #18 in bed with a urinary catheter drainage bag hanging from the side of the bed and directly touching the floor without a barrier.</p> <p>The surveyor made the following additional observations:</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- On 7/9/24 at 12:22 P.M., Resident #18 was laying in bed wearing a urinary catheter leg bag on his/her right thigh near the knee, which was half filled with clear yellow urine. The Resident's legs were elevated, placing the urinary catheter leg bag above the level of the bladder.</p> <p>- 07/09/24 at 1:50 P.M., Resident #18 was laying in bed wearing a urinary catheter leg bag on his/her right thigh near the knee, which was half filled with clear yellow urine. The Resident's legs were elevated, placing the urinary catheter leg bag above the level of the bladder.</p> <p>- On 7/10/24 at 7:15 A.M., Resident #18 was laying in bed wearing a urinary catheter leg bag on his/her right thigh near the knee, which was completely filled with clear yellow urine and the urine continued to fill entire length of visible tubing. The Resident's legs were elevated, placing the urinary catheter leg bag above the level of the bladder. Resident #18 said he/she does not like this leg bag and wanted to have a larger urinary catheter drainage bag that hangs from the side of the bed, but staff told him/her he could not have one because department of public health surveyors were in the building. Resident #18 said the urinary catheter leg bag fills up too quickly and that staff had not emptied it since he/she went to bed last night.</p> <p>During an interview on 7/10/24 at 7:18 A.M., Certified Nurse Assistant (CNA) #1 said she was assigned Resident #18 during the 11:00 P.M. to 7:00 A.M. shift that night. CNA #1 said Resident #18 should not have a urinary catheter leg bag when in bed, but that the larger urinary catheter drainage bags that hang from the side of the bed were locked in the storage room that only the nurses have access to, so she expected the nurse would change it. CNA #1 said she did not empty the urinary catheter leg bag during the 11:00 P.M. to 7:00 A.M. shift. CNA #1 said urinary drainage bags should never be directly touching the floor.</p> <p>During an interview on 7/10/24 at 7:25 A.M., Nurse #1 said he was assigned Resident #18 during the 11:00 P.M. to 7:00 A.M. shift that night. Nurse #1 said Resident #18 should not have a urinary catheter leg bag when in bed because the drainage bag should be below the level of the bladder. Nurse #1 said Resident #18 should only wear a urinary catheter leg bag when he/she is in common areas for privacy. Nurse #1 said he did not visualize or empty the urinary catheter drainage bag during his shift because Resident #18 is learning to manage the catheter him/herself in anticipation of discharge, but he should have checked to ensure it was completed. Nurse #1 said he assumed the 3:00 P.M. to 11:00 P.M. nurse had changed the leg bag to side hanging drainage bag, but never checked. Nurse #1 then asked Resident #18 if he/she wanted to urinary catheter drainage bag that hangs from the side of the bed and he/she said yes, so he changed it to as requested by Resident #18.</p> <p>During an interview on 7/10/24 at 10:07 A.M., the Director of Nursing (DON) said Resident #18 should not use a urinary catheter leg bag when in bed because it should be below bladder level. The DON said urinary catheter drainage bags should not be directly touching the floor.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41456</p> <p>Based on record review and interviews, the facility failed to maintain accurate medical records by ensuring ADL (Activities of Daily Living) documentation was completed on every shift for three Residents (#275, #225 and #226) out of a total sample of 12 residents.</p> <p>Findings include:</p> <p>1.) Resident #275 was admitted to the facility in July 2024 with diagnoses including vertigo.</p> <p>Review of Resident #275's medical record indicated the following documentation was not completed for the month of July.</p> <ul style="list-style-type: none"> - 7 out of 16 shifts failed to document the dressing, bathing and additional fluids documentation sections. - 17 out of 26 shifts failed to document the bed mobility, behavior monitoring, bladder and bowel continence, locomotion on unit, preventative skin care, skin observation, toilet use, transferring, walk in corridor, walk in room and wheelchair mobility documentation sections. - 8 out of 9 shifts failed to document the evening snack documentation section. - 8 out of 17 shifts failed to document the locomotion off unit documentation section. - 9 out of 26 shifts failed to document the amount eaten documentation section. - 8 out of 26 shifts failed to document the eating documentation section. - 53 out of 88 opportunities to document were left blank in the turn and positioning documentation section. <p>During an interview on 7/10/24 at 11:34 A.M., the Nursing Supervisor said the expectation is that staff documents all care provided on all shifts prior to leaving the building for the day. The Nursing Supervisor said incomplete documentation has been an ongoing issue at the facility.</p> <p>During an interview on 7/10/24 at 8:43 A.M., the Administrator said the Nursing Assistants are expected to document all care provided on all shifts. The Administrator said missing documentation has been an ongoing problem at the facility.</p> <p>2.) Resident #225 was admitted to the facility in July 2024 with diagnoses including end stage renal disease.</p> <p>Review of Resident #225's medical record indicated the following documentation was not completed for the month of July:</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- 2 out of 2 night shifts failed to document the bed mobility, behavior monitoring, bladder or bowel continence, locomotion on unit, preventative skin care, toilet use, skin observation, transferring, walk in corridor, walk in room or wheelchair mobility documentation sections.</p> <p>During an interview on 7/10/24 at 11:34 A.M., the Nursing Supervisor said the expectation is that staff documents all care provided on all shifts prior to leaving the building for the day. The Nursing Supervisor said incomplete documentation has been an ongoing issue at the facility.</p> <p>During an interview on 7/10/24 at 8:43 A.M., the Administrator said the Nursing Assistants are expected to document all care provided on all shifts. The Administrator said missing documentation has been an ongoing problem at the facility.