STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275043	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health & Rehabilitation	2651 South Ave W Missoula, MT 59804

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769 Based on interview and record review, the facility failed to implement a baseline care plan, for five days, for a newly admitted , nonverbal resident with a diagnosis of a subdural hematoma and stroke for 1 (#138) of 36 sampled residents. This deficient practice had the potential to affect the resident's quality of care. Findings include: A review of resident #138's EHR progress note, dated 4/26/24 at 3:08 p.m., showed: Note Text: [Resident #138] admitted on [DATE] 1:00 PM for SDH, CVA.Resident is unable to talk.Totally dependent on staff for late loss ADLs. Eating: Total dependence . A review of resident #138's care plan showed 18 focus areas. One focus area had an initiated date of 4/29/24, all other focus areas had an initiated date of 5/1/24 or later. During an interview on 7/31/24 at 10:35 a.m., staff member J stated the resident care coordinator nurse would perform an admission assessment and then trigger the baseline care plan for newly admitted residents. The expectation was the baseline care plan would be completed on the first day of the resident's stay. Staff member J stated she had forgotten to complete the baseline care plans in a timely manner on occasion. Staff member J further stated the timeframe for the completion of resident #138's baseline care plan would not meet her expectations. A review of a facility policy titled, Baseline Care Plans, reviewed 10/01/23, showed: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Include the minimum healthcare information necessary to properly care for a resident .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 14005 Based on interview and record review, the facility failed to initiate a care plan for PTSD (Post-Traumatic Stress Disorder) for 1 (#55) of 36 sampled residents. Findings include: Review of resident #55's electronic medical record showed the resident had unspecified PTSD as an admission diagnosis. Resident #55 did not have a plan of care for her PTSD. Due to the lack of a care plan, the staff would not be informed of PTSD triggers, and the best way to help resident #55 cope with events that trigger her PTSD. A SS- Trauma Screening Tool was completed on 6/18/24. Resident #55 answered no to the question of, have you ever experienced trauma in your life. There was no further documentation noted to identify trauma as shown on her diagnoses. During an interview on 7/30/24 at 11:18 a.m., resident #55 said her PTSD had been triggered because a CNA busted through her curtain and scared her. Resident #55 said if the staff knew what triggered her PTSD, the staff members would potentially knock before barging into her room. During an interview on 7/31/24 at 9:26 a.m., staff member G said she was unaware resident #55 had PTSD. Staff member G said she had not seen the physician's diagnoses list. Staff member G said a care plan had not been developed to address PTSD.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41952 Based on interview and record review, the facility failed to update the care plan related to catheter care for 1 (#107) of 36 sampled residents. Findings include: During an interview on 7/31/24 at 3:01 p.m., staff member L stated resident #107 had been followed by a local urology clinic and they managed his catheter orders. During an interview on 8/1/24 at 8:15 a.m., staff member B stated resident #107 and his POA decided to discharge from the urology clinic and focus on comfort care. Staff member B stated the nurses were supposed to change the scheduled catheter date if they used the PRN catheter change. Review of resident #107's progress note dated 5/14/24, showed, POA requested to DC out of facility appt at [local urology] and to focus on comfort needs at this time. Provider aware. Review of resident #107's Care Plan area for suprapubic catheter last updated on 2/1/24, showed an intervention as, [Resident #107] is followed by [Local Urology Clinic] for management of his suprapubic catheter. There was no intervention listed for the scheduled and PRN catheter changes. There was no intervention for the change to comfort care with discontinuation of urology appointments.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47785 Based on interview and record review, the facility failed to provide a safe environment for 1 (#90) of 36 sampled residents. This resulted in the resident falling and sustaining a significant injury. Findings include: Review of resident #90's EMR admission assessment, dated 2/3/2023, showed, .2. Fall Risks . 3. Requires use of assistive devices . 5. Impaired mobility/assist with toileting . 8. hx of falls in last month, 9. hx of falls in last 1-6 months . 4. Current fall preventative measures in place . 5. Frequent checks . 8. Call light within reach when in room . [sic] Review of resident #90's EMR nursing progress notes, dated 3/17/2024, showed, Nurse's Description: Heard CNA radio for help saying a resident is out of bed. Seen resident on the floor next to his bed, laying on his left side, with head under table metal leg . Injuries?: Left elbow skin tear with minimal bleed. Res. c/o left hip pain . Predisposing factors: Noted res bed on highest position with res saying I kept on pressing the emergency button but it doesn't work Call light not in reach . [sic] Review of resident #90's history and physical examination record from [hospital] dated 3/17/2024, showed, . [resident #90] rolled out of bed landing on his left hip .