| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245369 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St Marks Living | 400 15th Avenue Southwest<br>Austin, MN 55912 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>51576<br><br>Based on observation, interviews and document review the facility failed to provide a dignified dining experience for 1 of 1 resident (R4) observed for dining.<br><br>Findings include:<br><br>R4's face sheet dated 2/21/25, identified diagnoses of Alzheimer's disease (progressive disease the destroys memory) and malnutrition (lack of sufficient nutrients in the body).<br><br>R4's focus care plan dated 10/28/20, identified R4 is unable to communicate needs due to advanced dementia. Interventions for staff to anticipate needs.<br><br>R4's focus care plan dated 3/19/21, identified R4 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Intervention for staff to provide sensory stimulation activities such as music to hear, tactile objects to touch, taste, or smell.<br><br>R4's activities of daily living (ADL) care plan dated 12/4/24, identified R4 was extensive assistance to dependent on staff for eating.<br><br>During an observation on 2/20/25 at 8:37 a.m., R4 was sitting at table with three other residents in a reclining chair. R4 had a breakfast tray sitting in front of her at the table with oatmeal and juice. R4 was not feeding herself. Nursing assistant (NA)-F walked past R4 and began helping other residents at the table. At 8:39 a.m. , NA-F stood next to R4 and in standing position and gave R4 one spoon full of oatmeal. NA-F then walked away and began passing other resident's breakfast trays down the hallway. R4 with eyes open was chewing food and looking around the room. At 8:43 a.m., NA-F returned to table, asked R4 if she wanted another bite of food, proceeded to stand next to R4 while giving her another spoonful of oatmeal and left R4's table again. NA-F then began passing more trays down the hallway. At 9:00 a.m., R4 continued to sit in her reclining chair with the breakfast meal in front of her looking around the room with no staff sitting at the table assisting her with her meal. At 9:05 a.m., NA-A entered the dining area and began assisting R4 with the breakfast meal.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 2/20/25 at 8:47 a.m., trained medication aide (TMA)-B stated normally R4 would go to the main dining room for her meals and one staff would be assigned to feed her however R4 had gotten up late today. TMA-B explained since R4 took a long time to chew/swallow her food staff would give her bites but then do other things between the bites. The best practice would be to wait to feed her until all of the trays are passed so staff could spend the time with her uninterrupted.<br><br>During an interview on 2/20/25 at 9:14 a.m., NA-A stated trays were normally passed to all the other residents, then staff would be sit with R4 so they could be more attentive to her needs while also providing more attention.<br><br>During an interview on 2/21/25 at 11:31 a.m., social services director (SSD)-A stated staff should sit next to the resident and not stand. Staff should ensure they are having a conversation with that resident even if the resident is not able to communicate to provide residents a dignified and respectful meal.<br><br>During an interview on 2/21/25 at 2:08 p.m., Administrator stated staff should be sitting with each resident that needs assistance with their meals to allow them to eat a hot meal and have staff talk with them while eating. She would want that for herself if she needed to be helped.<br><br>Review of the facility's Resident Rights policy undated, identified residents in the facility have the right to be treated with respect, kindness, and dignity. |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51576<br><br>Based on interview and document review, the facility failed to properly insert an indwelling urinary catheter and failed to assess and monitor for complications following insertion for 1 of 3 (R1) residents reviewed for catheters. This resulted in harm for R1 when the catheter balloon was improperly inflated in the urethra causing perforation within urethra, hospitalization for hematuria (blood in urine), and a urinary tract infection. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance.<br><br>Findings include:<br><br>R1's face sheet dated 2/21/25, identified retention of urine, diabetes mellitus, and chronic kidney disease.<br><br>R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted on [DATE], had an indwelling catheter, and diagnosis of retention of urine.<br><br>R1's care plan focus dated 12/3/24, identified R1 had a catheter due to benign prostatic hyperplasia (BPH). Care plan goal was resident will be/remain free from catheter-related trauma with interventions. Interventions for catheter included: care and treatment per current orders; position catheter and tubing below the level of the bladder; and monitor/record/report to MD for signs and symptoms of urinary tract infection.<br><br>R1's physician orders dated 12/28/24, identified order for catheter exchange: 16F (French) and 10 milliliters (ml) balloon. Exchange monthly and as needed.<br><br>Review of facility's Standing Orders for Skilled Nursing Facilities dated 10/17/23, identified under care of indwelling catheter:<br><br>-Do not irrigate.