Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Divine Rehabilitation and Nursing at Shane Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: 10731 State Route 118 Rockford, OH 45882	

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident authorization form was in place for a resident with a personal fund account. This affected one (#15) of the six residents reviewed for personal fund accounts. The facility census was 64. Findings included: Review of the medical record for Resident #15 revealed an admitted [DATE], with medical diagnoses of diabetes mellitus, hyperlipidemia, anemia, and dementia. Review of the medical record for Resident #15 revealed an annual Minimum Data Set (MDS) assessment, dated 01/08/24, which indicated Resident #15 had moderate cognitive impairment and required moderate staff assistance with toilet hygiene and bathing and set-up assistance with transfers and bed mobility. Review of the medical record for Resident #15 revealed a Resident Fund Statement, dated 12/30/23 through 03/29/24 which indicated Resident #15 had a personal fund account with the facility. Further review of the medical record for Resident #15 revealed no documentation to support the resident or resident representative who had signed a personal fund account authorization form. Interview on 04/04/24 at 3:31 P.M., with Business Office Manager (BOM) #321 confirmed the medical record for Resident #15 did not contain documentation to support the resident or resident representative had signed an authorization form for a personal fund account. Review of the undated policy titled, Resident Personal Funds, stated if the resident chooses to deposit personal funds with the facility, upon written authorization of the resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited in the facility.

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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	366125	A. Building B. Wing	04/10/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on observations, staff and resident interviews, revealed the facility failed to maintain a homelike environment in completing repairs. This affected one (#60) of 23 resident rooms observed. The facility census was 64. Findings include: Review of medical record for Resident #60 revealed admitted [DATE]. The resident was admitted with diagnoses including dementia with sever psychotic disturbances, type two diabetes mellitus, anxiety, bipolar disease, and chronic pain syndrome. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 11 indicating impaired cognition. He was independent or required supervision only for activities of daily living. Interview on 04/03/24 at 8:34 A.M., with Resident #60, revealed he pointed out the drywall which was damaged from his recliner and his bathroom faucet dripped. He stated he placed paper towels in the sink to muffle the sound of the dripping. Observation on 04/03/24 at 8:34 A.M., revealed there were four damaged drywall areas approximately four feet from the floor and directly behind the top of the recliner. Three of the areas were approximately one inch () by (x) one eighth (1/8) inch. One of the areas was approximately 3.0 x one quarter (1/4) inch. Observation of the bathroom sink revealed the faucet had a slow, steady drip of water. This was verified with State tested Nursing Assistant #231. Interview on 04/03/24 at 11:05 A.M., with Maintenance Director #319 revealed he was unaware Resident #60's faucet was leaking, but it would not be a concern if it was leaking directly into the sink. He also denied knowledge of the drywall damage to the wall behind Resident #60's recliner and stated it would be something fixed after the resident moved out and the room would be redone. This deficiency represent the noncompliance investigated under Complaint Number OH00151833.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on observation of wound care, record review, resident interview, staff interview, and review of policy, the facility failed to ensure residents did not acquire pressure ulcers from medical devices in place. This affected one (#32) of three residents reviewed for pressure ulcers. The current census is 64. Findings include: Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #32 include fracture of right femur, transverse fracture of right fibula, acute kidney injury, diabetes type 2, asthma, heart disease, and pressure ulcers of bilateral buttocks. Review of the comprehensive Minimum Data Set (MDS) assessment dated revealed the resident had intact cognition, had pressure ulcer upon admission, and was a 2-person assist for Activities of Daily (ADL). Review of Resident #32's care plans dated 02/19/24 revealed a focus for cellulitis of the lower extremities, open area right lower leg. Interventions include on 02/26/24 keep right leg immobile, Unna boot with Profore wraps to bilateral leg, apply every other day using a 2-3 person assist to keep right leg immobile. Further review of the care plans revealed a focus for acute pain related to fracture of right femur. Interventions include pad splint and casting at the top of upper thigh and heel on the right lower leg with gauze pads to protect from skin breakdown. Keep splint on right leg, remove only for pulse and skin checks. Review of Resident #32's physician orders for the right leg revealed on 02/26/24 at 7:00 A.M., the resident was to have Unna boot with Profore wraps to bilateral legs every other day using a 2-3 person assist to keep right leg immobile, every other shift every other day. The order was discontinued on 03/01/24. Review of the order dated 03/01/24 the wound dressing order changed to cleanse open areas with Dakin's 0. 