[resident #90] was unable to get up due to severe left hip pain so brought here via EMS. Noted to have a left hip fracture and will be going to OR later today for repair . Review of the Interdisciplinary Team notes dated 3/18/2024, showed, .[resident #90] fell and fractured and called 911 himself; Staff report call light had fallen to the floor and he used bed control (thinking it was call light) pushing his bed into high position; thinking staff was not coming, he tried to get up . [sic] Review of the fall investigation for resident #90, dated 4/9/2024, showed, .resident #90 was in his bed and wanted to get up. He pushed the bed remote multiple times, thinking this was the call light. This resulted in his bed being in a high position. Staff member H found him lying on the floor and called for help from the nurse on duty. During an interview on 7/30/2024 at 1:42 p.m., NF1 stated, .[resident #90] said staff was taking the call light away from him at night but I am not sure if that is accurate .I feel .he is 'safeish' there . [sic] During an interview on 7/30/24 at 3:10 p.m., staff member I stated, .he [resident #90] didn't have a call light- it was on the bedside table too far away- he called 911 himself. I argued with staff member H who tried to say he did have it [the call light]. He was mixing up the bed control with the call light- the bed was high from him pushing the button. Typically, the CNA would make sure the call light was in reach . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/2024 at 8:49 a.m., staff member H stated, I was just coming on to shift, he had his small table beside him and was holding onto something. We were passing breakfast, and he was sleeping. Then when I was in the room next to his, I heard something and went into [resident #90's] room. He had his bed really high .he was yelling but had already called 911. His call light was on the floor after he raised his bed because the cord was too short to reach. Everything was on the floor. I think he grabbed the wrong control and pushed that instead of the light. Documentation of rounds for resident #90 prior to his fall were requested on 7/31/24 at 4:15 p.m., but were not received prior to exit or before noon the following day. A copy of the facility's rounding policy was requested on 7/31/24 at 4:15 p.m., but was not received prior to the survey exit or before noon the following day.

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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. 41952 Based on observation, interview, and record review, the facility failed to manage catheter changes as the physician ordered for 1 (#107) of 36 sampled residents. This deficient practice had the potential to increase risk of infection and complications from multiple catheter changes. Findings Include: During an interview on 7/31/24 at 3:01 p.m., staff member L stated resident #107 had something wrong with his bladder which caused the catheter to keep clogging. Staff member L stated his catheter had not gone a full month without having to be changed. Staff member L stated she was not aware of any pain or recent infections for resident #107 related to his catheter. During an interview on 8/1/24 at 8:15 a.m., staff member B stated the nurses on the floor should have been moving the scheduled catheter change date out if they used the as needed catheter change order for resident #107. Staff member B stated resident #107 and his POA decided to discontinue urology and focus on comfort care in May 2024. Staff member B stated she was not aware of resident #107 complaining of any pain or symptoms of infection related to his catheter. During an observation and interview on 8/1/24 at 9:05 a.m., resident #107 was lying in bed with a blanket covering him and his catheter. Resident #107 stated, Oh, in the bladder, it burns. They [facility staff] all know about it, when asked about having any pain. During an interview on 8/1/24 at 10:09 a.m., staff member B stated we did do the PRN catheter change, but did not do the manual change of the scheduled catheter. Review of resident #107's May 2024 MAR showed orders for: - Change SP Catheter every 3 weeks with 20f 10cc foley at bedtime every 21 day(s) with a start date of 2/23/24. The catheter was changed on 5/17/24. - Flush SP catheter as needed for clogs two times a day for suprapubic catheter, clog prevention flush with 60mL sterile saline to prevent clogging, with a start date of 3/26/24. Administered two times a day for all days except 5/3/24. - Place gauze over SP site after catheter changes at bedtime every 21 day(s), with a start date of 2/23/24. Documented as completed on 5/17/24. - Flush SP catheter as needed for clogs, with a start date of 3/26/24, had not been administered for the entire month of May. - supra pubic cath change prn if clogged / malfunction as needed for SP cath care, urinary retention document date changed and re-time routine SP change date [sic] with a start date of 4/5/24. The prn catheter change was completed on 5/12/24, 5/20/24, and 5/30/24. The scheduled catheter change was not re-timed after the PRN catheter changes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #107's