<br><br>-Change catheter as needed for leaking or decreased urinary output using similar-sized catheter.<br><br>-Change catheter and tubing prior to obtaining sample for urinalysis/urine culture.<br><br>-May attach leg bag when patient is out of bed; reattach to straight drainage when in bed.<br><br>R1's progress note dated 1/24/25 at 5:26 p.m., indicated R1's catheter was flushed with 60 cubic centimeters (cc) of normal saline with good return and color was yellow and clear. R1 had been having issues with the catheter leaking around the urethra. Nurse to call this evening and see if we can change it to a larger sized and a bigger balloon. R1's record did not identify a catheter assessment for placement and did not include a physician order to flush R1's catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1's progress note dated 1/24/25 at 9:53 p.m., identified R1 was complaining of urine leaking out of his catheter. Director of nursing (DON) asked nurse to contact on call doctor tonight. Order received for 18fr catheter. Nurse passed this message along to next shift nurse as well.<br><br>R1's outside medical record dated 1/24/25 at 9:28 p.m., identified nursing home called due to R1 had chronic leakage to size 16cc catheter and physician advised to try size eighteen. Facility's electronic health record (EHR) did not identify this physician order.<br><br>R1's progress note dated 1/25/25 at 5:50 a.m., included this nurse was told by p.m. nurse ok to place 18fr indwelling catheter due to leaking. A 18fr placed at 4:30 a.m., with no return at this time. The note further indicated although there was no physician order to flush the catheter, R1's Catheter flushed for patency. The progress note did not identify if catheter placement was checked, did not address how R1 tolerated the catheterization procedure, and did not identify what the catheter was flushed with and how much.<br><br>R1's progress note dated 1/25/25 at 1:35 p.m., identified R1 had 400cc of straight bright red blood noted in catheter bag after having catheter changed at 5:00 a.m., and had been experiencing pain. The progress note also included Report stated that after she placed the catheter, did not get any return and we were to watch him closely. Around 9:00 a.m., there was 200 cc of urine with a few clots and pink tinge to it. R1 was sent to emergency department (ED) at 1:30 p.m. due to the frank blood and pain. R1 was also on Eliquis (blood thinning medication)<br><br>R1's record dated 1/25/25 was reviewed between 5:50 a.m. and 1:35 p.m. identified although the progress note at 1:35 p.m. indicated R1 had been experiencing pain as a result of the catheterization, there was no indication of completed assessments and ongoing monitoring of urinary output/catheter placement/patency, and R1's pain.<br><br>R1's emergency department (ED) note dated 1/25/25, indicated since R1 had a urinary catheter change with a larger size catheter, there has been blood in the urine collection bag. Additionally R1 had discomfort in lower abdomen and the tip of penis. Patient stated underwent catheter placement with a larger catheter and stated procedure was very painful and feels like he needs to urinate but was unable to do so. On physical exam noted purulence (the state of containing or forming pus) present at the urethral meatus (external opening of the penis) with blood collecting through the urinary catheter and collection bag. An ultrasound of the bladder at bedside showed 600cc in the urinary bladder with no evidence of rupture (normal bladders can hold 400-600 cc's; urge to urinate usually starts when the bladder contains around 200 to 300 cc). Significant leukocytosis (elevated white blood cells) noted at 23,000 (normal for male is 5,000 to 11,000). A computed tomography (CT) scan of abdomen and pelvis revealed the catheter balloon inflated within the penile urethra. Urology consulted and reported R1 sustained perforation within the urethra and had staff placed a curved coude catheter and recommended admission to hospital due to concerns for urosepsis (severe and life-threatening infection that occurs when a urinary tract infection spreads to the bloodstream).<br><br>R1's outside medical record discharge summary dated 1/28/25, identified R1 was hospitalized [DATE] to 1/28/25 for a displaced chronic foley catheter leading to hematuria (blood in urine) and urinary tract infection. R1 was placed on intravenous antibiotics and switched to oral antibiotics due to E.Coli seen in the urine cultures.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1's outside medical record dated 2/10/25, identified R1 was seen by urology for hematuria. Recently during catheter replacement the catheter balloon was inflated within the urethra that caused significant hematuria. Recommended continuation of the catheter due to history of retention to protect his kidneys.<br><br>During an interview on 2/20/25 at 10:10 a.m., family member (FM)-A stated on 1/25/25 she had met R1 in the ED and R1 had reported to her that when the nurse inserted the catheter that morning it had been very painful.