| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245634 | A. Building<br>B. Wing | 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aurora on France | 6500 France Avenue<br>Edina, MN 55435 |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure care was provided to preserve dignity for 2 of 2 residents (R20, R307) who were reviewed for dignity.<br><br>Findings include:<br><br>R20:<br><br>R20's quarterly Minimum Data Set (MDS) dated [DATE], indicated R20 was moderately cognitively impaired with the diagnoses of hyperlipidemia, asthma, depression, anxiety, and diabetes.<br><br>R20's care plan last revised 5/21/25, indicated R20 required an assist of one personal hygiene. The care plan also indicated R20 had impaired vision and instructed staff to make sure R20's glasses were clean and to remind R20 to wear their glasses.<br><br>During an observation on 5/20/25 at 9:10 a.m., R20 was noted to have several long hairs on their chin. R20 stated they had not noticed they had chin hairs, and stated if they had known they would want the hairs pulled out. R20 stated staff had not asked if the chin hairs bothered them or offered to assist with removing them.<br><br>During an observation at 5/21/25 on 9:28 a.m., R20 was noted to have several visible chin hairs.<br><br>During an interview on 5/21/25 at 2:24 p.m., NA-D stated they would not ask a female resident if they wanted their chin hairs removed. Plucking chin hair was not something they did for residents.<br><br>During an interview on 5/22/25 at 10:40 a.m., NA-E stated they had not had a situation where they identified a female resident with chin hairs, and didn't think offering to pluck chin hairs was something they would do.<br><br>During an interview on 5/22/25 at 10:42 a.m., NA-F stated it was a personal thing, some women were embarrassed by chin hairs. If they saw a resident with chin hairs, they would ask the resident if they wanted the hairs plucked.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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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 on 5/22/25 at 11:46 a.m., RN-D stated they would expect their staff would offer to take care of chin hair if they noticed a resident had chin hairs growing. It can be embarrassing for some women to have long facial hairs and not know it. Staff should offer to assist residents with chin hairs removal.<br><br>During an interview on 5/22/25 at 12:31 p.m., the director of nursing (DON) stated dignity is important, and having unwanted facial hair can be a dignity issue for some residents. To be sensitive to all, we have discussed reviewing and putting facial hair preferences on the care plan at the time residents are admitted to the facility.<br><br>R307:<br><br>R307's admission Minimum Data Assessment (MDS), dated [DATE], indicated R307 had intact cognition, diagnosis for fractures, and needed partial to moderate assistance with personal hygiene. Further, the MDS indicated R307 rated the highest importance to clothing choices, bathing preferences and personal belongings.<br><br>R307's care plan, dated 5/6/2025, indicated personal preferences for facial hair to be removed to maintain dignity. R307 needed assist of one with bathing, transfers, dressing, and personal hygiene.<br><br>During an observation and interview on 5/19/25 at 4:19 p.m., R307 had white facial hair covering the entire chin area approximately ¼ inch long. In addition, the area under the nose and above the lip were covered with white hairs approximately ¼ long. R307 stated after a fall at home an ambulance transported her to the hospital, she caught a glimpse facial hair in the mirror and felt embarrassed, would not leave home with facial hair, and stated clearly that facial hair bothered her.<br><br>During an observation on 5/20/25 at 3:41 p.m., facial hair was still present on R307.<br><br>During an interview on 5/21/25 at 9:40 a.m., R307 stated facial hair bothers me and asked if it could be seen. If I was at home I would pluck them, I have some tweezers at home. There are a lot of things I don't have here.<br><br>During an interview on 5/21/25 at 11:55 p.m., registered nurse (RN)-A was unaware of R307's facial hair and would take care of it.<br><br>During an interview on 5/21/25 at 11:55 a.m., the director of nursing (DON) stated the facility needs to find a way to address this topic during admission concern over asking female residents about facial hair. The DON was unaware of R307's concerns of facial hair and how it made her feel and suggested possibly getting an electric razor.