suprapubic catheter was changed four times in three weeks in May 2024. Review of resident #107's June 2024 MAR showed orders for: - Change SP Catheter every 3 weeks with a 20f 10cc foley at bedtime every 21 day(s), with a start date of 2/23/24. The catheter was changed on 6/7/24 and 6/28/24. - Place gauze over SP site after catheter changes at bedtime every 21 day(s), with a start date of 1/10/24. Documented as completed on 6/7/24 and 6/28/24. - Flush SP catheter as needed for clogs two times a day for suprapubic catheter clog prevention flush with 60mL sterile saline to prevent clogging, with a start date of 3/26/24. Missing documentation for five times out of the 60 flushes. - Flush SP catheter as needed for clogs as needed for suprapubic catheter . with a start date of 3/26/24. No documentation of the as needed catheter flush being administered for the entire month. - supra pubic (SP) cath change prn if clogged / malfunction as needed for SP cath care, urinary retention document date changed and re-time routine SP change date, [sic] with a start date of 4/5/24. The catheter was changed on 6/19/24. Resident #107's scheduled catheter change was not re-timed after the PRN catheter change. Resident #107's catheter was changed three times in three weeks in June 2024. Review of resident #107's July 2024 MAR showed orders for: - Change SP Catheter every 3 weeks with 20f 10cc foley at bedtime every 21 day(s), with a start date of 2/23/24. The catheter was changed on 7/19/24. - Place gauze over SP site after catheter changes at bedtime every 21 day(s), with a start date of 1/10/24. Documented as completed on 7/19/24. - Flush SP catheter as needed for clogs two times a day for suprapubic catheter clog prevention flush with 60mL sterile saline to prevent clogging, with a start date of 3/26/24. Missing documentation for 7/24/24. - Flush SP catheter as needed for clogs as needed for suprapubic catheter . with a start date of 3/26/24. No documentation of it being administered for the entire month. - supra pubic (SP) cath change prn if clogged / malfunction as needed for SP cath care, urinary retention document date changed and re-time routine SP change date, with a start date of 4/5/24. The catheter was changed on 7/8/24 and 7/28/24. Resident #107's scheduled catheter change was not re-timed after the PRN catheter changes. Resident #107's catheter was changed three times in three weeks in July 2024.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44769 Based on interview and record review, the facility failed to ensure transportation was provided for a dialysis appointment for a resident receiving dialysis at a nearby facility for 1 (#121) of 36 sampled residents. This deficient practice had the potential to cause health complications for the resident. Findings include: During an interview on 7/30/24 at 2:51 p.m., resident #121 stated on or about the morning of 2/10/24, he was waiting for his transportation to his dialysis appointment in the reception area, near the front door of the facility and had seen the [bus company name] van pull up out front. He was unable to open the front door due to the coded keypad. Resident #121 further stated that [bus company name] would call the facility and if nobody had answered they would leave. During an interview on 7/30/24 at 3:07 p.m., NF2 stated the [Bus Company name] called the facility and nobody answered and they left. NF2 further stated that resident #121 had to go to the hospital the day after missing his dialysis appointment and was in ICU for three days. During an interview on 7/31/24 at 9:42 a.m., staff member K stated she coordinated transportation for residents. Resident #121, at the time of his missed dialysis appointment, was using [bus company name] and that she only filled out a standing order request form for days and times for resident transportation by [Bus Company name]. Staff member K further stated resident #121 came to her after missing [Bus Company name], with his concern for his transportation to his dialysis appointments and she arranged for facility transportation for future dialysis appointments. During an interview on 7/31/24 at 12:59 p.m., NF6 stated if the resident was not waiting at the door when the bus arrived, the driver would call the facility. If there was no answer at the facility the driver that was picking up a resident for transportation would leave, we don't have time to wait. During an interview on 7/31/24 at 1:22 p.m., staff member B stated that [Bus Company name] would not wait, if the facility found out that a resident had missed the [Bus Company name] bus, the facility would provide transportation for the resident to their appointment. During an interview on 7/31/24 at 2:27 p.m., staff member B stated, [resident #121] did not go to his dialysis appointment on 2/10/24 and [Bus Company name] did not pick him up. The facility transportation takes him now. A review of a progress note for resident #121 in the facility EHR, dated 2/10/24 at 8:02 p.m., showed: Note Text: Resident stated that he missed his dialysis today. A review of a facility document, titled, Memorandum of Agreement, with an effective date of April 20, 2021, between [Dialysis Facility name] and [LTC Facility name], showed: 1. Responsibilities of LTCF. a. LTCF shall be solely responsible for arranging for transportation of its patient(s) to and from the Facility .