125%, pat dry, apply Urgotul silver, followed by ABD pad, wrap full leg from toes to bend of knee with gauze/kerlix, then wrap with Ace wrap. Change daily and as needed every night shift for wound care. This order was discontinued on 03/04/24. Review of the order dated 03/05/23 the wound dressing order changed right lower leg cleanse open areas with Dakin's 0.125% pat dry, apply Urgotul silver, followed by ABD pad, wrap full leg from toes to bed of knee with gauze/kerlix, then wrap with Ace wrap every day shift once a day. This order was discontinued on 03/28/24. Review of Resident #32's progress notes dated 03/01/24 at 8:30 A.M., revealed the Certified Nurse Practitioner (CNP) #350 documented Resident #32's right posterior leg had a fluid filled blister. The right medial lower leg has an open area. The anterior ankle is noted to have a purple, non-blanchable area and a superficial open area at the center. Per the note the CNP documented her impression as a suspected deep tissue injury to the right anterior ankle related to a medical device and a suspected deep tissue injury and stage two pressure injury to the right upper posterior thigh. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's wound assessments dated 03/01/24 to 04/01/24 revealed the upper posterior thigh suspected deep tissue injury was staged at a pressure ulcer stage 2 had healed as of 03/28/24. The right anterior ankle suspected deep tissue injury was staged as a pressure ulcer stage 2 and was improving. Further review of Resident #32's progress notes revealed on 03/06/24 at 12:52 P.M., Registered Nurse (RN) #411 documented in a progress note the nurse observed and evaluated Resident #32's braces were not applied correctly, the Unna boots were not on correctly, the skin was cool to touch on the left leg and toes. Resident #32's right leg was warm to tough. Pressure ulcers present related to missing placement of the braces. Per the note the nurse updated CNP #350 and the provider ordered to send the resident to the hospital for evaluation and treatment. Interview on 04/01/24 at 3:40 P.M., with Resident #32 revealed the resident was alert and oriented. Resident #32 stated he has had a lot of issues with his legs and recently he was notified he had some more wounds due to the braces not being applied correctly. Resident #32 stated he did not have any increased pain with the new wounds. Resident #32 did state he had to go to the hospital, at the beginning of 03/2024, to be treated for possible blood clots due to the braces being too tight. Resident #32 stated he returned the same day and stated the hospital staff told him he did not have any blood clots. Resident #32 stated he did not have concerns regarding his wound care at the facility at the time he had the different dressings he understood the nursing staff were unsure of how to apply his braces to prevent new ulcers. Interview on 04/03/24 at 1:57 P.M., with RN #411 revealed the nurse was caring for Resident #32 prior to and after 03/01/24 when the pressure ulcers to his right leg were discovered. RN #411 stated she believed and notified Certified Nurse Practitioner (CNP) #350 the resident had new skin issues due to the staff not applying the boots and splints to his bilateral legs. RN #411 stated the CNP #350 ordered for Resident #32 to be sent to the hospital for treatment of the new wounds caused by the splints and boots. Interview on 04/04/24 at 10:20 A.M., with CNP #350 stated when she was assessing Resident #32's legs on 03/01/24 she noted the resident had two suspected deep tissue injuries from improper placements of the splints on the resident's right leg. Per CNP #350, both the wounds she observed did develop into stage two pressure ulcers. CNP #350 stated upon discovery of the Unna boots being applied too tightly on 03/01/24 she ordered new dressings for the resident. CNP #350 stated on 03/06/24 she was notified by the nurse the resident's legs and toes showed decrease signs of circulation so she ordered the resident to be seen at the hospital. CNP #350 verified she felt the pressure ulcers to the right leg on the thigh and the ankle were due to the improper placement and improper wrapping of the dressing. Observation of 04/04/24 at 10:30 A.M., of Resident #32's wound dressing revealed the right thigh wound appeared to be healed with no open areas. The right ankle wound appeared to be as described in the wound documentation, a stage two pressure ulcer. CNP #350 was observed measuring and documenting the conditions of the resident's wounds. CNP #350 was observed applying the wound dressing as prescribed. Resident #32 denied any issues with his wounds at the time of the observation. Review of the undated facility policy titled, Pressure Injury Prevention and Management, revealed the facility will assess and revised any interventions which may cause avoidable pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represent the noncompliance investigated under Complaint Number OH00151812 and OH00151833.