STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 11) had their urine collection bag fully covered. This deficient practice had the potential for Resident 11 to feel embarrassed and feel a loss of dignity. Findings: During a review of Resident 11's Admission Record (AR), the AR indicated Resident 11 was admitted to the facility on [DATE] and the reason for visit was for aftercare following joint replacement. During a review of Resident 11's History and Physical (H&P) dated 4/11/2025, the H&P indicated Resident 11's chief complaint was aftercare following joint replacement and Resident 11 had a past medical history of colon (longest part of the large intestine [long tubed-shaped organ in the abdomen that completes the process of digestion [breakdown of food]) cancer (type of cancer that develops in the colon, which is the longest part of the large intestine), heart disease (problems with the heart's ability to pump blood properly) and hypertension (condition where the force of your blood pushing against the artery walls is consistently too high.) During a review of Resident 11's current undated Minimum Data Set (MDS - a resident assessment tool) provided by the facility, the MDS indicated Resident 11's primary medical condition category that best described the primary reason for admission was hip and knee replacement. The MDS indicated Resident 11 used an external catheter (device placed outside the body, to help collect urine.) The MDS further indicated Resident 11 had intact cognition (ability to understand and process information) and was dependent (helper does more than half the work) on staff for toileting and bathing. During a concurrent observation and interview on 5/14/2025 at 8:31 AM with Certified Nursing Assistant (CNA) 1, Resident 11's urine collection bag was observed hanging on the left side of Resident 11's bed with a cover attached to the top of the bag. CNA 1 stated CNA 1 could see the bottom half of the urine collection bag and the bag should be fully covered for privacy of Resident 11 and to protect the resident's dignity. During an interview on 5/15/2025 at 3:29 PM with the Resource Nurse (RSN), the RSN stated the urine collection bag should be fully covered to protect Resident 11's privacy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights, last approved 10/2024, the P&P indicated the unit must provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 70) did not have more than three bed side rails while the bed was in the raised position. This deficient practice had the potential to result in Resident 70 to feel trapped in Resident 70's bed. Findings: During a review of Resident 70's Admission Record (AR), the AR indicated Resident 70 was admitted to the facility on [DATE] and indicated the reason for visit was respiratory failure with hypoxia (when the lungs cannot provide the body with enough oxygen [colorless, odorless gas]) During a review of Resident 70's History and Physical (H&P), dated 5/2/2025, the H&P indicated Resident 70 had multiple diagnoses including congestive heart failure (condition where the heart muscle weakens and can't pump enough blood to meet the body's needs). During a review of Resident 70's current undated Minimum Data Set (MDS - a resident assessment tool) provided by the facility, the MDS indicated Resident 70 had intact cognition (ability to understand and process information) and required maximal assistance (helper does more than half the work) for eating, toileting, and bathing. During a concurrent observation and interview on 5/12/2025 at 11:19 AM with Certified Nursing Assistant (CNA) 1, Resident 70 was observed in bed with four of four side rails in the raised position. CNA 1 stated Resident 70 should only have three side rails up in the raised position. CNA 1 also stated having all four side rails raised had the potential for Resident 70 to feel as if Resident 70 was in prison or feel trapped in bed. During an interview on 5/15/2025 at 2:13 PM with the Resource Nurse (RSN), the RSN stated Resident 4 should not have all four side rails in the up position because it could be considered a restraint. During a review of Resident 70's Orders - All Active (OAA), dated as of 5/14/2025, the OAA indicated Resident 70 had an active physician's order for up to three side rails, the order's start date was 4/30/2025. During a review of Resident 70's Transitional Care Unit - Side Rails Assessment (SRA) dated 4/30/2025, the SRA indicated the number of side rails used at resident/ resident representative preferences or request was up to three side rails. The SRA further indicated the number of side rails indicated to assist in bed mobility was up to three side rails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Side/Bed Rail Use Policy, last approved 10/2024, the P&P indicated no more than three (3) side/ bed rails will be used, unless resident is on seizure precautions with padded side rails or if the resident or resident representative exercises their right(s) to have all four (4) side rails up.

