

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Thornapple Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Nashville Rd Hastings, MI 49058	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221</p> <p>Based on observation, interview, and record review, the facility failed to implement care plan interventions to prevent falls in 1 of 28 residents (Resident #114) reviewed for comprehensive care plans, resulting in the potential for falls and injury.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #114 was a male, with pertinent diagnoses which included dementia, heart failure, diabetes, and high blood pressure.</p> <p>Review of a Fall Risk Assessment for Resident #114, dated 1/21/25, revealed he was at High Risk for falls.</p> <p>Review of a current Care Plan for Resident #114 revealed the focus .I AM AT RISK FOR FALLS R/T (related to) A HIGH FALL RISK ASSESSMENT SCORE AND fell ATTEMPTING TO TRANSFER OUT OF THE RECLINER WITH THE FOOTREST ELEVATED . with interventions which included .NON-SKID STRIPS IN FRONT OF RECLINER . both revised 1/24/25.</p> <p>In an observation on 3/17/25 at 11:59 AM, Resident #114 was in his recliner in his room. Noted non-skid strips on the floor under the recliner, sticking out along the left side (not in front of the recliner).</p> <p>In an observation on 3/17/25 at 4:25 PM, Resident #114 was in his recliner in his room with the footrest elevated. Noted non-skid strips on the floor under the recliner, sticking out along the left side (not in front of the recliner).</p> <p>In an observation on 3/18/25 at 4:03 PM, Resident #114 was in his recliner in his room with the footrest elevated, apparently asleep with his eyes closed. Noted non-skid strips on the floor under the recliner, sticking out along the left side (not in front of the recliner).</p> <p>In an observation on 3/19/25 at 8:50 AM, Resident #114 was not present in his room. Observed Resident #114's recliner and noted non-skid strips on the floor under the recliner, sticking out along the left side (not in front of the recliner).</p> <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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/19/25 at 1:13 PM, Registered Nurse (RN) JJ reported Resident #114 was independent with transfers and ambulation, but did have a history of falls. RN JJ reported the non-skid strips to the floor in front of Resident #114's recliner were added as an intervention after a fall to provide additional traction when transferring out of the recliner. RN JJ reported the non-skid strips should be positioned in front of the recliner.</p> <p>In an observation on 3/19/25 at 1:21 PM, Resident #114 was in his recliner in his room with the footrest elevated, visiting with family. Noted non-skid strips on the floor under the recliner, sticking out along the left side (not in front of the recliner).</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.19.1, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, dated October 2024, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care .</p> <p>According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures .The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate and adequate oxygen management and tubing care for 3 of 3 residents (R19, R53, and R117) reviewed for respiratory and oxygen care, resulting in the potential of a vulnerable population being at risk for infection and harm.</p> <p>Findings include:</p> <p>R19</p> <p>According to R19's Minimum Data Set (MDS) dated [DATE], the resident had a diagnosis of debilitating cardiorespiratory conditions and received oxygen therapy.</p> <p>Review of R19's Diagnoses dated 4/1/24, revealed, Dependence on supplemental oxygen.</p> <p>Review of R19's Order Summary dated 3/28/225 revealed, Continuance oxygen at 2L/Min (liters per minute) via Nasal cannula (NC).</p> <p>Review of R19's Medication/Treatment Administration dated 3/1/25-3/31/25 indicated the resident received 2L/MIN via nasal cannula on day and night shifts from 3/1/25 throughout the survey, 3/19/25.</p> <p>Review of R19's eMAR (electronic chart) Kardex (CNA (certified nursing assistant) guide to resident-specific cares) dated, as of 2/13/25 revealed, O2 (oxygen) w/ (with) Liter Flow-Oxygen continuous oxygen at 2L/MIN via nasal cannula.</p> <p>During an observation and interview on 3/17/25 at 10:49 AM, R19 was being transferred from toilet to wheelchair by Certified Nursing Assistant (CNA) U who asked resident if she wanted to be put on her room oxygen concentrator. A portable tank was on the back of resident's wheelchair with tubing not labeled. R19's room oxygen concentrator was set at 2 lpm (liters per minute) with tubing dated 3/3/25. R19 stated, I wear oxygen 24/7 and I feel dry, and my nose runs.