

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Plainwell		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Brigham St Plainwell, MI 49080	

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>47955</p> <p>Based on observation, interview, and record review the facility failed to implement a resident care plan in 1 (Resident #102) of 3 residents reviewed for care plan implementation, resulting in the potential for a decline in oral intake of food, a decline in oral intake of fluids, and improper body alignment and/or comfort.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Parkinson's disease (a progressive disease that affects the nervous system and the parts of the body controlled by nerves), dementia, muscle weakness and lack of coordination.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #102 was cognitively intact.</p> <p>Review of Physician Orders for Resident #102 revealed . adaptive device: pt (patient) to have lateral wedge cushion to R (right) side to decrease lateral leaning . started on 12/18/2023 .</p> <p>Review of Care plan for Resident #102 revealed . provide resident with assistance with eating and drinking . initiated on 1/14/24 .has an ADL self-care performance deficit .is receiving therapy to address . posture . initiated on 3/28/2023 .bed mobility .requires the assistance of one staff to turn and reposition in bed as necessary initiated on 7/18/2023 .at risk for falls r/t . decreased mobility, weakness, poor coordination .assist with ADLs as needed initiated on 1/14/2024 .body pillow to the outer edge of the bed when in bed initiated on 7/20/2023 .provide adaptive equipment or devices as needed initiated on 3/1/23 . When up, place in Geri chair to assist with positioning support initiated on 2/5/24 .encourage and assist to turn and reposition frequently while in bed as allows .position with pillows and/or assistive devices as indicated initiated 1/14/2024 .</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>During an observation on 6/26/24 at 9:06 AM., Resident #102 was in bed, leaning to the right side of the bed with her right arm under her, pressed against the bed by her own body weight, and the right-side temporal area of her head was within a few inches of touching the wall. No pillows or other assistive devices for positioning were noted in place to assist Resident #102's body alignment while in bed. Resident #102's over the bed table was positioned over the bed with her breakfast tray present, no sip cup noted on the tray. A 480 ml styrofoam cup with a lid and straw with what appeared to be water in it was noted on the over the bed table.</p> <p>During an observation on 6/26/24 at 9:44 AM., Resident #102 was in bed, leaning to the right side of the bed with her right arm under her, pressed against the bed by her own body weight, and the right-side temporal area of her head was touching the wall. No pillows or other assistive devices for positioning were noted in place to assist Resident #102's body alignment while in bed.</p> <p>During an observation on 6/24/24 at 10:19 AM., Resident #102 was positioned on her back, leaning towards the right side of her bed with no noted assistive devices or pillows used for positioning.</p> <p>During an observation and interview on 6/26/24 at 12:22 PM., Resident #102 was in her Geri chair (a chair that can recline completely into a laying position with a footrest attached) in the reclined/laying position in her room, positioned on her back, knees bent at 45 degrees, and her feet flat on the seat cushion of the chair. Resident #102's neck was hyper-extended (positioned with the chin away from the body, looking up towards the ceiling) and the crown of her head was resting on the seat back of the Geri chair. No assistive devices or pillows for positioning were noted in use in the chair and there was no pillow under her head or neck. This surveyor asked Resident #102 if she was comfortable and she replied No. Resident #102's over the bed table was positioned at the foot of the Geri chair, out of reach of the resident.</p> <p>During an observation and interview on 6/26/24 at 3:13 PM., Resident #102 was in her room, sitting in her Geri chair, with the chair in the reclined/laying position, leaning to the left so far that her head and left shoulder were off the chair back. Resident #102 had a pillow behind her right shoulder, no other assistive devices or pillows were present in the chair for positioning. The surveyor asked Resident #102 if she was comfortable and she replied, Not really. Resident #102 was holding a s 480mL styrofoam cup with a plastic lid for a straw on it that was labeled ice with no date. No straw was present in the cup.</p> <p>During an observation and interview on 6/27/24 at 10:15 AM., CNA I repositioned Resident #102 while she was in bed, onto her back, and elevated the head of her bed to 90 degrees (straight up) and did not use any assistive devices or pillows to assist Resident #102 with her position. CNA I placed the over the bed table with a breakfast tray on it in front of Resident #102.