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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** 48729 Based on observation, interview, and record review the facility failed to ensure pressure ulcer/injury [PU/PI, localized injury to the skin and or underlying tissue usually over a bony prominence as result of pressure or pressure in combination with shear (mechanical force that cause the skin to break off) and/or friction [movement of one surface of the skin against the others]) prevention interventions were implemented for one of two sampled residents (Resident 10) to minimize the risk of developing PIs. Additionally, the facility failed to treat Resident 10's existing moisture associated skin damage (MASD) by failing to: a. Ensure Resident 10's heels were not touching the mattress b. Ensure Resident 10 was turned every two hours c. Ensure the facility's protocol for MASD was implemented This deficient practice had the potential to result in the development of PIs to Resident 10 and result in further damage to Resident 10's skin, pain, discomfort, and an infection. Findings: a. During a review of Resident 10's Inpatient Facesheet (IF, admission record), the IF indicated Resident 10 was admitted to the facility on [DATE]. The IF indicated the reason for visit was urinary a tract infection (UTI - an infection of the urinary system, which includes the kidneys, ureters, bladder, and urethra). During a review of Resident 10's Family Practice History and Physical (H&P), dated 4/5/2025, the H&P indicated Resident 10 had multiple diagnoses including cerebrovascular accident (medical condition where blood flow to the brain is interrupted) with hemiparesis (muscle weakness on one side of the body), and seizures (sudden and uncontrolled waves of electrical activity in the brain, causing involuntary movement or loss of consciousness). During a review of Resident 10's undated Minimum Data Set (MDS - a resident assessment tool) provided by the facility, the MDS indicated Resident 10 had moderate impaired cognition (ability to understand and process information), was dependent (helper does all of the effort) on staff for toileting, and required maximal assistance (helper does more than half of the effort) with bathing and rolling left to right. The MDS further indicated Resident 10 was at risk for developing PIs. During a review of Resident 10's physician order titled, Pressure Injury: Prevention Protocol with a start date 4/5/2025, the order indicated to float both heels off the bed by placing pillows under both calves. During a review of Resident 10's Braden Scale, Pressure Injury Prevention Assessment, dated 5/12/2025, the assessment indicated Resident 10 was at high risk for developing PIs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/14/2025 at 9:23 AM in Resident 10's room, Resident 10 was observed with one pillow underneath both legs and both heels were touching the mattress. During a concurrent observation and interview on 5/15/2025 at 9:54 AM with Certified Nursing Assistant (CNA) 2, Resident 10 was observed with a pillow underneath both legs and both heels were touching the mattress. CNA 2 stated Resident 10's heels were touching the mattress and Resident 10 needed a second pillow underneath the legs to lift the heels off the mattress. CNA 2 stated to float a resident's heels meant the heels should not be touching the mattress and should hang off the pillows to prevent any potential injury. During an interview on 5/15/2025 at 2:13 PM with the Resource Nurse (RSN), the RSN stated to float a resident's heels, a pillow should be placed underneath the calves and ensure the heels were not touching the mattress. This was important to prevent any deep tissue injury or blanchable redness. The RSN stated the heels were especially prone to pressure injuries. b. During a review of Resident 10's physician order titled, Pressure Injury: Prevention Protocol with a start date 4/5/2025, the order indicated to turn patients every 1-2 hours. During a review of Resident 10's TCU High Risk Turning Protocol dated 5/2/2025 to 5/15/2025, the following dates and times did not indicate Resident 10 was turned every two hours: - On 5/2/2025 at 8 AM, 10 AM, and 12 PM Resident 10's position was supine (a person lying flat on their back). - On 5/3/2025 at 8 AM, 10 AM, 12 PM, 2 PM, 4 PM, and 6 PM Resident 10's position was supine. - On 5/5/2025 at 8 AM, 10 AM, and 12 PM Resident 10's position was supine. - On 5/6/2025 at 8 AM, 10 AM, and 12 PM Resident 10's position was supine. - On 5/9/2025 at 8 AM, 10 AM, 12 PM, 2 PM, 4 PM, 6 PM, and 8 PM Resident 10's position was supine. - On 5/10/2025 at 8 AM, 10 AM, and 12 PM Resident 10's position was supine. - On 5/13/2025 at 8 AM, 9:56 AM, and 12 PM Resident 10's position was supine. During an interview on 5/14/2025 at 4:04 PM with Registered Nurse (RN) 3, RN 3 stated Resident 10 was at high risk for skin breakdown because Resident 10 could not really move independently and needed maximum assistance to reposition. RN 3 further stated interventions to prevent skin breakdown included turning residents every two hours. During an interview on 5/15/2025 at 9:54 AM with CNA 2, CNA 2 stated interventions to help prevent skin breakdown included turning residents every two hours and as needed. During an interview on 5/15/2025 at 2:13 PM with the RSN, the RSN stated residents were turned even if they were sleeping and if a resident was not turned, the nurses should document a comment indicating the reason. The RSN stated Resident 