</p> <p>During an interview on 3/18/25 at 8:15 AM, Licensed Practical Nurse (LPN) EE stated, Usually day-shift nurses and CNAs check oxygen tubing to make sure it has been dated within the week for infection control purposes.</p> <p>During an observation on 3/18/25 at 10:51 AM, R19's room oxygen concentrator tubing dated 3/3/25.</p> <p>During an observation and interview on 3/18/25 at 10:56 AM, R19 was in the common area wearing her portable oxygen via a nasal cannula. The portable tank indicated the tank was empty with the arrow pointing in the red. The tubing was not labeled. The tank had a label card indicating it belonged to R19, with a start date of 3/17/25, at a liter flow of 2 lpm (liters per minute). R19 stated, I wear oxygen all the time. If I don't wear it I get out of breath. The resident was audibly wheezing slightly.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 3/18/25 at 11:02 AM, CNA DD stated, Agency CNA staff got (R19) up into her wheelchair this morning. All nursing staff are responsible for checking on oxygen levels in the portable tanks. It takes a badge to go out the doors and into the oxygen storage areas. Agency does not have a badge to get into the oxygen storage areas. CNA DD replaced R19's portable tank with a full one and continued using the unlabeled tubing. CNA reported night shift replaces the oxygen tubing.</p> <p>During an interview on 3/18/25 at 2:15 PM, CNA W stated, I am here through a staffing agency. I have a badge, but I am not sure if it gets me into the oxygen storage. If a resident needs a new oxygen tank, I have to inform another CNA or nurse and they would tell me to go get a tank or they would go get one. I got (R19) ready this morning by looking at her Kardex in her closet. It said to put on her portable oxygen at 2 liters so that is what I did.</p> <p>Review of CNA W Agency Certified Nursing Orientation Checklist dated 12/6/24 indicated was oriented to Oxygen Room/Humidifier Bottles.</p> <p>During an interview on 3/18/25 at 2:25 PM, CNA V stated, I am here through a staffing agency. I have a badge, but I've never tried in 5 months I've been here to use it to get into the oxygen storage area. Usually, a facility CNA will go get portable oxygen tanks if they are needed.</p> <p>Review of CNA V Agency Certified Nursing Orientation Checklist dated 2/7/25 indicated was oriented to Oxygen Room/Humidifier Bottles.</p> <p>Observed on 3/18/25 at 2:30 PM R19's Kardex in her closet indicated the resident was to wear oxygen at 2 lpm. The resident was napping in a recliner wearing oxygen running from the concentrator via a nasal cannula that was dated 3/3/25 2L.</p> <p>R46</p> <p>According to R46's Minimum Data Set (MDS) dated [DATE], the resident scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status) with diagnoses that included debilitating cardiorespiratory conditions that required oxygen therapy.</p> <p>Review of R46's Diagnoses included chronic obstructive pulmonary disease, unspecified (COPD), dependence on supplemental oxygen, chronic respiratory failure with hypoxia (low level of oxygen in body tissues)</p> <p>Review of R46's Order Summary dated 5/14/2021, revealed, O2 2 to 4 liters NC continuous with Humidifier for SOB (shortness of breath)</p> <p>Review of R46's Medication/Treatment Administration Record (MAR/TAR) March 2025 revealed no orders for oxygen use.</p> <p>Review of R46's Care Plan dated 1/13/2025, LTC (long term care) due to a previous left hip fracture with repair and CHF (congestive heart failure) with goals of showing no declines with ADLs (activities of daily living) AEB (as evidenced by) no significant changes, and using interventions that included O2 liter flow-2 to 4 liters O2 via nasal cannula/humidifier continuously.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R46's Kardex as of 3/18/25 revealed, O2 liter flow - 2 TO 4 liters O2 via nasal cannula/humidifier continuously.</p> <p>During an observation on 3/17/25 at 9:20 AM, R46 was wearing oxygen via a portable oxygen tank with tubing that was not labeled. The oxygen concentrator that was next to the resident's bed had tubing that was not labeled with a humidifier bottle that was dated 2/25/25.</p> <p>During an observation and interview on 3/18/25 11:13 AM, R46 was in her room sitting in her wheelchair wearing oxygen connected to a portable oxygen tank via tubing. The portable oxygen tank was empty as indicated by the pressure gauge with the arrow in the red. CNA Z stated, I put (R46) in the wheelchair this morning and looked at her oxygen tank (portable). Now, I see It is empty. I changed the tank at 7:30-8:00 am this morning. She should be put on the concentrator when she is in her room. I don't know who last looked in on her. CNA Z left the room to get another portable oxygen tank and a pulse oximeter (measures oxygen in body) R46 stated, I feel like heck. I am tired out. The resident then self-ambulated out of her room and headed to the dining room. She was breathing with audible gasps.