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 14005 Based on observation, interview, and record review, the facility failed to provide behavioral health services for a resident with PTSD, who had previously attended counseling for managing her mental health for 1 (#55) of 36 sampled resident. Findings include: During an interview on 7/30/24 at 11:18 a.m., resident #55 said none of the facility's staff had ever talked to her about her PTSD. Resident #55 said her PTSD was triggered once while here, but she was unable to remember the date. Resident #55 said a certified nurse assistant burst through her privacy curtain which triggered her PTSD. Resident #55 said the incident scared her. Resident #55 said the social worker came in to see her twice, maybe. Resident #55 stated she had developed no relationships here, because the staff were too busy to take any time with her. Resident #55 stated she had no one she could talk to other than one bus driver. Resident #55 said it would help to have someone to talk to and someone to help her deal with the changes going on in her life. Resident #55 was recently started on dialysis, resident #55 said she was struggling with deciding to continue or potentially discontinue this life saving treatment. Resident #55 stated she had never been offered an appointment with a mental health provider or assistance with contacting her personal mental health provider. During an interview on 7/31/24 at 9:26 a.m., staff member G stated she did not know resident #55 had a diagnosis of PTSD. Staff member G did not attempt to do any local referrals for mental health care for resident #55. Staff member G did not know resident #55 had her own mental health counselor in a local town. Staff member G did not assist the resident with contacting her counselor or assist with arranging a private place to talk with the counselor. Review of resident #55's electronic medical record, dated 6/11/24 through 8/1/24, failed to show the resident had been referred for mental health services. Resident #55's care plan failed to identify triggers or direct staff on managing the resident #55's PTSD.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51133 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff wore beard coverings in the kitchen, failed to label and date food items in the walk-in freezer, and failed to properly cool left-over chicken. This deficient practice had the potential to affect all residents eating food from the facility's kitchen. Findings include: 1. During an observation on 7/28/24 at 1:35 p.m., staff member N was observed with facial hair and was not wearing a beard net in the kitchen. During an observation and interview on 7/29/24 at 1:50 p.m., staff member P was observed not wearing a beard covering in the kitchen. Staff member P stated he should have been wearing a beard covering in the kitchen. During an observation on 7/30/24 at 2:20 p.m., staff member Q had facial hair and was not wearing a beard covering in the kitchen. Review of the facility's policy, General Food Preparation and Handling, reviewed 8/10/23, showed, Hair restraints - Dietary staff must wear hair restrains (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food. 2. During an observation on 7/29/24 at 1:35 p.m., Danish pastries, round food items wrapped in cellophane, and a yellowish substance in small drink cups, in the walk-in freezer, were not labeled or dated. During an interview on 7/29/24 at 1:50 p.m., staff member P stated the Danishes in the walk-in freezer should have been dated. During an interview on 7/30/24 at 2:25 p.m., staff member O stated the round food items wrapped in cellophane were birthday cakes. Staff member O said he knew they were made about 2.5 weeks ago before the supervisor went on vacation. During an observation on 7/31/24 at 1:51 p.m., the birthday cakes wrapped in cellophane, and yellowish substance in small drink cups, in the walk-in freezer were not labeled or dated. During an observation on 8/1/24 at 8:21 a.m., the birthday cakes wrapped in cellophane in the walk-in freezer were not labeled or dated. Review of the facility's policy, General Food Preparation and Handling, reviewed 8/10/23, showed, Leftovers must be dated, labeled, covered, cooled and stored . 3. During an observation on 7/29/24 at 1:35 p.m., diced chicken was sitting out on the counter in a metal container. Staff member P stated it was sitting out for five to ten minutes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/29/24 at 1:39 p.m., staff member O said the chicken had been sitting out for 40 minutes, and he felt the bottom of the pan for the temperature during the cooling process. Staff member O said he did not know what the policy was for cooling leftovers. During an interview on 7/29/24 at 1:50 p.m., staff member O stated the chicken sitting out was at 90 degrees Fahrenheit before he put it in the walk-in cooler. During an interview on 7/30/24 at 2:41 p.m., staff member O stated the chicken cooling on the counter the previous day was, . used in soup this morning. Staff member O stated he waited until food was at room temperature or lower, and sometimes used an ice bath when cooling foods. During an interview on 8/1/24 at 1:49 p.m., staff member O was unable to locate the food cooling logs in the kitchen logbook and stated he could only locate the food temperature logs. Review of the