</p> <p>In an interview on 6/27/24 at 12:59 PM., Director of Nursing (DON) B reported that her expectations were that staff would follow the policy and procedures related to repositioning residents. DON B reported that residents should be repositioned as necessary to promote body alignment and comfort. DON B reported that her expectation was that physician orders and care plan interventions be followed.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47955</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview, and record review the facility failed to ensure that a dependent resident had access to fluids for hydration in 1 (Resident #102) of 3 residents review for hydration status resulting in the potential for dehydration.</p> <p>Findings include:</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Parkinson's disease (a progressive disease that affects the nervous system and the parts of the body controlled by nerves), dementia, muscle weakness and lack of coordination.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #102 was cognitively intact.</p> <p>During an observation on 6/26/24 at 10:19 AM., Resident #102 was in bed and Resident #102's over the bed table with a styrofoam cup of water was out of reach towards the foot of her bed. Resident #102's lips appear to be dry and cracked.</p> <p>During an observation and interview on 6/26/24 at 12:22 PM., Resident #102 was in her Geri chair (a chair that can recline completely into a laying position with a footrest attached) in the reclined/laying position in her room. Resident #102's lunch tray was on the over the bed table that was positioned against the dresser and at the foot of the Geri chair out of Resident #102's reach. Resident #102's lips appear dry and cracked.</p> <p>During an observation and interview on 6/26/24 at 3:45 PM., Resident #102 was in her room, sitting in her Geri chair, with the chair in the reclined/laying position, leaning to the left so that her head was off the chair. Her left shoulder appeared to be wet, there was liquid on the floor beneath her left shoulder that appeared to be water, that was covered with a towel, and Resident #102 was holding an empty styrofoam cup with the lid dislodged. Resident #102 stated I wanted a drink of water. Resident #102's over the bed table was noted to have the non-bar end at the left side of the Geri chair positioned perpendicular to the chair. A sip cup with handles and a lid with no date was noted out of Resident #102's reach on the other end of the table.</p> <p>During an observation on 6/27/24 at 8:38 AM., Resident #102 was noted in bed and her over the bed table was positioned at the foot of her bed out of Resident #102's reach with her breakfast tray, styrofoam cup of water, and a sip cup half full of water on the table.</p> <p>During an observation on 6/27/24 at 9:02 AM., Resident #102 was noted in bed and her over the bed table was positioned at the foot of her bed out of Resident #102's reach with her breakfast tray, styrofoam cup of water, and a sip cup half full of water on the table.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 6/27/24 at 9:20 AM., Resident #102 was noted in bed and her over the bed table was positioned at the foot of her bed out of Resident #102's reach with her breakfast tray, styrofoam cup of water, and a sip cup half full of water on the table. Resident #102's lips appear to be dry and cracked.</p> <p>In an interview on 6/27/24 at 10:15 AM., Certified Nurse Assistant (CNA) I reported that Resident #102 will not drink from the styrofoam cup, because she cannot pick the cup up.</p> <p>In an interview on 6/27/24 at 11:40 AM., CNA I reported that she had completed the water pass for her residents. CNA I reported that she had passed water to Resident #102, and it was in a styrofoam cup with a straw. CNA I reported that she did not provide Resident #102 with the sip cup that was half full on the bedside table this shift.</p> <p>In an interview on 6/27/24 at 12:59 PM., Director of Nursing (DON) B reported that her expectation was that water was passed to every resident at least twice a day. DON B reported the CNAs were assigned to complete water pass and nurses are to ensure that water was passed to all the residents. DON B reported that there was a list with special instructions for water pass in the pantry where water cups are prepped, and her expectation was that the sheet was followed. DON B reported that her expectation was that residents should always have access to drinkable water.</p> <p>Review of Care plan for Resident #102 revealed .Focus . at risk for dehydration, or potential fluid deficit related to early satiety, poor appetite and severe malnutrition .observe and report signs of dehydration . cracked lips .provide access to water whenever possible .initiated on 1/2/24 .all drinks to be in sip cups . initiated on 12/15/23 .