STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365489	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Rehabilitation & Healthcare Center	1330 S Fulton St Port Clinton, OH 43452

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on record review, resident interview, staff interview, medical record review, employee file review, self reported incident review and review of policy, the facility failed to ensure residents were free from abuse by staff. This affected two (#14 and #60) of three residents reviewed for abuse. The facility census was 64. Findings include: 1. Review of the facility electronic medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses include pneumonia, dysphagia, lack of coordination, abnormalities of gait and mobility, generalized muscle weakness, need for assistance with personal care, difficulty in walking, unspecified fracture of shaft of left fibula, chronic obstructive pulmonary disease (COPD), hypo-osmolality and hyponatremia, atrial fibrillation (a. fib), congestive heart failure (CHF), anemia, supraventricular tachycardia (SVT), respiratory failure with hypercapnia, fibromyalgia, alcohol abuse, obesity, gastroesophageal reflux disease (GERD), dependence on supplemental oxygen, post traumatic stress disorder (PTSD), atherosclerotic heart disease, bipolar disorder, spinal stenosis, personal history of nicotine dependence, and type two diabetes mellitus (DM2). Review of the most recent Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #14 was relatively cognitively intact. Further review of the MDS assessment revealed Resident #14 required substantial/maximal assistance or was dependent for all functional abilities. Review of the facility Self-Reported Incident (SRI) tracking number 251671 revealed on 09/08/24 State tested Nursing Assistant (STNA) #198 was aggravated and grouchy with Resident #14. STNA #198 was listed as a perpetrator. The facility unsubstantiated the verbal abuse. Review of Social Services Director #231 progress note dated 09/09/24 at 10:26 A.M., revealed she was made aware this morning (09/09/24), Resident (#14) stated she experienced verbal abuse from an aide (STNA #198) last night (09/08/24). Interview on 11/13/24 at 4:21 P.M., with the Director of Nursing (DON) revealed two Residents (#14 and #60) reported to her STNA #198 would taunt them from the hallway, even when they were not assigned to be in her care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 4:25 P.M., with Resident #14 revealed when she utilized her call light, STNA #198 would often ignore it and when she would come in to assist the resident, she would respond in a rude and unprofessional manner. Resident #14 stated on 09/08/24, STNA #198 threw a pillow at her and hit her orchid, damaging it. Resident #14 states the DON was aware of the events occurred on 09/08/24. Interview on 11/14/24 at 10:20 A.M., with the Administrator and the Director of Nursing (DON) revealed knowledge of the 09/08/24 incident. Interview on 11/14/24 at 2:25 P.M., with the Administrator revealed the only corrective action taken for SRI #251671 was education provided to STNA #198 regarding abuse and there was no other corrective action taken. 2. Review of the facility electronic medical record for Resident #60 revealed an admitted [DATE], with diagnoses of other sequelae of cerebral infarction, generalized muscle weakness, lack of coordination, need for assistance with personal care, difficulty in walking, unspecified protein-calorie malnutrition, contractures of right wrist, right hand, right elbow, and left knee, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, peripheral vascular disease (PVD), occlusion and stenosis of unspecified carotid artery, overactive bladder (OAB), anxiety, depression, hypertension (HTN), and hyperlipidemia. Review of the most recent Medicare Five-Day MDS assessment dated [DATE] revealed a BIMS score of 10, indicating Resident #60's cognition was moderately intact. Further review of the MDS revealed Resident #60 was dependent for all functional abilities, was always incontinent of urine, and frequently incontinent of bowel. Review of SRI tracking number 253243 revealed Resident #60 stated a girl with a ponytail had been rough with her during care, but did not provide a name of the caregiver or dates. STNA #198 was listed as a perpetrator. The facility unsubstantiated the self reported incident. Review of Resident #60's right hip x-ray report, dated 10/22/24, revealed findings of irregularity of the right femoral neck, which may represent a nondisplaced fracture. Review of Resident #60's right hip computed tomography (CT) scan report, dated 10/23/24, revealed no fracture or dislocation. Interview on 11/13/24 at 7:40 A.M., with the DON revealed Resident #60 originally could not identify the caregiver who hurt her leg. Interview on 11/13/24 at 1:05 P.M., with Resident #60 revealed she felt STNA #198 did not like her and STNA #198 would be mean to Resident #60 when she was providing Care. Resident #60 stated STNA #198 would throw her in bed against the bed railing. Resident #60 stated when STNA #198 was not providing care to her, she would taunt her from the hallway. Interview on 11/13/24 at 4:21 P.M., with the Director of Nursing (DON) revealed two residents (#14 and #60) reported to her STNA #198 would taunt them from the hallway, even when they were not assigned to be in her care. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 9:20 A.M., with the Administrator revealed when Resident #60 was initially hurt during care provided by STNA #198, Resident #60 was unable to identify who the perpetrator was, but it was later identified the perpetrator was STNA #198. STNA #198's employment was terminated for performance issues. Review of STNA #198's employee file revealed she was terminated on 11/04/24, for gross misconduct, violating company policies, and harassing fell ow employees. Further review of the employee file for STNA #198 revealed she had been previously disciplined on 12/28/23 for insubordinate behaviors. Review of the policy titled, Abuse Investigation and Reporting, dated September 2021, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Review of the policy titled, Abuse Prevention Program, dated September 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. This deficiency represents non-compliance investigated under Complaint Number OH00159507.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, record review, Enhanced Information Dissemination and Collection (EIDC) system review, witness statement review, fall occurrence review, and policy review, the facility failed to timely report an incidence of potential neglect to the appropriate state agency. This affected one (#65) of three resident reviewed for reporting potential abuse and neglect. The facility census was 64. Findings include: Review of the facility electronic closed medical record for Resident #65 revealed an admitted [DATE], with diagnoses of unspecified B-cell lymphoma, generalized muscle weakness, lack of coordination, abnormal posture, dementia, type two diabetes (DM2), cataract, anorexia, cachexia, reduced mobility, weakness, chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypo-osmolality and hyponatremia, hypertensive heart and chronic kidney disease, stage four chronic kidney disease (CKD), gastrointestinal reflux disease (GERD), hypertension (HTN), overactive bladder (OAB), depression, and asthma. Resident #65 was on hospice prior to fall and passed away in the facility on 10/06/24. Review of the care plan, updated on 03/23/23, revealed Resident #65 had activities of daily living (ADL) self-care performance deficit related to HTN, chronic kidney disease (CKD), cognitive impairment, COPD, dementia, depression, generalized weakness, history of falls, impaired mobility, left femur fracture. Interventions included two-person assistance for bed mobility, toileting, and transfers. This intervention was to ensure that Resident #65 will maintain the current level of function with ADLs and her needs will be met. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 09, indicated Resident #65 was moderately cognitively impaired. She was dependent for toileting, putting on/taking off footwear, sitting to lying, lying to sitting, chair/bed to chair transfer, tub/shower transfer, and being wheeled in a wheelchair. She required maximal assistance of two staff members with showering/bathing, lower body dressing, and rolling left and right in bed. She required supervision for personal hygiene. Resident #65 had no falls prior to this incident. Review of the Morse Fall Risk Assessment score of 45, indicated Resident #65 was a high risk for falls. Review of the progress noted dated 09/28/24 at 5:15 A.M. revealed Resident #65 fell out of bed while one staff member, State tested Nursing Assistant (STNA) #159 was providing care without any other staff members assisting, when Resident #65 fell out of bed and onto the floor. An assessment was completed with Resident #65 complaining of left leg pain with palpation (process of using one's hand or fingers to identify a disease or injury of the body or the location of pain). The physician was notified, and orders were received to send Resident #65 the emergency room (ER) for evaluation and treatment and emergency services were notified to facilitate this transfer. The facility also notified Resident #65's husband. When asked what was being attempted when her fall occurred, Resident #65 stated, my legs went over the side. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the witness statement from STNA #159, dated 09/28/24 at 5:15 A.M., revealed STNA #159 was in the middle of care and was rolling Resident #65 way from himself and she put her legs off of the side of the bed, and she slid off the other side. She landed on her legs and her left leg was twisted to the side. She complained it was hurting her, and he helped her lie down on the floor. He put a pillow behind her head and went to tell Licensed Practical Nurse (LPN) #166. Review of the progress noted dated 09/28/24 at 11:09 A.M., revealed the facility received a call from the ER stating x-rays were completed and diagnosed Resident #65 with a left femur fracture. The ER placed Resident #65 in a cast from the left foot to hip and she would be returning to the facility on [DATE] in the afternoon. Review of the Fall Occurrence Evaluation dated 09/28/24 revealed Resident #65 slid out of bed (OOB) while one staff member was rendering care. Resident #65 complained of (c/o) pain to left leg when palpated. The physician was notified and an order to send Resident #65 to the emergency room (ER) for evaluation and treatment (eval et tx) was provided. The facility also notified Resident #65's husband. Review of the Enhanced Information Dissemination and Collection (EIDC) system, used to collect self-reported incident (SRI) by facilities, revealed there was no SRI related to Resident #65 being potentially neglected by STNA #159. Interview on 11/12/24 at 3:54 P.M., with the Administrator revealed the facility did not file a self-reported incident (SRI) for potential neglect when Resident #65 fell out of bed on 09/28/24. Interview on 11/12/24 at 4:17 P.M., with the Director of Nursing (DON) verified Resident #65 was care planned to be toileted and have bed mobility completed with the assistance of two people. Interview on 11/14/24 at 1:55 P.M., with STNA #159 revealed he was providing care for Resident #65 independently and had no other staff members in her room to assist him. He stated that at the time of the incident, he was not aware that her care plan stated she required two people to provide care. STNA #159 stated at the time the incident occurred, he was rolling Resident #65 away from him to complete her incontinence care and she placed her legs off of the side of the bed subsequently sliding off of the bed and falling to the floor. He stated at the time of the fall, both side rails were in place. Review of the policy titled, Abuse Prevention Program, dated September 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Identify and assess all possible incidents of abuse. Investigate and report any allegations of abuse within timeframes required by federal requirements. Review of the policy titled, Abuse Investigation and Reporting, dated September 2021, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on record review, hospital discharge instruction reviewed, witness statement review, fall occurrence evaluation review, staff interviews, and policy review, the facility failed to ensure a resident requiring two staff members for bed mobility was implemented which resulted in a fall from the bed with an injury. This resulted in Actual Harm when Resident #65, who was moderately cognitively impaired, required the assistance of two staff for bed mobility sustained a fall from bed, when one staff member was providing care, and the resident fell to the floor. Resident #65 experienced left leg pain and was transferred to the hospital and returned with diagnosis of a supracondylar fracture of the left femur (fracture of the shaft of the left femur), requiring a cast from the foot to the hip and treatment for pain. This affected one resident (Resident #65) of five residents reviewed for accidents. The facility census was 64. Findings include: Review of the facility electronic closed medical record for Resident #65 revealed an admitted [DATE], with diagnoses of unspecified B-cell lymphoma, generalized muscle weakness, lack of coordination, abnormal posture, dementia, type two diabetes (DM2), cataract, anorexia, cachexia, reduced mobility, weakness, chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypo-osmolality and hyponatremia, hypertensive heart and chronic kidney disease, stage four chronic kidney disease (CKD), gastrointestinal reflux disease (GERD), hypertension (HTN), overactive bladder (OAB), depression, and asthma. Resident #65 was on hospice prior to fall and passed away in the facility on 10/06/24. Review of the care plan, updated on 03/23/23, revealed Resident #65 had activities of daily living (ADL) self-care performance deficit related to HTN, chronic kidney disease (CKD), cognitive impairment, COPD, dementia, depression, generalized weakness, history of falls, impaired mobility, left femur fracture. Interventions included two-person assistance for bed mobility, toileting, and transfers. This intervention was to ensure that Resident #65 will maintain the current level of function with ADLs and her needs will be met. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 09, indicated Resident #65 was moderately cognitively impaired. She was dependent for toileting, putting on/taking off footwear, sitting to lying, lying to sitting, chair/bed to chair transfer, tub/shower transfer, and being wheeled in a wheelchair. She required maximal assistance of two staff members with showering/bathing, lower body dressing, and rolling left and right in bed. She required supervision for personal hygiene. Resident #65 had no falls prior to this incident. Review of the Morse Fall Risk Assessment score of 45, indicated Resident #65 was a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the progress noted dated 09/28/24 at 5:15 A.M. revealed Resident #65 fell out of bed while one staff member, State tested Nursing Assistant (STNA) #159 was providing care without any other staff members assisting, when Resident #65 fell out of bed and onto the floor. An assessment was completed with Resident #65 complaining of left leg pain with palpation (process of using one's hand or fingers to identify a disease or injury of the body or the location of pain). The physician was notified, and orders were received to send Resident #65 the emergency room (ER) for evaluation and treatment and emergency services were notified to facilitate this transfer. The facility also notified Resident #65's husband. When asked what was being attempted when her fall occurred, Resident #65 stated, my legs went over the side. Review of the witness statement from STNA #159, dated 09/28/24 at 5:15 A.M., revealed STNA #159 was in the middle of care and was rolling Resident #65 way from himself and she put her legs off of the side of the bed, and she slid off the other side. She landed on her legs and her left leg was twisted to the side. She complained it was hurting her, and he helped her lie down on the floor. He put a pillow behind her head and went to tell Licensed Practical Nurse (LPN) #166. Review of the progress noted dated 09/28/24 at 11:09 A.M., revealed the facility received a call from the ER stating x-rays were completed and diagnosed Resident #65 with a left femur fracture. The ER placed Resident #65 in a cast from the left foot to hip and she would be returning to the facility on [DATE] in the afternoon. Review of the Fall Occurrence Evaluation dated 09/28/24 revealed Resident #65 slid out of bed (OOB) while one staff member was rendering care. Resident #65 complained of (c/o) pain to left leg when palpated. The physician was notified and an order to send Resident #65 to the emergency room (ER) for evaluation and treatment (eval et tx) was provided. The facility also notified Resident #65's husband. Review of Emergency Department Discharge Instructions for Resident #65 dated 09/28/24 revealed a diagnosis of a supracondylar fracture of the left femur (fracture of the shaft of the left femur). Resident #65 was to elevate leg with one to two pillows to reduce swelling, evaluate cast routinely (at least twice daily) to evaluate for integrity and sore sports, administer one Norco tablet every six hours for pain, administer Lactulose twice daily to reduce risk of constipation, and contact the orthopedic surgeon for follow-up. Review of the electronic medical record for Resident #65 revealed new orders for pain management were received. Resident #65 discharged from the hospital with orders for one tablet of Hydrocodone/Acetaminophen (Norco) 5/325 milligram (mg) to be administered every six hours as needed (PRN) for pain. The order for Hydrocodone/Acetaminophen 5mg/325mg was discontinued on 09/29/24 due to not effectively managing the pain from fracture. On 09/29/24, orders were received to administer Methadone every six hours as well as Morphine Sulfate (MS) every four hours PRN. Interview on 11/12/24 at 1:15 P.M., revealed STNA #159 was changing Resident #65 by himself. Interview on 11/12/24 at 4:17 P.M., with the Director of Nursing (DON) verified Resident #65 was care planned to be toileted and have bed mobility completed with the assistance of two people. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/12/24 at 4:35 P.M., with the Administrator and the DON revealed there was a fall investigation completed by the facility after this incident and the corrective action was taken by educating all staff on following resident care plans appropriately and to always use two staff members when caring for Resident #65 on 11/11/24. The facility also completed a fall audit on 11/08/24 on all past falls. Interview on 11/14/24 at 1:55 P.M., with STNA #159 revealed he was providing care for Resident #65 independently and had no other staff members in her room to assist him. He stated that at the time of the incident, he was not aware that her care plan stated she required two people to provide care. STNA #159 stated at the time the incident occurred, he was rolling Resident #65 away from him to complete her incontinence care and she placed her legs off of the side of the bed subsequently sliding off of the bed and falling to the floor. He stated at the time of the fall, both positioning side rails were in place. Review of the facility policy titled, Falls, dated September 2021, revealed the staff will identify interventions related to the resident's specific risks and causes to try to prevent he resident from falling and try to minimize complication from falling. This deficiency represents non-compliance investigated under Complaint Number OH00159072 and OH00159507.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure proper infection control practices were maintained for residents in isolation. This affected one resident (Resident #54) of one resident reviewed for enhanced barrier precautions (EBP). The facility census was 64. Findings include: Review of the facility electronic medical record for Resident #54 revealed an admitted [DATE] with diagnoses of cellulitis, other gram-negative sepsis, atrial fibrillation (a. fib), heart failure, unspecified protein-calorie malnutrition, non-pressure chronic ulcer of unspecified part of unspecified lower leg, non-pressure chronic ulcer of unspecified part of right lower leg, non-pressure chronic ulcer of unspecified part of left lower leg, non-pressure chronic ulcer of unspecified heel and midfoot, other disorders of plasma-protein metabolism, other disorders of glycoprotein metabolism, other signs and symptoms involving the musculoskeletal system, acute kidney failure (AKF), bradycardia, hypotension (HOTN), cellulitis of unspecified part of limb, severe sepsis without shock, urinary tract infection (UTI), obstructive and reflux uropathy, and stage three chronic kidney disease (CKD3). Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #54 was dependent for all functional abilities and was moderately cognitively impaired. Observation on [DATE] at 5:00 A.M., of Resident #54's room revealed a sign by the door for EBP. At this time, State tested Nursing Aide (STNA) #116 and STNA #117 entered Resident #54's room to provide incontinence care without wearing the required personal protective equipment (PPE) required when providing incontinence care to a resident in EBP. The required PPE for EBP is a gown and gloves. Interview on [DATE] at 5:04 A.M., with STNA #116 and STNA #117 revealed both aides were entering Resident #54's room to provide incontinence care without utilizing the required PPE for EBP. Further interview on [DATE] at 5:04 A.M. ,with STNA #116 and STNA #117 revealed they were not aware that Resident #54 was still in EBP and thought the order was expired. Review of the facility electronic medical record for Resident #54 revealed an order for EBP was placed on [DATE] at 3:04 P.M., for a wound to coccyx. Interview on [DATE] at 5:05 A.M., with STNA #116, STNA #117, Licensed Practical Nurse (LPN) #138, and LPN# 167 verified Resident #54 had an order for EBP that was placed on [DATE] at 3:04 P.M. for a wound to coccyx. Interview on [DATE] at 8:40 A.M., with the Director of Nursing (DON) verified Resident #54 had an order for EBP that was placed on [DATE] at 3:04 P.M. for a wound to coccyx. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Enhanced barrier Precautions, dated [DATE], revealed Enhanced Barrier Precautions (EBP) are an infection control method used in the facility to reduce transmission of drug-resistant organisms (MDROs). EBP refers to the use of glow and gloves during high-contact care activities for residents with the following: known infection or colonization with a resistant organism when Contact Precautions do no otherwise apply, chronic wounds, indwelling medical devices. Chronic wounds include: pressure ulcers/diabetic ulcers/non-healing surgical wounds/Venous Stasis Ulcer. The high-contact resident care activities are typically bundled care activities that are provided either during the morning or evening care and include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device (for example, central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care), performing wound care.