<br><br>During an interview on 2/20/25 at 9:50 a.m., LPN-A stated she had worked the overnight shift 1/24/25 into 1/25/25. LPN-A explained she was told by the nurse before her that an order for 18fr was to be placed. Around 4:30 a.m., LPN-A placed the 18 fr catheter and did not get any urine return. Around 5:50 a.m., LPN-A flushed the catheter, it was patent, and R1 did not complain of pain with insertion or after the insertion. LPN-A indicated she did not check placement and there was not an order to flush the catheter.<br><br>During an interview on 2/20/25 at 11:19 a.m., nursing assistant (NA)-B stated on the day of 1/25/25, R1 was complaining of pain from his catheter and he was not very good. That morning, R1 had told NA-B, I would have rather been dead when she [LPN-A] put the thing in me. NA-B explained she had not been informed there had not been any urine return after R1's catheter insertion and had not been directed to monitor his output. NA-B indicated had she been made aware there had been no urine output when the catheter was inserted that morning, she would have watched him more closely that day.<br><br>During an interview on 2/20/25 at 12:14 p.m., trained medication aide (TMA)-A worked the day shift on 1/25/25 and was told by LPN-A that when R1's catheter was changed earlier there was no urine return and staff were to watch him closely. Around 7:30 a.m., TMA-A observed what appeared to be 200 cc's urine in the tubing with blood clots. TMA-A replaced the overnight collection bag with the leg bag at which time R1 had complained of pain on the tip of his penis. TMA-A notified registered nurse (RN)-C that R1 was having output. TMA-A could not differentiate if the fluid in the collection bag was urine or fluid that was used for flushing the catheter. TMA-A stated RN-C looked at R1 after she had notified her, but did not recall if she had assessed him. TMA-A explained R1 had not complained of any further pain and she had not check the collection bag until around 1:30 p.m. when a nursing assistant informed her of bright red blood in the bag. TMA-A called RN-C over the walkie talkie to come and evaluate R1. RN-C called the ambulance to take R1 in for evaluation. R1 was complaining of pain when the emergency management service (EMS) came. During a follow up interview at 4 p.m., TMA-A stated it could have been the flush she observed in the tubing and not urine. TMA-A stated she did a set of vitals before R1 left, but did not enter them into the chart and was unsure if RN-C performed any assessment before the ambulance arrived.<br><br>During an interview on 2/20/25 at 4:45 pm., RN-C stated in report on 1/25/25 she was told by LPN-A that an 18fr catheter had been placed in R1 earlier that morning with no urine return so the catheter was flushed and R1 was to be monitored. RN-C stated she did observe him around 7:00 a.m.-8:00 a.m., after being told by TMA-A he had blood clots in the tubing. R1 had been lying in bed and did not complain of any discomfort. RN-C stated she did not do a comprehensive assessment on R1, or bladder scan him.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 2/20/25 at 2:30 p.m., RN-B reviewed R1's records dated 1/25/25 and verified there was no order transcribed for the 18fr catheter, no order to flush the catheter, and no documentation of monitoring the catheter or pain after the catheter was inserted. RN-B indicated the order for the catheter should have been in R1's record, flushes required a physician order, the catheter should have been monitored for patency, and R1's pain should have been monitored.<br><br>During an interview on 2/20/25 at 1:05 p.m., director of nursing (DON) stated R1 had been having trouble with his catheter leaking prior to the catheter change on 1/25/25. On 1/24/25, R1 had requested to be sent to the ER to be evaluated for his leaking catheter, but she talked with him, and he agreed to try a larger size. DON stated she flushed R1's foley catheter with 60cc of normal saline and instructed the evening shift nurse to call the on-call provider to get an order for a larger catheter. DON interviewed LPN-A on 1/27/25, LPN-A had reported she was unaware she should not have blown up the foley balloon until she got urine return and was unaware of how far to insert a male catheter. DON stated LPN-A did not have any foley insertion competencies prior to her inserting the catheter for R1. DON reviewed R1's record and identified the record did not include assessment.<br><br>During an interview on 2/21/25 at 9:28 a.m., certified nurse practitioner (CNP) stated if a nurse puts a catheter in a resident and does not get urine return, they should not blow up the balloon. They should have repositioned the catheter, bladder scanned to see if urine in the bladder, took that catheter out and tried a different catheter.<br><br>During an interview on 2/21/25 at 11:51 a.m., medical director (MD) stated after a catheter is inserted in the bladder and no urine return after insertion the catheter should either repositioned, removed, perform a bladder scan, and should not inflate the bulb until get that urine return. MD stated the facility should have monitored R1 closely and performed bladder scans due to no urine return after insertion.<br><br>The following corrective actions were verified as implemented prior to the survey:<br><br>-Beginning 2/3/25 the facility updated the procedure procedure for male and female foley catheter insertion which included. Additionally the facility implemented an on-call nurse to trouble shoot any catheter related problems if they arise.