</p> <p>During an observation and interview on 3/18/25 at 11:21 AM, CNA 'Z brought a portable tank to R46 in the hall outside of the resident's room and checked her pulse ox. During this time, Registered Nurse (RN) LL came to R46's side and stated, The oxygen tubing is dated 3/11/25) and R46 is on between 2 to 4 liters per minute depending on what the resident wants and needs. CNA Z then assisted R46 into her room where she placed a new portable oxygen tank to R46's wheelchair and read the pulse ox to be 95%. After reading the pulse ox, CNA Z connected R46 to the portable oxygen via a nasal cannula and set the flow rate to 3 lpm per R46 request. R46 stated to CNA Z and surveyor, I'm sleepy then self-ambulated to the dining room where breakfast was being served.</p> <p>Observed in R46's closet a resident-specific Kardex that indicated O2 liter flow 2 to 4 liters O2 via nasal cannula/humidifier continuously.</p> <p>During an interview on 3/19/25 at 11:28 AM, Infection Control Preventionist (IPC) MM and Director of Nursing (DON) B stated, Oxygen tubing should be changed out every Tuesday night by night shift. Humidifiers should also be changed out with tubing weekly. Our policy reflects this.</p> <p>36221</p> <p>Resident #117</p> <p>Review of an Admission Record revealed Resident #117 was a male, with pertinent diagnoses which included heart disease, high blood pressure, and cancer.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #117, with a reference date of 1/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated he was cognitively intact.</p> <p>Review of an Order Summary Report for Resident #117 revealed the active physician order .Oxygen 2 Liters NC (nasal cannula) prn (as needed) for SOB (shortness of breath) as needed . with a start date of 7/15/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 3/17/25 at 2:44 PM, Resident #117 was in bed in his room. Observed an oxygen concentrator along the wall beside his bed, not in use. Observed the oxygen tubing (nasal cannula) laying directly on the floor, not stored in a plastic bag. No date noted on the oxygen tubing to indicate when it was last changed.</p> <p>In an observation and interview on 3/18/25 at 3:56 PM, Resident #117 was in bed in his room. Observed an oxygen concentrator along the wall beside his bed, not in use. Observed the oxygen tubing (nasal cannula) laying directly on the floor, not stored in a plastic bag. No date noted on the oxygen tubing to indicate when it was last changed. Resident #117 reported he has not required supplemental oxygen for several weeks, and stated .they kept it (the oxygen concentrator and tubing) there in case I needed it .</p> <p>In an interview on 3/19/25 at 1:19 PM, Registered Nurse (RN) JJ reported oxygen tubing should be changed weekly.</p> <p>Review of the policy/procedure Oxygen Use & Storage, revision date 12/2024, revealed .Policy: To provide oxygen therapy in a safe and clean method per each resident's individual need .Gather, label, date, and change, equipment i.e. concentrator, oxygen tank, nasal cannula, or mask, and if needed extension tubing for the resident .Nursing Assistants are expected to check the oxygen flow liter and poundage gauge whenever they are providing care to the resident .Change cannula, mask, plastic bags, and if present the humidifier bottle weekly on midnight shift according to schedule. Nursing Assistant's will label tubing with a sticker, which indicates liter flow rate ordered, date opened, and their initials .Oxygen tubing cannulas and/or masks are to be stored in the plastic bags when residents are not using the equipment .</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1.) implementation of Enhanced Barrier Precautions (EBP) per standards of practices for 1 of 6 residents (R53) all reviewed for infection control, and 2.) adequate handling of soiled linen, resulting in the potential for cross-contamination, harborage of bacteria, and increased infections in a vulnerable population.</p> <p>Findings include:</p> <p>According to R53's Minimum Data Set (MDS) dated [DATE], the resident had diagnoses that included non-traumatic brain dysfunction requiring her to be dependent for all cares including toileting and unhealed stage 3 and stage 4 pressure ulcers.