<br><br>During an interview on 5/22/25 at 12:15 p.m., the DON stated staff assisted R307 with a disposable razor, R307 told her she had never been shaved before, but it made her feel better.<br><br>Facility policy, Dignity dated 3/25, identified residents groomed as they wish.<br><br>Facility policy, AM Cares dated 4/25, identified shaving women and men's facial hair. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement new orders for 1 of 1 resident (R26) with fluid retention and failed to recognize hypertensive blood pressure readings and follow provider orders for as-needed (PRN) blood pressure medication for 1 of 1 resident (R307) reviewed with hypertension.<br><br>Findings Include:<br><br>R26:<br><br>R26's admission MDS (Minimum Data Assessment) dated 5/12/25, indicated R26 was cognitively intact and had diagnoses of cardiorespiratory (heart & lung) conditions, coronary artery disease, heart failure, hypertension, diabetes mellitus, and respiratory failure.<br><br>R26's care plan dated 5/16/25, indicated diuretic therapy, congestive heart failure intervention such as assessments, monitored labs, documented weights, recorded fluid amounts, and administered cardiac medications.<br><br>R26's provider orders identified the following:<br><br>-5/7/25 give furosemide (a medication used to rid the body of excess fluid) 80 milligrams (mg) in the morning, and 40 mg later in the day for heart failure. The order was discontinued on 5/19/25.<br><br>-5/15/25 a faxed medication order indicated to increase furosemide to 80 mg twice a day (8 a.m. and 4 p.m.). Hold for dizziness/lightheadedness or diarrhea and give furosemide 40 mg instead.<br><br>R26's medication administration record (MAR) for May 2025, indicated furosemide 80 mg was given in the morning, and furosemide 40 mg was given at 12 p.m. from the 15th through the 18th.<br><br>Progress notes for R26 identified the following:<br><br>-5/15/25 at 10:02 a.m., indicated the provider was made aware of R26's weight gain and would start R26 on 80 mg of furosemide twice a day (BID).<br><br>-5/21/25 at 4:45 a.m., indicated R26 complained of chest pain and was transported by emergency medical services (EMS) to the hospital.<br><br>Facility-provided emails dated 5/15/25, identified medical doctor (MD)-A and registered nurse (RN)-A discussed new order for R26. A follow-up email was sent on 5/19/25 at 11:39 a.m., RN-A stated the order sent over on 5/15/25 was missed.<br><br>During an interview on 5/19/25 at 5:37 p.m., family member (FM)-A stated the provider increased an order for furosemide last week, the order was sent to RN-A, and labs would be checked on Monday, 5/19/25. FM-A stated after the care conference on 5/19/25, MD-A called FM-A back and explained the facility staff didn't enter the new orders for furosemide from last week.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/21/25 at 1:11 p.m., RN-A stated the provider would either give a verbal order or send an email because providers at the hospital use a different computer system. The facility nurses would then enter the order into the electronic medical record (EMR). The main source of communication was through email or verbal communication. The faxed orders went into the resident's paper chart. RN-A confirmed a fax was received on 5/15/25 for R26 to increase the dose of furosemide to 80 mg twice a day and to hold for dizziness, light headiness, or diarrhea and to give furosemide 40 mg instead.<br><br>During an interview on 5/21/25 at 1:21 p.m., the director of nursing (DON) verified there was no order in R26's EMR updating the furosemide order of 5/15/25. At 3:43 p.m., the DON confirmed the facility did not follow up with the provider on Friday, 5/16/25, for clarification of the medication order received on 5/15/25.<br><br>During an interview on 5/21/25 at 6:31 p.m., MD-A stated she saw R26 on 5/15/25, and wrote and faxed a new order for furosemide to be increased to 80 mg twice a day. MD-A stated they didn't hear anything back after the original email was sent, so on Monday 5/19/25, after reviewing R26's chart, she emailed RN-A and increased the furosemide orders. MD-A confirmed RN-A didn't attempt to clarify the medication orders on Friday, 5/16/25 or at any time over the weekend. MD-A stated the facility could contact her directly by phone or contact triage regarding order clarification. MD-A stated the furosemide order did delay R26's progress but didn't directly cause harm. MD-A stated the facility had notified her R26 was sent to the hospital with chest pain this morning, and didn't believe the missed medication order and the chest pain were related.