</p> <p>Review of facility policy titled Hydration and Nutrition with a reviewed date of 8/24/23 revealed .fluid is available to residents at all times .</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>47955</p> <p>Based on observation, interview, and record review the facility failed to provide assistive devices as ordered in 1 (Resident #102) of 3 residents reviewed for assistive devices, resulting in the potential for a decline in oral intake of food and fluids.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Parkinson's disease (a progressive disease that affects the nervous system and the parts of the body controlled by nerves), dementia, muscle weakness and lack of coordination.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #102 was cognitively intact.</p> <p>Review of Physician Orders for Resident #102 revealed Regular diet .all drinks in sip cups (cup with a lid and sip spout) plate guard . adaptive device: pt (patient) to have lateral wedge cushion to R (right) side to decrease lateral leaning . started on 12/18/2023 .</p> <p>Review of Care plan for Resident #102 revealed .Focus . at risk for dehydration, or potential fluid deficit related to early satiety, poor appetite and severe malnutrition .provide access to water whenever possible . encourage the resident to drink fluids of choice . provide resident with assistance with eating and drinking . initiated on 1/14/24 .has an ADL self-care performance deficit .is receiving therapy to address . posture . initiated on 3/28/2023 .provide adaptive equipment or devices as needed initiated on 3/1/23 .</p> <p>In an interview on 6/27/24 at 11:25 AM., Registered Dietician (RD) R reported that Resident #102 was to have a plate guard with all meals, a sip cup with all drinks at meals, and a sip cup with water at the bed side. RD R reported that dietary was to place the sip cups and plate guard on the meal trays and that CNAs were the ones that passed water at the bedsides.</p> <p>During an observation on 6/26/24 at 9:06 AM., Resident #102 was in bed, leaning to the right side of the bed with her right arm under her, pressed against the bed by her own body weight, and the right-side temporal area of her head was within a few inches of touching the wall. No pillows or other assistive devices for positioning were noted in place to assist Resident #102's body alignment while in bed. Resident #102's over the bed table was positioned over the bed with her breakfast tray present, no sip cup noted on the tray. A 480 ml styrofoam cup with a lid and straw with what appeared to be water in it was noted on the over the bed table.</p> <p>(continued on next page)</p>		

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<p>F 0810</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 6/26/24 at 12:22 PM., Resident #102 was in her Geri chair (a chair that can recline completely into a laying position with a footrest attached) in the reclined/laying position in her room, positioned on her back, knees bent at 45 degrees, and her feet flat on the seat cushion of the chair. Resident #102's neck was hyper-extended (positioned with the chin away from the body, looking up towards the ceiling) and the crown of her head was resting on the seat back of the Geri chair. No assistive devices or pillows for positioning were noted in use in the chair and there was no pillow under her head or neck. Resident #102's lunch tray was on the over the bed table, no sip cup or plate guard was noted on the lunch tray. Resident #102's over the bed table was positioned at the foot of the Geri chair, out of reach of the resident.</p> <p>During an observation and interview on 6/26/24 at 3:13 PM., Resident #102 was in her room, sitting in her Geri chair, with the chair in the reclined/laying position, leaning to the left so far that her head and left shoulder were off the chair back. Resident #102 had a pillow behind her right shoulder, no other assistive devices or pillows were present in the chair for positioning. Resident #102 was holding a s 480mL styrofoam cup with a plastic lid for a straw on it that was labeled ice with no date. No straw was present in the cup.</p> <p>During an observation and interview on 6/26/24 at 3:45 PM., Resident #102 was in her room, sitting in her Geri chair, with the chair in the reclined/laying position, leaning to the left so that her head was off the chair. Her left shoulder appeared to be wet, there was liquid on the floor beneath her left shoulder that appeared to be water, that was covered with a towel, and Resident #102 was holding an empty styrofoam cup with the lid dislodged. Resident #102 stated I wanted a drink of water. A sip cup with handles and a lid was noted out of Resident #102's reach on the other end of the table.