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44076 Based on record review and staff interviews, the facility failed to ensure residents were free of potential hazards and accidents. This affected one (#60) resident and had the ability to affect 19 additional residents (#7, #8, #11, #14, #28, #29, #30, #34, #36, #39, #40, #41, #48, #50, #51, #53, #56, #58, and #59) in the memory unit who were cognitively impaired and independently mobile. The facility census was 64. Findings include: Review of medical record for Resident #60 revealed admitted [DATE]. The resident was admitted with diagnoses including dementia with severe psychotic disturbances, type two diabetes mellitus, anxiety, Bipolar Disease, and chronic pain syndrome. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 11 indicating impaired cognition. He was independent or required supervision only for activities of daily living. Review of the progress note on 03/07/24 at 9:29 P.M., revealed Licensed Practical Nurse (LPN) #104 documented she had been informed by an unidentified State tested Nursing Assistant, that Resident #60 had gotten into staffs' bag and took a lighter and cigarette. Staff had been able to get the lighter, but Resident #60 refused to give them the cigarette. Attempts to redirect Resident #60 were unsuccessful, and his family was called. Resident #60's son-in-law came to the facility and the incident was deescalated. Interview on 04/04/24 at 8:42 A.M., with LPN #104 revealed she had gotten in report at shift change Resident #60 had been having increased moodiness. She was alerted by staff around shift change Resident #60 had gotten into a staff members coat which had been hanging in a common area at the end of the unit. Staff had been able to get the lighter from him. However, multiple attempts to get the cigarette were unsuccessful. The family was then called to inform them of the incident and increased behaviors. Resident #60's son in law came to the facility and after walking Resident #60 outside the facility for a bit, he was able to get Resident #60 to turn over the cigarette. LPN #104 then explained, normally the staff's personal items would be locked in the nursing office, however, the area was under construction at the time of the incident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on observation, record review, staff and resident interviews, interview with respiratory care provider, and policy review, the facility failed to ensure a resident's noninvasive ventilator such as bi-level positive airway pressure (BiPap), average volume-assured pressure support (AVAPS), or continuous positive airway pressure was administered as ordered. This affected one (#25) resident of four residents reviewed for noninvasive ventilators. The facility identified four residents had noninvasive ventilators. The facility census was 64. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE], with medical diagnoses of chronic obstructive pulmonary disease, morbid obesity, chronic kidney disease stage III, and congestive heart failure. Review of the medical record for Resident #25 revealed a quarterly Minimum Data Set (MDS) assessment, dated 01/11/24 which indicated Resident #25 was cognitively intact and required moderate staff assistance for bed mobility, maximum staff assistance for transfers and toilet hygiene, and was dependent for bed mobility. Review of the MDS revealed the use of oxygen and noninvasive mechanical ventilator. Review of the medical record for Resident #25 revealed a physician order dated 07/19/22, for BiPap mode with setting at eight minimum pressure support, six maximum pressure, 18 target rate, and 14 bleed in three liters of oxygen every night shift. Review of the medical record for Resident #25 revealed the March and April 2024 Treatment Administration Record (TAR) revealed no documentation to support the Bipap was administered as ordered on 03/25/24 - 03/31/24 and on 04/01/24. Review of the medical record for Resident #25 revealed a nurse progress note, dated 03/25/24 at 6:03 A.M., which stated the Bipap mask was broken-blue plastic loop that connects the mask straps. The note stated the respiratory company was called but could not reorder parts due to after hours and would pass it on to the dayshift nurse to order. Review of the order form from the respiratory company dated 03/25/24 revealed the facility ordered the mask for Resident #25. Interview on 04/03/24 at 9:50 A.M., with Registered Nurse (RN) #106 stated she called the respiratory company and ordered the part for resident on the morning on 03/25/24. RN #106 stated Resident #25 had two Bipap masks in her room and was not sure if either mask worked. Observation with interview on 04/03/24 at 10:00 A.M., with Resident #25 stated she has not worn her Bipap machine since 03/25/24 because her mask was broken. Resident #25 confirmed she had two Bipap masks sitting on the bedside table but was not sure if either of the masks worked properly. Observation revealed two Bipap masks sitting on her bedside table near the Bipap machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/03/24 