<br><br>A facility policy, Order Transcription dated 10/24, identified verification and communication of orders/transcription and verification: HUC/nurse reviews chart after provider visit to check for any new orders. Orders must be transcribed into the EHR. A second licensed staff member must confirm the order placed in the EHR. Double verification by another nurse is required for medications or critical treatments. Order is faxed to the pharmacy. Schedule labs or special supplies as needed. Staff uploads any paper copies of order(s) into EHR. Examples: telephone orders, physician written order(s), referral forms, etc. Communication to the care team.<br><br>R307:<br><br>R307's admission MDS dated [DATE], identified intact cognition and diagnoses of renal insufficiency and hypertension. R307's MDS also indicated a fall prior to admission that resulted in a fracture.<br><br>R307's care plan dated 5/7/25, identified a problem statement for hypertension and included interventions to administer anti-hypertensive medications, monitor blood pressure readings and any side effects and report these to the provider.<br><br>R307's medication order dated 5/9/25, identified hydralazine hydrochloride (HCL) oral tablet 25 mg with directions to give as needed for hypertension three times a day as need for blood pressures with the top number (systolic) above 160 and the bottom number (diastolic) over 110.<br><br>R307's MAR dated May 2025, identified hydralazine HCL 25 mg tablet had never been administered. From 5/9/25 through 5/19/25, R307's blood pressure summary report indicated 10 incidents where the blood pressure readings met criteria to report to the provider and to administer hydralazine HCL 25 mg.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R307's progress notes for May 2025 failed to document provider notification of elevated blood pressures or that anti-hypertensive medications were given.<br><br>During interview on 5/21/25 at 9:47 a.m., RN-C stated the process for an abnormal blood pressure would be to first check if there was a PRN medication for pain and elevated blood pressures, for example hydralazine. Then her skill set would be used through assessment and reviewed vital signs to determine interventions. The EMR would be reviewed, PRNs could be given, the provider and the nurse manager would be notified and then reassess the patient.<br><br>During an interview on 5/21/25 at 11:21 a.m., RN-B stated the nurses completed vital signs for their own residents, and if an abnormal vital sign was received, they would use their assessment skills, check the PRN medications, notify the provider and the nurse manager by phone or email. RN-B stated most residents with blood pressure management have PRN orders for hydralazine, it was a very common medication given in the facility. RN-B added once the resident was treated and the plan was completed, a progress note was placed in the residents' chart showing the nurses had followed up on the order with either medication or a different plan the provider wanted to follow. RN-B confirmed nursing assistants didn't check vital signs in this facility, so if there was an elevated blood pressure that was not reported to a provider or medication was not given, then a nurse didn't use their assessment skills. RN-B stated the importance of giving anti-hypertensive medications was elevated blood pressures could result in stroke.<br><br>During an interview on 5/21/25 at 2:55 p.m., the DON confirmed the completed neurological sheet completed on 5/19/25 documenting the elevated blood pressures after R307's fall. The DON confirmed the elevated blood pressures should have been documented into the EMR, but confirmed the provider was notified of the fall. The DON stated the RNs involved with caring for R307 at the time of the fall felt the blood pressure and the fall could have been related because medication was not given to reduce the blood pressure. The nurse continued to monitor the blood pressures as they decreased and never administered any medications. The provider agreed with this plan and the details of this conversation were documented. The DON confirmed it would be a medication error for missed doses every time R307 had an elevated blood pressure and there was no provider notification or no anti-hypertensive medication administered. Further, the DON stated her expectation would be if a nurse received an abnormal vital sign, they would notify the provider, provide interventions, and check the PRN orders.