</p> <p>During an observation and interview on 3/17/25 at 10:23 AM, R53 was in bed being prepared for a brief change by two Certified Nursing Assistants (CNA) BB and TT Inside the resident's room on the wall next to the door was CDC (Centers for Disease Control) signage indicating the resident was on Enhanced Barrier Precautions with gown and gloves to be worn with direct cares. CNA BB stated, (R53) has one wound on her coccyx that is deep. She also has a small wound on her ankle. CNA TT stated, I am an agency CNA. Both CNAs donned gloves but did not don gowns before starting the brief change for R53. R53's soiled brief was removed after which a bandage dated 3/16 was seen on the resident's coccyx. After removing the soiled brief neither CNA changed their gloves throughout the process and applying a clean brief and pants. Part way through the brief change, CNA BB stated, We (both CNAs) were supposed to wear a gown because of (R53's) open wound. CNA TT stated, I'm used to the PPE sign and supplies being on the door before you enter a room. I've been here since October 2024.</p> <p>During an interview on 3/17/25 at 10:49 AM, CNA U stated, I am on my 3rd shift in the facility. I am used to Enhanced Barrier Precautions being noted on the resident's door by a sign and PPE on the door in a cart as your first walk in.</p> <p>During an interview and record review on 3/19/25 at 8:20 AM, Licensed Practical Nurse (LPN) EE reviewed R53's Kardex in the resident's closet. The Kardex did not specifically say resident was on Enhanced Barrier Precautions but indicated gown and gloves were to be worn during high-contact cares.</p> <p>During an interview on 3/19/25 at 11:28 AM, Infection Control Preventionist (IPC) MM and Director of Nursing (DON) B stated During brief change, gloves should be changed out when going from dirty to clean. Every morning all nursing staff have a meeting and residents on EBP is discussed. There is a huddle board at each nursing station that has a list of residents on EBP. The DON stated, I don't want the EBP signs on the outside of resident's door to make them feel like they are in isolation because this is their home. There is a Kardex for each resident in their closet where staff can view their needs. On the Kardex is does not say specifically Enhanced Barrier Precautions. But does say within a paragraph among other things to wear gown and gloves. The Charge Nurses do weekly audits to make sure the whole care guide is followed by nursing staff.</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>Review of facility policy Enhanced Barrier Precautions effective date 10/2023, revealed, It is the policy of (name of facility) to follow the CDC's guidance on Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent the Spread of Multidrug Resistant Organisms (MDROs). Enhanced Barrier Precautions (EBP) refer to the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a targeted MDRO who do not meet the criteria for Contact Precautions, as well as those at increased risk of targeted MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .PROCEDURE: Staff will receive training on EBP upon hire and annually and are expected to comply with designated precautions .The new Enhance Barrier Precautions sign hanging above the gown and glove holder inside the resident's room .Indwelling medical devices (e.g. central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomies) even if the resident is not known to be infected or colonized with a MDRO. Chronic Wounds. Examples may include but are not limited to: Pressure Injuries/Pressure Ulcers .</p> <p>During an observation on 3/17/25 at 10:49 AM, observed CNA U carrying soiled and dirty linen in a clear plastic bag to the hamper room holding the bag in ungloved hands and against her clothes in the 200 Hall.</p> <p>Review of facility policy, Laundry Transportation revised date 12/2023, revealed, Policy .This policy is to ensure the appropriate transporting of clean, dirty and infectious linen to minimize the risk of infection throughout the facility . Contaminated linen and laundry bags are not held close to the body or squeezed when transporting to hamper/utility room .</p> <p>Review of the facility policy, Nursing Standards of Care revised date 2/2025, revealed, .The employee will wear appropriate PPE (see policy: Standard precautions) when handling, cleaning or transporting soiled material .Following the residents individualized care guide/Kardex (resident specific care guide) is extremely important to providing safe quality care while meeting our resident's needs. In the care guide there is a section labeled Safety Interventions all staff should ensure these interventions are in place prior to leaving the resident .</p>		