at 11:05 A.M., with a representative from the respiratory company confirmed the facility ordered Resident #25 a new Bipap mask on 03/25/24 and stated the new mask was delivered to the facility on [DATE]. Interview on 04/03/24 at 4:11 P.M., with Director of Nursing (DON) confirmed the new Bipap mask for Resident #25 arrived on 03/27/24. DON confirmed staff has not administered the Bipap machine as ordered for 03/27/24 through 04/02/24. Review of the undated policy titled, Noninvasive ventilation (CPAP, Bipap, AVAPS, Trilogy), stated the facility was to provide noninvasive ventilation as per physician's order and current standards of practice. The policy stated Bipap or bi-level positive airway pressure was a respiratory therapy intervention used to provide a patent airway during periods of sleep apnea. It uses air pressure generated by a machine, delivered through a tube into a mask that fits over the nose or mouth. The policy stated to replace equipment immediately or when equipment is available, when it was broken and malfunctions, or if visible soiling remains after cleaning. This deficiency represents non-compliance in regards to the allegations for Complaint Number OH00151883.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff interview, and review of policy, the facility failed to monitor blood pressure prior to the administer of medications as ordered. This affected for one (#24) of five residents observed for medication administration. The facility census was 64. Findings include: Review of the medical record of Resident #24 revealed an admitted [DATE]. Diagnoses include hypertension, diabetes mellitus type II, and schizoaffective disorder. Review of the physician order dated 07/09/23 revealed metoprolol tartrate 50 milligrams (mg) by mouth two times daily for hypertension, hold in SBP (systolic blood pressure) is less than 110 mm/Hg (milliliters of mercury) or heart rate less than 60 beats per minute. A second order dated 07/11/23 for amlodipine 10 mg once daily for acute kidney injury and hold if SBP less than 110 mm/Hg. Observation of medication administration on 04/03/24 at 10:20 A.M., revealed Licensed Practical Nurse (LPN) #114 removed a 50 milligram (mg) tablet of metoprolol and a 10 mg tablet of amlodipine (both for hypertension) to administer to Resident #24. Both medications had instructions to hold if the systolic blood pressure was less than 110 milliliters of mercury (mm/Hg) and for the metoprolol hold if the heart rate was less than 60 beats per minute. LPN #114 administered both medications without obtaining a blood pressure or heart rate value. Interview with LPN #114 immediately following the administration provided verification LPN #114 had not obtained a blood pressure or heart rate value prior to administering the medications. Review of the undated policy titled Medication Administration revealed to obtain and record vitals signs when applicable and or ordered by the physician. This deficiency represents non-compliance in regards to the allegations for Complaint Number OH00151883 and OH00151405.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on observation, staff interview and review of the product insert instructions, the facility failed to ensure insulin pen needles were primed after a new needle was applied. This affected one (#24) of two residents observed for insulin administration. The facility census was 64. Findings include: Review of the medical record of Resident #24 revealed an admitted [DATE]. Diagnoses include hypertension, diabetes mellitus type II, and schizoaffective disorder. Review of the physician order dated 11/20/23 revealed Insulin Aspart (with Niacinamide) eight (8) units routinely and additional units as necessary related to sliding scale to be injected subcutaneously four times daily related to diabetes mellitus type II. Observation on 04/03/24 at 10:20 A.M., revealed Licensed Practical Nurse (LPN) #114 placed a new needle onto the Aspart insulin pen for Resident #24. LPN #114 dialed the pen to 18 units and injected Resident #24 with the insulin, LPN #114 verified he had not primed the needle stating I thought that was just with a new pen. Review of the manufacturer's product insert revealed instructions to check the flow of medication through the needle before every injection.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on observation, staff interview, and review of policy, the facility failed to ensure personal protective equipment (PPE) was utilized during a procedure for one resident (#04) of two residents with Enhanced Barrier Protection (EBP) in place. The facility also failed to ensure staff performed proper hand hygiene when performing tracheostomy care for one (#04) resident out of the two residents reviewed for tracheostomy care. Furthermore, the facility failed to ensure a sanitary environment was provided during meal service. This directly affected one resident (#20) and had the possibility to affect five males (#13, #17, #20, #24, and #61) who eat in their rooms. The facility census was 64. Findings included: 1. Review of the medical record for Resident #04 revealed an admitted [DATE], with medical diagnoses of chronic obstructive pulmonary disease, heart failure, traumatic subarachnoid hemorrhage, and