<br><br>-Beginning on 2/3/25, staff were informed of the policy and on 2/14/25 staff development coordinator completed competency evaluations with licensed staff for all scheduled foley catheter changes and will continue until all licensed staff have shown competency.<br><br>-Sampled resident records were reviewed from 1/1/25 to 2/21/25 did not identify deficient practices pertaining to catheter management.<br><br>Review of the facility's Indwelling Catheter Policy dated 1/2025, identified the resident has the right to timely and appropriate assessments of the catheter by nursing staff as ordered and as needed and to maintain care of indwelling catheters in collaboration with the medical director, director of nursing, and current professional standards of practice.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the facility's Foley Catheterization Insertion/male procedure dated 2/3/25, identified staff to insert catheter 5-7 inches until resistance met, wait 2-3 seconds and advance catheter for about two inches and drain bladder. If you do not have urine output, slowly advance until urine output is obtained. Once obtained, insert another two inches. Inflate balloon slowly with ordered amount. If resident complains of any pain or pressure when inflating the balloon, stop, deflate the balloon, and advance the catheter another inch. Inflate balloon slowly. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>51576<br><br>Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 1 of 1 (R1) residents reviewed for complete and accurate medical records.<br><br>Findings include:<br><br>During an interview on 2/19/25 at 1:53 p.m., licensed practical nurse (LPN)-B indicated facility nurses had access to view resident records from hospitals and clinic appointments through a electronic health record (EHR) portal. LPN-B was unsure of how those records were uploaded into the facility EHR system for each resident so that the resident records were complete and accurate.<br><br>R1's face sheet dated 2/21/25, identified retention of urine, diabetes mellitus, and chronic kidney disease.<br><br>R1's progress note dated 1/24/25 at 9:53 p.m., identified nurse contacted on call provider and obtained an order for 18F indwelling urinary catheter. Review of R1's electronic health record (EHR) on 2/19/25, did not reflect the physician order therefor R1's record was not complete and not accurate.<br><br>R1's progress noted dated 1/28/25, identified R1 was readmitted to facility from the hospital. Review of R1's EHR on 2/19/25, did not reflect a history and physical and/or discharge summary from the outside hospital stay from 1/25/25 to 1/28/25 that identified reason for admission, care provided, and any follow-up care R1 required.<br><br>R1's progress noted dated 1/31/25 at 12:05 a.m., identified facility received call from emergency department (ED) indicating R1 was returning to the facility. A computed tomography (CT) scan was completed and showed catheter in correct placement. Resident continues to have hematuria and will have a follow up with outpatient urology. No new interventions or orders placed. Review of R1's EHR on 2/19/25, did not included a discharge summary from the ED that identified reason for visit, care provided, and any required after care.<br><br>R1's late entry progress note dated 2/11/25 at 5:57 a.m., identified that R1' s brief was wet and no output in catheter bag. Catheter flushed without difficulty, good return with some blood clots present, after clots passed urine in tubing was clear yellow, obtained 200 cc output after flush. Registered nurse questioned resident about urology appointment he had the other day. R1 reported the doctor told him everything looked fine, and he was doing good.<br><br>Review of R1's EHR on 2/19/25 did not identify a urology note from visit on 2/10/25.<br><br>During an interview on 2/19/25 at 2:59 p.m., health unit coordinator (HUC) stated for any verbal/telephone order nurses received they would need to go into the outside facility's EHR, print the order, and then she would scan them into the resident's chart. HUC confirmed the order from 1/24/25 for catheter order was not in R1's chart until 2/19/25.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/21/25 at 10:07 a.m., registered nurse/infection preventionist (RN-IP) stated not all nurses had access to the outside medical records to view notes and orders. RN-IP stated orders or notes not received from a provider would need to be printed from the outside EHR and then added to the chart to verify accurate information.<br><br>During a follow up interview on 2/21/25 at 11:10 a.m., HUC stated she was unsure whether the outside medical information she scanned into resident records from the external EHR had been reviewed by the nursing department beforehand. HUC does not consistently receive all the necessary documents to scan into the resident's charts and relied on the nursing department to provide the information for scanning.