10 was at increased risk of developing PIs by not getting turned every two hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. During a review of Resident 10's TCU - Admission Physical Assessment (APA), dated 4/4/2025, the APA did not indicate Resident 10's skin had any MASD. During a review of Resident 10's physician order titled, Pressure Injury: Prevention Protocol with a start date of 4/5/2025, the order indicated to keep skin clean and dry. During a review of Resident 10's TCU - Physical Assessment (PA) dated 5/2/2025, the PA indicated Resident 10 had MASD on the right groin. During a concurrent observation and interview on 5/14/2025 at 9:23 AM with CNA 1, Resident 10 was observed with redness and raised bumps on the upper inner bilateral thigh area near the groin and redness to the right abdominal fold and buttocks. CNA 1 stated Resident 10's left buttock had a small pink area that looked like an opened blister. CNA 1 was observed placing a moisture barrier cream to Resident 10's buttocks. CNA 1 stated the cream was to treat the redness on Resident 10's buttocks but Resident 10 did not have a cream to treat the redness near the thighs and groin. CNA 1 further stated CNA 1 was unaware of when the redness first occurred. During a concurrent observation and interview on 5/14/2025 at 4:04 PM with RN 3, Resident 10 was observed lying in bed on a soiled disposable absorbent pad. RN 3 stated Resident 10 was wet because Resident 10's external catheter (device placed outside the body, to help collect urine) sometimes leaked urine. RN 3 stated Resident 10 had MASD to the groin area which did not have any treatments other than keeping the skin dry. RN 3 stated Resident 10 had dermatitis (skin inflammation) or irritation from the external catheter on the inner thighs. RN 3 was observed assessing Resident 10's left buttock and stated Resident 10 had an open area of skin. RN 3 stated CNA 1 did not report the opened skin to RN 3. RN 3 stated RN 3 would take a picture of the opened skin and consult with the wound care nurse. RN 3 stated interventions to prevent skin breakdown included keeping the resident's skin clean and dry. During an interview on 5/15/2025 at 1:52 PM with the Wound Care Nurse (WCN), the WCN stated Resident 10 had existing MASD on the bilateral (both) inner buttocks, the perineal (area extending from the anus to the genitals) area, and the right groin abdominal fold. The WCN stated the facility's protocol for MASD included taking pictures of the area and using a moisture barrier product to the affected skin. The WCN stated, per the facility's protocol, a picture should have been taken when the MASD was first identified but WCN had not seen one. The WCN stated the purpose of the picture was to show if the skin was getting better or worse with treatment. The WCN stated Resident 10's nurse should have initiated the MASD protocol in the facility's charting system to ensure the appropriate orders were implemented when the MASD was first identified but the protocol had not been activated prior to 5/14/2025. The WCN stated Resident 10 was first noted to have MASD on 5/2/2025 according to the nurse's documentation on the PA. The WCN stated Resident 10 had a Braden score (tool used by health care professionals to assess a patient's risk of developing pressure ulcers) of 12 which indicated Resident 10 was a high risk. During an interview on 5/15/2025 at 2:13 PM with the RSN, the RSN stated the RSN could not find any documentation that indicated Resident 10's MASD was being treated prior to 5/14/2025. The RSN stated it should have been documented if there was treatment for Resident 10's MASD. The RSN stated that without treatment, the MASD could develop further injury, cause more pain and discomfort, and potentially lead to an infection. The RSN stated skin treatment could not be proven unless it was documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Skin Care Wound Care, dated 10/2023, the P&P indicated pictures will be taken of all wounds, pressure injury, abrasions, bruising, etc., at time of admission, transfer, discharge, and /or change in wound condition and once weekly. The P&P indicated after admission, any skin impairment will be documented in the shift or physical assessment and may be documented in patient care notes. The P&P further indicated documentation in the electronic medical record included stage or level of injury, care plan and interventions initiated. The P&P indicated residents with total Braden Score of 10-12 is considered high risk, and 9 or less considered very high risk. Interventions include: a. frequent turning a minimum of every 2 hours b. keep skin moisturizer at bedside and apply as needed c. incontinence management