<br><br>During an interview on 5/21/25 at 6:56 p.m., MD-A stated she was notified R307 had a fall on 5/19/25, but staff failed to clarify R307's blood pressure was elevated prior to the fall and was unaware of any other instances of elevated blood pressures prior to 5/19/25 when MD-A assumed R307's care. MD-A confirmed elevated blood pressures could cause headaches, stroke, chest pain, congestive heart failure, but didn't feel the elevated blood pressure and the fall were related in this scenario.<br><br>Facility policy, Change of Condition/Notification dated 3/25, identified attending physicians/nurse practitioner were to be contacted of all health status changes immediately.<br><br>Facility policy, Medication Administration dated 3/10/23, identified medications were administered as prescribed in accordance with good nursing principles and practices. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food was properly stored in refrigeration units. In addition the facility failed to ensure dishes were properly air dried prior to stacking for storage. These deficient practices had the potential to impact all residents who consumed facility prepared food.<br><br>Findings include:<br><br>During a kitchen tour on 5/19/25 at 2:27 p.m., led by the culinary manager (CM) the following were noted:<br><br>---The bottom 3 racks on the right of the walk-in freezer were less than 6 inches from the floor of the freezer and held food. The middle rack bottom shelf touched the floor. There was a prep pan of raw whole turkeys on it. The prep pan had a brownish red substance on the bottom of the pan.<br><br>---The first-floor fridge had a stack of boxes sitting directly on the fridge floor. The CM stated they had just got a shipment, and the boxes were still being put away.<br><br>---On the clean side of dish room there were 18 stacks of plastic glasses that had visible moisture between and in the glasses. The CM stated the glasses had been stacked wet instead of being completely air dried before they were stacked.<br><br>---The first-floor food prep area contained several shelves of food storage containers and metal prep table pans. There were multiple stacked 8-quart, 4-quart, and 2-quart food storage containers that appeared to be wet with visible moisture between items. The DM confirmed there was visible moisture inside the storage containers and stated they should not have been stacked until they were completely dry.<br><br>During an interview on 5/19/25 at 2:46 p.m., dietary aide (DA-A) stated they had stacked the glasses after they came out of the dishwasher to air dry. The CM instructed DA-A not to stack the glasses until they were completely dry. The CM stated letting the glasses air dry was important for infection prevention reasons.<br><br>During an observation of the walk-in freezer on the first floor on 5/21/25 at 8:34 a.m., it was noted the bottom food shelves on the 3 storage racks on the right of the freezer were about an inch off the floor, with the second rack's bottom shelf touching the floor on two corners. Two of the bottom shelves contained food.<br><br>During an interview on 5/21/25 at 8:43 a.m., the CM confirmed three of the rack's shelves in the walk-in freezer were not greater than 6 inches from the bottom of the freezer floor. The DM indicated the racks should not be that close to the floor. The boxes of chicken should not be on the floor of the freezer, they should have been put on a shelf. Ideally when food is delivered it should be put on the shelf by the person that received it. The DM stated pans that held food should be clean and indicated pans in the freezer would be replaced with clean ones.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation on 5/21/25 at 8:55 a.m., the in the second-floor dish area there were stack of glasses with visible moisture on both the inside and outside surface areas. In addition, there were cold and hot food storage containers stacked with visible moisture on them. The CM confirmed the glasses and food containers were stacked and wet. The CM stated this was not acceptable, the items needed to air dry before they were stacked for infection control reasons.<br><br>During a follow-up on 5/21/25 at 9:14 a.m., the CM stated the chicken stacked in the freezer had been there since last evening when it was delivered. The food on the lower shelves in the freezer had all been moved to higher shelves.