</p> <p>In an interview on 6/27/24 at 10:15 AM., Certified Nurse Assistant (CNA) I reported that Resident #102 will not drink from the styrofoam cup, because she cannot pick the cup up.</p> <p>In an interview on 6/27/24 at 11:25 CNA K reported that there was a water pass census that informed CNAs if a resident needed a special liquid consistency, was on a fluid restriction, or needed a special cup for the water pass for each shift.</p> <p>Review of Water Pass Census dated for 6/26/24 revealed that Resident #102 has special instructions that included a sip cup.</p> <p>In an interview on 6/27/24 at 11:40 AM., CNA I reported that she had completed the water pass for her residents. CNA I reported that she had passed water to Resident #102, and it was in a 480 ml styrofoam cup with a straw.</p> <p>During an observation on 6/27/24 at 12:45 PM., Resident #102's lunch tray was on the over the bed table in her room. No plate guard or sip cup was noted on the tray.</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>47955</p> <p>Based on observation, interview, and record review the facility failed to ensure that infection control enhanced barrier precautions were implemented in 1 (Resident #102) of 3 residents reviewed for infection control resulting in the potential for the spread of infection, cross contamination, and disease transmission.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Parkinson's disease (a progressive disease that affects the nervous system and the parts of the body controlled by nerves), dementia, muscle weakness and lack of coordination.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #102 was cognitively intact.</p> <p>During an observation on 6/26/24 at 9:06 AM., signage indicating the use of enhanced barrier precautions by staff when providing care to Resident #102 was noted posted on her room door. A clear and black plastic bin with three drawers stocked with yellow gowns and boxes of gloves and masks was noted in the hallway outside of Resident #102's room accessible to all staff.</p> <p>Review of Physician Orders for Resident #102 revealed . enhanced barrier precautions, foley g-tube every shift for foley, g-tube . ordered on 4/3/2024 .</p> <p>Review of Care Plan for Resident #102 revealed .Focus foley catheter .enhanced barrier precautions . initiated on 5/16/24 .</p> <p>During an observation and interview on 6/26/24 at 9:44 AM., Certified Nurse Assistant (CNA) M was observed in Resident #102's room providing personal care. CNA M was not wearing personal protective equipment (PPE) as indicated by the signage posted on Resident #102's room door.</p> <p>In an interview on 6/27/24 at 9:25 AM., CNA O reported that the enhanced barrier precautions signage posted on the door to Resident #102's room indicated the staff needed to wear a gown and gloves when providing personal care.</p> <p>In an interview on 6/27/24 at 9:35 AM., Licensed Practical Nurse (LPN) G reported that the enhanced barrier precaution signage posted on Resident #102's room door indicated the need for staff to wear a gown and gloves when providing personal care.</p> <p>During an observation on 6/27/24 at 10:15 AM., CNA I entered Resident #102's room, applied gloves, and performed catheter care. CNA I did not apply a gown prior to providing catheter care to Resident #102.</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>In an interview on 6/27/24 at 10:28 AM., CNA I reported that the enhanced barrier precautions signage on Resident #102's room door indicated that staff should wear a gown and gloves when performing personal care. This surveyor asked CNA I if she wore the PPE indicated on the signage posted on Resident #102's door when she provided catheter care to Resident #102 and CNA I replied, No, I did not put a gown on.</p> <p>In an interview on 6/27/24 at 10:35 AM., Registered Nurse/Infection Preventionist (RN/IP) E reported that her expectations were that a gown and gloves should be worn by any staff that was performing any of the care listed on the signage posted outside of the resident's room. RN/IP E reported that a gown and gloves should be worn when performing catheter care.</p> <p>In an interview on 6/27/24 at 12:59 PM., Director of Nursing (DON) B reported that her expectations were that enhanced barrier precautions should be used when providing residents who meet the criteria for enhanced barrier precautions when staff was providing personal care.</p> <p>Review of facility policy titled Enhanced Barrier Precautions with a review date of 6/3/24 revealed . the facility should use enhanced barrier precautions (EBP) as an additional MDRO mitigation strategy for residents who meet the criteria during high-contact resident care activities .indwelling medical devices examples include . urinary catheter, feeding tubes .Enhanced barrier precautions . targeted gown and glove use during high contact resident care activities .high contact care activities include bathing, dressing . medical device care or use .</p>		