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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. 50016 Based on observation, interview, and record review, the facility failed to reassess the continued need for an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) and failed ensure a physician's order was obtained for the use of the device for 1 of five 5 sampled residents (Resident 121) upon admission from the intensive care unit (ICU, a special area in a hospital where patients receive very intensive care, including monitoring and treatment, for serious illnesses or injuries). Resident 121 remained with a urinary catheter for 2 days without a physician order indicating the medical necessity or indication in accordance with the facility's policy and procedure (P&P) titled, Catheterization, Urinary, #C-110. This failure had the potential to result in unnecessary invasive treatment and increased the risk for catheter-associated urinary tract infections (CAUTIs, germs enter the urinary tract through a urinary catheter and cause infection) to Resident 121. Findings: During a review of Resident 121's History and Physical (H&P), dated 5/6/2025, the H&P indicated Resident 121 had a diagnosis of pneumonia (an infection/inflammation in the lungs), acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide [a gas formed when carbon and oxygen combine] from tissues) with hypoxemia (the body isn't getting enough oxygen), and acute kidney injury (a sudden and often reversible decline in kidney function). During a review of Resident 121's Admission Record (AR), the AR indicated the facility admitted Resident 121 on 5/9/2025. During a review of Resident 121's Care Assessment - Admission Physical Assessment, dated 5/9/2025, the Care Assessment indicated Resident 121 was awake, alert, oriented to person, place, time, situation, and was able to follow commands. During a review of Resident 121's Discharge Summary, dated 5/09/2025, the summary's plan indicated Resident 121 was hemodynamically stable (when a person has a stable blood flow, with consistent blood pressure [the force of your blood pushing against the walls of your arteries as your heart pumps blood throughout your body] and heart rate, ensuring adequate blood circulation and oxygen delivery to tissues) and was cleared to be discharged to transitional care unit (TCU, a specialized part of a hospital or medical facility that provides a bridge between acute care and a patient's return home or to another care setting) to continue physical therapy and intravenous (fluids or medications given directly into the blood stream) antibiotics. There was no documented indication in the summary of the need to continue the use of the urinary catheter. During a review of Resident 121's Orders - All Active, dated 5/09/2025, the orders did not indicate the initiation or continuation of the use of the urinary catheter. The orders indicated a physician's order for the urinary catheter that indicated place and manage urinary catheter for acute urinary retention, this order was dated 5/11/2025 (2 days after Resident 121's admission to TCU). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 121's Care Assessment - Physical Assessment, dated 5/9/2025 and 5/10/2025, the following entries were documented: - On 5/9/2025 at 08:00 PM, Resident 121 had a urinary (foley) catheter for retention. - On 5/10/2025 at 08:00 AM, Resident 121 had a foley catheter for retention. - On 5/10/2025 at 08:00 PM, Resident 121 had a foley catheter. These entries indicate the urinary catheter remained in use from 5/9/2025 through 5/10/2025 without a physician order with an indication (necessity) for the medical device. During a review of Resident 121's Nursing Note (NN), dated 5/10/2025, the following entries were documented: - At 04:03 AM, Registered Nurse (RN) 4 documented Resident 121 had a urinary catheter in place for retention and CAUTI protocol was observed. The catheter line was assessed as patent and draining appropriately. - At 08:19 AM, RN 5 documented Resident 121's urinary catheter was intact with pale, clear yellow urine. - At 07:05 PM, RN 5 documented Resident 121's urinary catheter was in place. The entries in the NN indicated Resident 121's urinary catheter remained in place throughout 5/10/2025 without a physician order with an indication (necessity) for the medical device. During an observation on 5/12/2025 at 10:45 AM, Resident 121 was lying in Resident 121's bed and Resident 121 had a urinary catheter in place. During a concurrent interview and record review on 5/15/2025 at 11:58 AM, with the Director of Nursing (DON), Resident 121's Orders - All Active and ICU discharge summary, dated 5/09/2025 were reviewed. The DON confirmed there was no order for a urinary catheter dated 5/9/2025 (admission). The DON acknowledged the discharge summary did not include an indication to continue the use of the catheter. The DON stated staff should have clarified with the physician the continued medical necessity for the urinary catheter and should have obtained a physician order. The DON stated Resident 121 went 2 days without a physician order indicating the medical necessity of the urinary catheter. The DON stated staff should have removed the catheter on admission if there was no indication from the physician to continue the use. The DON stated urinary catheters should be removed as soon as possible when there was no physician order because prolonged use increased the risk of urinary tract infections (UTI, an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]), including CAUTIs, which could lead to serious complications. During a review of the facility's P&P titled, Catheterization, Urinary, #C-110, revision dated 12/2024, the policy indicated: - Avoid the use of an indwelling urinary catheter if possible. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- All patients should be assessed daily for the need for an indwelling catheter. - Indwelling catheters should be removed as soon as possible. - If the patient does not meet criteria for retaining/maintaining an indwelling catheter and there is not a specific provider order to continue the catheter, the RN shall remove the indwelling urinary catheter. - If the RN is uncertain as to whether to remove the indwelling urinary catheter, the provider shall be contacted.