<br><br>The facility policy Food Storage dated 2/2024, directed food should be stored at a minimum of six inches off of the floor.<br><br>The facility policy Cleaning Dishes dated 7/2022, directed dishes should be air dried on racks and should not stacked until they were completely dry. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure staff adhered to infection control standards including the use of personal protective equipment (PPE) in enhanced barrier precaution (EBP) and contact precaution rooms, as well as failing to properly perform hand washing and gloving for 3 of 3 residents (R208, R23, R259) reviewed for infection prevention and control.<br><br>Findings include:<br><br>R208:<br><br>R208's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses including non-pressure chronic ulcer of other part of the right foot with necrosis of muscle, gangrene, cellulitis of right lower limb, osteomyelitis, diabetes mellitus, peripheral vascular disease (PVD), chronic kidney disease. The MDS indicated R208 needed moderate assistance of one person for transfers, was taking antibiotics, and had been participating in occupational and physical therapy.<br><br>R208's provider order dated 5/9/25 included an order for wound care to her right foot. And on 5/6/25, an order for physical and occupational therapy to evaluate and treat as clinically indicated due to an infection on the right foot.<br><br>R208's care plan dated 5/7/25, identified a problem statement for EBP indefinitely due to right heel diabetic ulcer chronic wound. Interventions included required personal protective equipment (PPE) of gloves and gown prior to the high-contact care activity. High contact care activities included, but were not limited to, dressing, grooming, bathing, transferring, personal hygiene, changing linens, changing briefs or and assisting with toileting.<br><br>During an observation on 5/20/25 from about 2:30 p.m., to 3:20 p.m. therapy assistant (TA)-E made a few trips from R208's room, with gloves on, down the hall away from R208's room, and then walk back to her room with different items including some free weights, and still wearing gloves. From the hallway, TA-E was observed in the doorway of R208's bathroom, back and forth to her bedroom area, and then transferring R208 out of the bathroom and to her room. TA-E was wearing gloves during these contacts but was not wearing a gown.<br><br>During an interview on 5/20/25 at 3:28 p.m., TA-E stated he had infection prevention training, through online orientation. TA-E explained he looked at the signs outside the doors to know what kind of precautions were in place, and stated EBP was an infection control measure to keep things from spreading from one person to another. TA-E stated PPE for EBP should be used any time he was touching the person, for activities of daily living, (ADLs), transfers, or bed mobility. TA-E confirmed he was working with R208 today and had transferred her, including in the bathroom after she had gone to the bathroom, and helped her to brush her teeth. TA-E acknowledged he shouldn't be wearing gloves in the hallway unless he was cleaning something up.<br><br>R23:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R23's admission MDS dated [DATE], indicated resident was cognitively intact with diagnoses that included recurrent enterocolitis due to Clostridium difficile (bacterial infection that can cause diarrhea), thrombocytopenia (low blood platelet count), sleep apnea, history of falling, and malaise. R23 required a moderate level of assistance for ADLs and was frequently incontinent of bowels.<br><br>During observation on 5/19/25 at 2:39 p.m., physical therapy aide (PTA)-A entered R23's room. PTA-A was wearing gloves but was not wearing a personal protective gown. PTA-A adjusted R23's shirt collar and left the room. Signs posted in the hallway outside R23's room indicated resident was on contact precautions. Also observed outside resident room was a small cart containing yellow personal protective gowns, bleach based cleaning wipes, and alcohol based hand sanitizer.<br><br>During interview on 5/19/25 at 2:40 p.m., PTA-A stated being aware of contact precautions for R23. PTA-A explained being in a hurry and was helping a coworker before the end of the shift. PTA-A did not complete hand washing after leaving R23's room.