hypertension. Review of the medical record for Resident #04 revealed a quarter Minimum Data Set (MDS) assessment, dated 02/18/24, which indicated Resident #04 had moderate cognitive impairment and required maximum staff assistance for bathing, bed mobility, and transfers and was dependent upon staff for toilet hygiene. Further review of the MDS revealed Resident #04 had a colostomy, tracheostomy, and indwelling catheter. Observation on 04/03/24 at 12:45 P.M., of Registered Nurse (RN) #106 providing catheter care for Resident #04 revealed RN #106 pulled down the front of Resident #04's pants and adult incontinence briefs with ungloved hands. RN #106 then donned a plastic isolation gown and gloves. RN #04 obtained a basin of water and two wash cloths. RN #106 wet one wash cloth with soapy water and cleansed the insertion site of the suprapubic catheter using aseptic technique. RN #106 removed her gloves and placed a split four-inch by four-inch gauze around the catheter and taped it in place. Interview with RN #106 immediately after the procedure provided verification, she had not used proper enhanced barrier precautions when providing catheter care for Resident #04. Observation on 04/04/24 at 10:07 A.M., of RN #109 complete tracheostomy care for Resident #04 revealed RN #109 washed her hands prior to donning gown and gloves. RN #109 removed Resident #04's inner tracheostomy cannula and dressing around the tracheostomy site then removed her gloves. RN #109 then donned new gloves and inserted the new clean inner cannula. RN #109 proceeded to remove her gloves and opened a tracheostomy kit to get the normal saline and cotton tipped applicators from the kit. RN #109 continued to open both bedroom and bathroom drawers with her bare hands looking for additional supplies prior to applying new gloves and using the supplies to clean around Resident #04's tracheostomy site. RN #109 applied new tracheostomy ties and sponge drainage dressing around the tracheostomy site. RN #109 removed her gloves and handed Resident #04 his water pitcher. RN #109 washed her hands prior to leaving Resident #04's room. (continued on next page)

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 at 10:25 A.M., with RN #109 confirmed she did not perform hand hygiene after removing her gloves at any time during the tracheostomy care or prior to handing Resident #04 his water pitcher. RN #109 confirmed Resident #04 was under EBP and she did not wear a mask when performing the tracheostomy care. Review of the policy titled, Enhanced Barrier Precautions dated 03/20/24 revealed personal protective equipment for enhanced barrier precautions is necessary only when performing high-contact activities. The policy stated EBP would be obtained for residents with wounds and/or indwelling devices (central lines, indwelling catheter, tracheostomy/ventilator tubes). Review of the undated policy titled, Tracheostomy Care stated the facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-center care plan and resident goals and preferences. Policy stated tracheostomy care would be provided per physician orders. The policy stated to perform hand hygiene per facility policy, put exam gloves on both hands, masks and eye wear should be work if there is a likelihood of splashes and splattering. The policy state to remove old dressing and remove gloves and discard dressing and gloves. Perform hand hygiene, apply gloves, insert new inner cannula, clean stoma with normal saline moistened cotton-tipped applicators, change trach ties, and replace split dressing. The policy continued to state to dispose of equipment and perform hand hygiene. 2. Observation on 04/03/24 at 12:45 P.M., of Registered Nurse (RN) #106 providing catheter care for Resident #04 revealed RN #106 pulled down the front of Resident #04's pants and adult incontinence briefs with ungloved hands. RN #106 then donned a plastic isolation gown and gloves. RN #04 obtained a basin of water and two wash cloths. RN #106 wet one wash cloth with soapy water and cleansed the insertion site of the suprapubic catheter using aseptic technique. RN #106 removed her gloves and placed a split four-inch by four-inch gauze around the catheter and taped it in place. Interview with RN #106 immediately after the procedure provided verification she had not used proper enhanced barrier precautions when providing catheter care for Resident #04. 3. Observation on 04/01/24 at 11:48 A.M., revealed State tested Nursing Assistant (STNA) #233 sat a tray of food on the overbed table of Resident #20. A urinal was on one end of the table with approximately 200 milliliters of urine in it. This surveyor interviewed STNA #233 after she exited the room about the urinal placed on the overbed table, near the food. STNA #233 stated That is where he likes it and gets upset if it is not there. STNA #233 verified there was urine in the urinal and then emptied it in the toilet and replaced the urinal on the over bed table. Review of the policy titled Enhanced Barrier Precautions dated 03/20/24, revealed personal protective equipment for enhanced barrier precautions is necessary only when performing high-contact activities. This deficiency represents non-compliance investigated under Complaint Number OH00151883 and OH00151938.