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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** 50016 Based on observation, interview, and record review the facility failed to uphold its infection prevention and control program for 1 of 5 sampled residents (Resident 119) by failing to inform Resident 119's family Resident 119 was on Enhanced Barrier Precaution (EBP, an approach to use Personal Protective Equipment [PPE, protective clothing or equipment, designed to protect the wearer from injury or the spread of infection or illness] to reduce transmission of multi-drug-resistant organism), the purpose of the precautions, and the appropriate times and procedures for donning (putting on) gowns. This deficient practice had the potential to result in the transmission of infectious microorganisms and increased the risk of infection for Resident 119. Findings: During a review of Resident 119's Admission Record (AR), the AR indicated the facility admitted Resident 121 on 5/6/2025. During a review of Resident 119's History and Physical (H&P), dated 5/6/2025, the H&P indicated Resident 119 had diagnoses including diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with neuropathy (a disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), aortic stenosis (a condition where the aortic valve, which controls blood flow from the heart to the body, becomes narrowed), and urinary tract infection (UTI, an infection in the bladder/urinary tract). During a review of Resident 119's Care Assessment - Admission Physical Assessment, dated 5/6/2025, the Care Assessment indicated Resident 119 was awake, alert, oriented to person, place, and was able to follow commands. During a review of Resident 119's Care Plans (CP), dated 5/14/2025, the CPs indicated Resident 119 had an active CP for pressure ulcer (a partial-thickness skin loss, meaning it damages the top two layers of skin [epidermis and dermis]). The CP identified the presence of a stage two (2) pressure ulcer located on the right lateral heel. The CPs indicated Resident 119 had an active CP for at risk of infection and was on EBP for the wound. During an observation on 5/12/2025 at 9:58 AM, there was signage indicating EBP located outside of Resident 119's room. During an observation on 5/12/2025 at 10:34 AM, Family Member (FM) 1 was at Resident 119's bedside. FM 1 was leaning in closely and directly over Resident 119, making contact with the resident's linens and clothing. FM 1 was not wearing a gown or gloves. Resident 119 remained in bed during the interaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/12/2025 at 10:38 AM, with FM 1 at Resident 119's bedside, FM 1 stated no facility staff had explained anything to FM 1 about EBP. FM 1 stated the facility had not provided sufficient information regarding EBP and FM 1 was unaware her father was on these precautions. FM 1 stated FM 1 had been helping take care of Resident 119 since he got to the facility. FM 1 stated FM 1 would lean over Resident 119's bed to help feed him, adjust his pillows, and sit close to talk to him. FM 1 stated no staff made FM 1 aware FM 1 needed to wear a gown or gloves. FM 1 stated Resident 119 was admitted on [DATE], and she and her sister alternated daily visits, but neither of them had been informed that he was on EBP. During an interview on 5/15/2025 at 10:15 AM, with the Director of Nursing (DON), the DON stated the facility followed Centers for Disease Control and Prevention (CDC, national public health agency of the United States), guidance for EBP. The DON stated EBP was implemented to prevent the spread of multidrug-resistant organisms (MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs), especially in residents with wounds. The DON stated the facility's protocol was to notify the resident's family representative at the time of admission if EBP was in place, or any time EBP was implemented thereafter. The DON stated staff provided education materials from CDC to help them understand the reason and the importance in preventing the spread of MDROs. The DON stated if a resident was on EBP, family members were not permitted to provide high-contact care unless they wore appropriate PPE. The DON stated that if staff observed family members attempting or performing high-contact care, staff were expected to remind and re-educate family immediately, as this was critical to infection control. The DON stated all visitors were required to wear a gown and gloves if they engaged in high-contact resident activities, such as leaning over a patient, repositioning pillows, or brushing clothing against a resident's linens. The DON stated this practice helped prevent the spread of MDROs. The DON stated Resident 119's family representatives should have been educated on EBP. The DON stated staff should have ensured the family was aware of and followed EBP protocols. During a review of the facility's Policy and Procedure (P&P) titled, TCU - Enhanced Barrier Precautions, revision date 6/2024, the P&P indicated: The Transitional Care Unit strives to reduce the transmission of MDROs by adhering to enhanced barrier precautions as clinically indicated during high-contact activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. High-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting (continued on next page)

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	555610	A. Building B. Wing	05/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressing during therapy. When anticipating close physical contact while assisting with transfers/mobility When working with residents in the therapy gym During bathing in a shared/common shower room The P&P indicated EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The P&P indicated EBP are to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The P&P indicated nursing will be responsible for initiation/discontinuation of the care plan for EBP. The P&P indicated residents and/or their family/representatives will be notified upon admission on the use of EBP with information from the CDC website related to resident/family education.