<br><br>During an interview on 2/21/25 at 1:57 p.m., director of nursing (DON) stated the facility had obtained access for a portion of the nurses to view and print outside facility's EHR documents, but did not have a policy/procedure to ensure how that information was added to the resident's chart. The outside medical records are not the facility's records and the facility just uses the access to view and retrieve needed information for their residents. Not having a complete and thorough medical record could lead to orders or medications being missed.<br><br>Review of the facility's Electronic Health Record Policy undated, did not identify how the facility maintains a complete, accurate, and ready accessible medical record. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>51576<br><br>Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 3 of 4 residents (R4, R2, R1) observed for EBP. In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 3 of 5 residents (R4, R2, R5) observed for hand hygiene.<br><br>Findings include:<br><br>R4's face sheet dated 2/21/25, identified diagnoses of Alzheimer's disease (progressive disease the destroys memory), malnutrition (lack of sufficient nutrients in the body).<br><br>R4's care plan focus dated 5/13/24, identified R4 required use of EBP for high contact cares due to wounds.<br><br>During an observation on 2/19/25 at 12:08 p.m., R4's room had signage by the door indicating enhanced barrier precautions were needed. Nursing assistant (NA)-C entered R4's room applied a clothing protector and began feeding R4 her meal. NA-C was not wearing gown or gloves and did not perform hand hygiene before or after cares.<br><br>R2's face sheet dated 2/21/25, identified diagnoses of heart failure (condition in which heart does not pump blood as well as it should) and pressure ulcer of left heel (injury to skin and underlying tissue from prolonged pressure).<br><br>R2's order summary report dated 2/21/25, identified R4 required use of EBP for high contact care due to foley catheter and wounds.<br><br>During an observation on 2/19/25 at 12:21p.m., R2's room had signage outside his door that enhanced barrier precaution were needed. Nursing assistant (NA)-C entered R2's room, removed the clothing protector off R2's chest and did not apply gown or gloves. NA-C left room and did not perform hand hygiene prior to leaving.<br><br>During an observation on 2/19/25 at 12:24 p.m., NA-B entered R2's room and placed R2's legs on the leg rest of the wheelchair, however, did not apply gown or gloves or perform hand hygiene before and after cares.<br><br>R5's face sheet dated 2/21/25, identified diagnoses of heart failure and chronic obstructive pulmonary disease (a common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough).<br><br>During a continuous observation on 2/20/25 from 8:39 a.m. to 9:10 a.m., NA-F was feeding R4 her meal in the dining room. NA-F then removed R5's tray from the meal cart and entered R5's room, however, did not perform hand hygiene prior to removing meal tray or entering R5's room. NA-F moved R5's bedside table by the side and applied clothing protector to R5's chest. NA-F did not perform hand hygiene after cares. NA-F then returned to dining room and began feeding R4 her meal. NA-F did not perform hand hygiene prior to assisting R4 with meal.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245369 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Marks Living | 400 15th Avenue Southwest<br>Austin, MN 55912 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R1's face sheet dated 2/21/25, identified retention of urine (inability to empty bladder), diabetes mellitus (condition that affects how the body uses sugar as fuel), and chronic kidney disease (condition where kidneys have been damaged).<br><br>R1's care plan dated 11/14/24, identified R1 identified R4 required use of EBP (gown and gloves) for high contact care due to foley catheter.<br><br>During and observation and interview on 2/20/25 at 7:43 a.m., R1's room had signage by the door indicating EBP were needed. Licensed practical nurse (LPN)-B entered R1's room and re-positioned R1's foley catheter bag and then applied lotion on both of R1's feet and applied socks. LPN-B applied gloves, however, did not apply gown. LPN-B then applied gown and gloves and assisted R1 with a transfer to his wheelchair. LPN-B stated gown, and gloves should be worn when performing any type of catheter care or any close contact cares.<br><br>During an interview on 2/21/25, registered nurse/infection preventionist (RN-IP) stated staff should be using gown and gloves for any close contact cares for a resident identified that have a wound or catheter. For handwashing/hand hygiene staff should be performing this when enter a room and when leave a room, before and after touching a resident, before and after removing gloves and when hand visibly soiled. Her expectation would be for staff to follow the EBP and performing hand hygiene.<br><br>During and interview on 2/20/25 at 1:05 p.m., director of nursing (DON) stated her expectation would be for staff to apply gown and gloves for any high contact cares of a resident on EBP and to perform handwashing/hand hygiene before and after leaving a resident room, before and after care, before applying gloves and removing gloves, and if hands visibly soiled.<br><br>Facility's Handwashing/Hand Hygiene Policy undated, identified staff should perform handwashing/hand hygiene before and after direct contact with residents.<br><br>Requested facility's Enhanced Barrier Precaution Policy and did not receive. |