facility's policy, General Food Preparation and Handling, reviewed 8/10/23, showed: - .All leftover or cooked food for use at a later time will be required to be handled using a time and temperature process using the following procedure. All items entering this process must be documented using a Food Cooling log sheet . - Cool from 135 degrees F to 70 degrees F in 2 hours and from 70 degrees F to 41 degrees F in 4 hours (not to exceed 6 hours).Take temperatures frequently to determine if altered methods are needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51111 Based on observation, interview, and record review, the facility failed to ensure nursing staff changed gloves and practiced hand hygiene, according to standard infection control practices, during pericare and wound care for 1 (#111); and failed to initiate enhanced barrier precautions for a resident with a PICC line for 1 (#390) of 36 sampled residents. Findings include: 1. During an observation on 7/31/24 at 2:14 p.m., staff member E gathered wound care supplies and placed them on resident #111's bedside table. Staff member E opened a drape and laid it on the bedside table. Staff member E did not sanitize the table before placing the drape and wound care supplies on the surface. Staff member E had gloves in her pants pockets to use during the resident's wound care and dressing change. Staff member F had gloves on and removed resident #111's brief prior to assisting staff member E with the dressing change for the resident's pressure ulcer. The brief was soiled and staff member F threw it away. Staff member F performed pericare around resident #111's foley catheter with clean wipes. Staff member F assisted staff member E with positioning the resident to his left side to perform wound care and a dressing change to his sacral area pressure ulcer. Staff member F wiped the resident's buttocks and the area in between his legs with clean wipes. Staff member F placed a clean brief under the resident and assisted the resident to his back. Staff member F grabbed pillows and placed them under resident #111's arms for positioning. Staff member F placed a call light on resident #111's abdominal area. Staff member F did not change her gloves or perform hand hygiene before placing a clean brief under the resident, placing the pillows, or placing the call light on the resident. During an interview on 7/31/24 at 2:34 p.m., staff member E stated she used purple top sanitizing wipes before placing wound care supplies on bedside tables. Staff member E stated she forgot to use purple top sanitizing wipes on resident #111's bedside table before placing wound care supplies upon it for his dressing change. During an interview on 7/31/24 at 2:51 p.m., staff member F stated CNAs wore gloves and practiced hand hygiene when performing pericare on residents. Staff member F stated she did not change gloves when changing a brief when she did not touch the inside of the brief. Staff member F stated before putting a clean brief on a resident, she would take her gloves off and practice hand hygiene before putting new gloves on. Staff member F acknowledged she did not change her gloves or practice hand hygiene when performing pericare and a brief change for resident #111 earlier in the afternoon when assisting staff member E. During an interview on 7/31/24 at 3:05 p.m., staff member B stated she expected CNA staff to practice hand hygiene and change gloves after pericare, before placing clean briefs on residents, and prior to performing any other cares. Staff member B stated the skills and competency checks for CNAs performing pericare happened during an annual skills fair. A review of the facility's policy, Wound Care, dated 10/24/23, reflected: . 4. Assemble supplies and place supplies on a clean surface. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275043	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health & Rehabilitation	2651 South Ave W Missoula, MT 59804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. If using disinfectant wipe to clean read the kill time and wait before placing a clean drape get enough gloves and place on clean field, not in pocket. [sic] A review of the facility's policy, Hand Hygiene, dated 10/21/23, reflected: . 1. Hand hygiene requirements: . b. Before and after contact with residents. . e. After toileting or assisting residents with . catheters, soiled linens, towels, wash cloths. . m. After contact with . urine, feces, . 51133 2. During an observation and interview on 7/29/24 at 3:18 p.m., resident #390's door did not contain a sign for enhanced barrier precautions. NF5 said resident #390 had a PICC line in place and he was being seen at the wound clinic. During an observation on 7/30/24 at 8:52 a.m., there was no PPE or signage that indicated the need for enhanced barrier precautions outside resident #390's room. During an interview on 7/31/24 at 2:23 p.m., staff member C stated enhanced barrier precautions were required for a resident with a PICC line. Staff member C stated enhanced barrier precautions were expected to be adhered to in resident #390's room, including a sign on the door. A review of the facility's policy, Enhanced Barrier Precautions, reviewed 3/20/2024, reflected: .2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for resident with any of the following: i. indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) .