<br><br>During observation on 5/19/25 at 2:53 p.m., nursing assistant (NA)-B in R23's room taking resident's breakfast order for 5/20/25. NA-B observed not wearing PPE while in R23's room. NA-B did not complete hand washing after leaving resident's room.<br><br>During observation on 5/20/25 at 9:19 a.m., NA-A entered R23's room carrying tablet computer. NA-A did not put on any PPE before entering R23's room. NA-A exited resident room and did not do hand hygiene before walking away.<br><br>During interview on 5/20/25 at 9:20 a.m., NA-A stated R23 was on contact precautions due to having C. diff (Clostridium difficile). NA-A explained going into resident room without personal protective equipment was okay since she did not touch the resident. NA-A did not complete hand washing after leaving R23's room.<br><br>R259:<br><br>R259's diagnoses list included aftercare following a joint replacement surgery, right artificial knee, heart failure, hypertension, hyperlipidemia, type 2 diabetes, asthma, obstructive sleep apnea, depression, anxiety, and insomnia.<br><br>During observation on 5/20/25 at 10:06 a.m., signs indicating R259 was on EBP displayed on resident's door observed. NA-C put on gloves and entered R259's room. NA-C changed R259's brief, completed perineal care, and helped resident wash his face and hair. During interview after NA-C left R259's room, NA-C stated not knowing why resident was on EBP. NA-C acknowledged understanding EBP and the need to wear gown and gloves for certain cares. NA-C confirmed wearing gloves and no gown during cares. NA-C further stated he should have worn a gown while giving cares.<br><br>During an interview on 5/22/25 at 12:39 p.m., the director of nursing (DON) stated she would not expect staff to wear gloves in the hallway unless they were using a hazardous product to clean something. The DON stated this situation was not acceptable, and she also expects staff to wear PPE when precautions are posted. The DON added they have done education to employees on-the-spot regarding precaution types and gloves in the hall.<br><br>A policy, Hand Hygiene/Glove Use dated 11/8/24, identified:<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 |
|---|---|---|---|
| | 245634 | A. Building<br>B. Wing | 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aurora on France | 6500 France Avenue<br>Edina, MN 55435 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1.<br><br>Hand hygiene could be performed with soap and water or alcohol-based hand rub. When<br><br>hands were not visibly dirty, AHBR would be the preferred method for hand hygiene in the healthcare setting. The policy gave guidelines when soap and water would be used.<br><br>2.<br><br>Steps for glove use:<br><br>3.<br><br>Don gloves before touching non-intact skin, open wounds or mucus membranes.<br><br>4.<br><br>Change gloves during patient care if the hands will move from a contaminated body site to a clean body site.<br><br>5.<br><br>Perform hand hygiene after doffing gloves and donning a new pair.<br><br>6.<br><br>Remove gloves after contact with a patient and/or the surrounding environment using proper technique to prevent hand contamination.<br><br>7.<br><br>Perform hand hygiene after removing gloves.<br><br>8.<br><br>Do not wear the same pair of gloves for the care of more than one patient.<br><br>9.<br><br>Do not double glove.<br><br>10.<br><br>Do not reuse gloves.<br><br>11.<br><br>Do not wear gloves in the hallway.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A policy, Enhanced Barrier Precautions (EBP) dated 1/22/25, identified its purpose was to reduce the risk of infectious agent transmission in healthcare settings. EBP, including gowns and gloves, would be used for chronic wounds, including pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, indwelling medical devices (catheters, tubes, lines, ostomies). To be used when providing high contact resident care such as dressing, bathing, transferring, changing linens, changing briefs, assisting to the toilet, device care or wound care.<br><br>A policy, Transmission/Isolation Precautions dated 1/1/25, identified transmission-based precautions were actions implemented in addition to standard precautions based on the means of transmission. Contact precautions included gown (impermeable to fluid) gloves, and face mask or shield if splashing was likely. These precautions would be used for things such as clostridium difficile. After performing hand hygiene don gown and gloves prior to entering the room. Remove PPE and dispose of in the appropriate container before leaving the resident room. Perform hand hygiene. |