</p> <p>3.) Resident #226 was admitted to the facility in July 2024 with diagnoses including bladder cancer.</p> <p>Review of Resident #226's medical record indicated the following documentation was not completed for the month of July:</p> <p>- 4 out of 13 shifts failed to document the bathing, dressing, locomotion off unit, personal hygiene and additional fluids documentation sections.</p> <p>- 1 out of 7 shifts failed to document the evening snack documentation section.</p> <p>- 11 out of 20 shifts failed to document the bed mobility, locomotion on unit, behavior monitoring, bladder and bowel continence, preventative skin care, skin observation, toilet use, transferring, walk in corridor, walk in room and wheelchair mobility sections.</p> <p>- 38 out of 68 opportunities to document were left blank in the turn and positioning documentation section</p> <p>During an interview on 7/10/24 at 11:34 A.M., the Nursing Supervisor said the expectation is that staff documents all care provided on all shifts prior to leaving the building for the day. The Nursing Supervisor said incomplete documentation has been an ongoing issue at the facility.</p> <p>During an interview on 7/10/24 at 8:43 A.M., the Administrator said the Nursing Assistants are expected to document all care provided on all shifts. The Administrator said missing documentation has been an ongoing problem at the facility.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>48990</p> <p>Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1.) Ensure healthcare personnel remove gloves and perform hand hygiene before leaving a resident room. 2.) Ensure healthcare personnel appropriately don (put on) a precaution gown while caring for a Resident on enhanced barrier precautions (EBP). <p>Findings include:</p> <p>Review of United States Centers for Disease Control and Prevention's (CDC) guidance titled 'Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs)', updated July 12, 2022, indicated:</p> <ul style="list-style-type: none"> - Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. - Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: device care or use of urinary catheter. <p>Review of the facility policy titled 'Handwashing/Hand Hygiene', revised 11/2020, indicated:</p> <ol style="list-style-type: none"> 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: <ol style="list-style-type: none"> m. After removing gloves. <ol style="list-style-type: none"> 1.) On 7/9/24 at 7:01 A.M., the surveyor observed Certified Nurse Assistant (CNA) #2 wearing a glove on her left hand at the bedside of a resident room. CNA #2 exited the resident room, without removing the glove or performing hand hygiene, and entered another resident room still wearing the glove on her left hand and continued to assist the other resident in bed. The Assistant Director of Nursing (ADON) then intervened and told CNA #2 she had to remove the glove and sanitize her hands. <p>During an interview on 7/10/24 at 11:33 A.M., the ADON said she had asked CNA #2 to remove the glove and wash her hands when she noticed CNA #2 had left a resident's room without removing her glove or performing hand hygiene. The ADON said staff should remove gloves and perform hand hygiene before leaving a resident's room and should never care for more than one resident wearing the same glove.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 7/10/24 at 7:21 A.M., the surveyor observed CNA #1 at the bedside of a resident room wearing gloves. CNA #1 exited the resident room, without removing the gloves or performing hand hygiene, and walked down the hall to get a new trash bag out of a cabinet. CNA #1 used her gloved hands to open and close the cabinet. CNA #1 then re-entered the resident room and resumed providing urinary catheter care without changing gloves or performing hand hygiene. At 7:25 A.M., CNA #1 exited the room again holding a filled trash bag with her gloved hands and walked down the hall. CNA #1 had not removed or changed gloves and did not perform hand hygiene upon exit of the resident room.</p> <p>During an interview on 7/10/24 at 7:37 A.M., CNA #1 said she had been emptying a resident's urinary catheter bag during the surveyors observation. CNA #1 declined to answer the surveyors questions regarding glove use in the hallway. CNA #1 said she was supposed to wash her hands when leaving a resident room after providing care.</p> <p>During an interview on 7/10/24 at 7:40 A.M., Nurse #1 said staff is not supposed to wear gloves in the hallway and that hand hygiene should be performed before leaving a resident's room after providing care.</p> <p>During an interview on 7/10/24 at 9:30 A.M., the Administrator said staff need to remove gloves and clean hands before leaving a resident's room. The Administrator said staff should never provide care for more than one resident wearing the same gloves.</p> <p>During an interview on 7/10/24 at 10:07 A.M., the Director of Nursing (DON) said staff need to remove gloves and clean hands before leaving a resident's room. The Administrator said staff should never provide care for more than one resident wearing the same gloves.</p> <p>2.) On 7/10/24 at 7:21 A.M., the surveyor observed CNA #1 emptying a urinary catheter drainage bag. CNA #1 was wearing gloves, but was not wearing a precaution gown. There was a sign posted at the doorway that indicated the Resident was on enhanced barrier precautions (EBP) and that everyone must wear gloves and gown for high-contact resident care activities including device care or use of urinary catheter.</p> <p>During an interview on 7/10/24 at 7:37 A.M., CNA #1 said a precaution gown and gloves must be worn when emptying a urinary catheter drainage bag of a Resident on EBP.</p> <p>During an interview on 7/10/24 at 7:40 A.M., Nurse #1 said a precaution gown, in addition to gloves, must be worn when emptying a urinary catheter drainage bag of a Resident on EBP.</p> <p>During an interview on 7/10/24 at 9:30 A.M., the Administrator said the facility does not have a policy on Enhanced Barrier Precautions, but that the facility follows the CDC guidance on Enhanced Barrier Precautions.</p> <p>During an interview on 7/10/24 at 10:07 A.M., the Director of Nursing (DON) said CNA #1 should have worn a precaution gown, in addition to gloves, when emptying a urinary catheter drainage bag of a Resident on EBP.</p> | | |