STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676234	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Gleannloch Farms	9505 North Pointe Blvd Spring, TX 77379

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review the facility failed to conduct a comprehensive and accurate assessment of (Resident #20, Resident #8 and Resident #2) of 8 residents whose records were reviewed for accurate assessments. -The facility failed to list Resident #20's fall on 1/8/24 and 6/14/24 on the MDS. -The facility failed to list Resident #8's oxygen continuously at 2 lpm via NC, on the MDS. -The facility failed to list Resident #2's oxygen PRN at 2 lpm via NC, on the MDS. These failures could place residents at risk of not receiving the care needed to maintain their highest, practicable, physical, social, and psychosocial level of well-being. Findings include: Resident #20 Record review of Resident #20's undated face sheet revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of displaced fracture of second cervical vertebra (break in the vertebra of the neck), fracture with routine healing, displaced fracture of first cervical vertebra (break in the vertebra of the neck), and unspecified fall. Record review of Resident #20's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 6 out of 15 which indicated severely impaired cognition. She was dependent with toileting, hygiene, shower/baths, lower body dressing, and putting on/taking off footwear. She was max assist with upper body dressing and personal hygiene. The MDS said Resident #20 had not had any falls since admission/entry or reentry or the prior assessment. Record review of Resident #20's Annual MDS assessment dated [DATE], revealed a BIMS score of 6 out of 15 which indicated severely impaired cognition. The MDS indicated the resident had not had any falls since admission/entry or reentry or the prior assessment. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #20's Care Plan dated 3/21/23, revealed a Focus: Resident is at risk for falls. She had a CVA (stroke) and fell before admission (Initiated: 3/21/23 Revised: 3/30/23). Goal: Resident will not sustain serious injury through the review date (Initiated: 1/8/24 Revised: 1/8/24 Target: 10/20/24). Interventions: Resident had a fall from bed. She will be on a low bed and will have fall mats. She will be on a bolster mattress. Record review of Resident #20's chart revealed a Change in Condition note from 1/8/24 at 6:25 a.m., that said an aid notified the nurse that the resident had an unwitnessed fall. Upon entering the room, the resident was seen with her feet in the bed and her back on the floor. A fall assessment was performed with no injuries noted. The resident reported hitting her head, vitals were checked, and the resident was put back in bed. The resident's SBP (top number in the blood pressure) was elevated, hospice was notified, and the hospice nurse was going to come evaluate the resident. Record review of Resident #20's chart revealed a Nurse's Note from 6/14/24 at 5:10 p.m., that said the resident was yelling and when the nurse went into her room, she was found laying on the floor mat, on her left side. Resident was assisted back to bed and there were no injuries noted. Hospice was notified and they sent a nurse to evaluate resident. Record review of Resident #20's chart revealed a Post Fall Evaluation from 6/14/24 at 6:39 p.m., that said the resident fell on [DATE] and was found in the resident's room. Record review of Resident #20's chart revealed an IDT Meeting note from 6/17/24 at 9:42 a.m., that revealed it was for the resident's fall on 6/14/24. The note said MDS was in attendance and her care plan was updated. In an observation of Resident #20 on 8/18/24 at 10:02 a.m., she was asleep in bed with fall mats on both sides of the bed. Resident #8 Record review of Resident #8's undated face sheet revealed she was a [AGE] year-old female admitted [DATE], with an original admitted [DATE]. She had diagnoses of hypertensive heart and chronic kidney disease with heart failure and chronic kidney disease (heart and kidney disease due to high blood pressure with the heart not pumping effectively), stage 3 pressure ulcer (pressure sore through the skin and fat but not to the bone), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), seizures, and cellulitis (skin infection). Record review of Resident #8's Annual MDS assessment from 5/19/24 revealed a BIMS score of 15 out of 15, which indicated normal cognition. The MDS revealed under Special Treatments, Procedures, and Programs, oxygen therapy was not selected for the resident. Record review of Resident #8's Care Plan dated 5/11/21 revealed a Focus: Resident has oxygen therapy r/t heart failure and COPD (lung disease causing restricted airflow and breathing problems) (Initiated: 2/21/23 Revised: 2/21/23). Goal: Resident will have no s/sx of poor oxygen absorption through the review date (Initiated: 2/21/23 Revised: 7/5/24 Target: 8/29/24). Interventions: Monitor O2 sat and titrate O2 to keep O2 sat >90%. Resident has oxygen at 2 L via NC. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's Physician Orders revealed the following orders from MD D read in part . -O2: Oxygen at 2 liters per nasal cannula, every shift. Ordered 1/4/24. -O2: Change tubing every night shift, every Sunday, for infection control. Ordered 5/14/24 . Record review of Resident #8's August 2024 MAR-TAR revealed staff documented for each shift that the resident was on 2L O2 via NC, and the oxygen saturation at that time. In an observation of Resident #8 on 8/18/24 at 10:27 a.m., she was on oxygen 2L via NC. Resident #2 Record review of Resident #2's undated face sheet revealed she was a [AGE] year-old female admitted [DATE], with diagnoses of atrial fibrillation (heart skips a beat), hypertensive heart disease with heart failure (heart does not pump effectively due to chronic high blood pressure), and hypertension (high blood pressure). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15, which indicated moderately impaired cognition. Under Special Treatments, Procedures, and Programs oxygen therapy was not marked. Record review of Resident #2's Care Plan dated 1/10/24 revealed a Focus: Resident has self-care deficit related to diagnosis of acute respiratory failure with hypoxia (not enough oxygen in the blood) (Initiated: 4/17/24). Record review of Resident #2's Physician Orders revealed the following orders from MD D read in part . -Oxygen via nasal cannula at 2L/min PRN for shortness of breath, every 1 hour as needed for shortness of breath or O2 sat <90%. Ordered on 5/17/24 Record review of Resident #2's August 2024 vital signs revealed the resident used oxygen on 8/6/24, 8/8/24, 8/12/24, and 8/19/24. Interview and observation of Resident #2 on 8/18/24 at 10:10 a.m., there was an oxygen concentrator next to the resident's bed that was not in use. The resident said she used the oxygen as needed when she felt short of breath. Interview with the MDS Coordinator on 8/21/24 at 9:25 a.m., she said she had been with the facility for [AGE] years. She said she updated the MDS by looking through the resident charts and observing the residents. She said she tried to make sure everything was correct on the MDS but sometimes she made a mistake and overlooked something. She did not think anything would happen to the resident if the MDS was wrong, she just wanted to make sure the MDS was correct. The MDS Coordinator said Resident #20's falls should have been on the MDS, and Resident #8's and Resident #2's oxygen should have been on their MDS. She was not sure how they were left off and said they must have been overlooked. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not have a policy and procedure on completing the MDS and followed the RAI Manual.

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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** 38644 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals, and preferences for 1 of 8 residents (Resident #15) reviewed for oxygen therapy. - Resident #15's oxygen setting was on 4 L instead of 2 L as ordered by the physician. This failure could place residents at risk of adverse side effects or inadequate therapeutic outcomes. The findings were: Record review of Resident #15's face sheet revealed an [AGE] year-old male who readmitted to the facility on [DATE]. His diagnoses included acute on chronic combined systolic and diastolic heart failure (in systolic heart failure, the heart cannot effectively contract with each heartbeat. In diastolic heart failure, your heart cannot relax between heartbeats), atrial fibrillation (irregular heart rhythm), and hypertension (high blood pressure). Record review of Resident #15's admission MDS assessment dated [DATE] revealed his BIMS score was 15 out of 15 which indicated intact cognition. The resident was on oxygen therapy. Record review of Resident #15's care plan dated 8/2/24 revealed he was on oxygen therapy related to congestive heart failure. Interventions were to give medications as ordered by physician. Record review of Resident #15's Physician orders for August 2024 revealed an order for O2: oxygen at 2 liters per nasal cannula, order date 7/31/24. In an observation and interview on 8/18/24 at 10:31 a.m., Resident #15's oxygen was on 4 L. He was sitting in his wheelchair with the nasal cannula in place. He said he did not have concerns with his oxygen. In an observation on 8/19/24 at 2:58 p.m. Resident #15's oxygen was on 4 L, he was in his room with the nasal cannula in place. In an observation on 8/20/24 at 10:36 a.m. Resident #15's oxygen was on 4 L, he was in his room with the nasal cannula in place. In an observation on 8/20/24 at 1:16 p.m. Resident #15's oxygen was on 4 L, he was in his room with the nasal cannula in place. (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 8/20/24 at 1:28 p.m., LVN W said Resident #15 was on 4L of O2 and had been since she started working with him (unknown date). She said she was made aware he was on 4L of oxygen through the hospital records and nurse report. LVN W said she did not see the physician's order for 4L in his medical record but instead saw the batch order that was put in by the admitting nurse for 2L of oxygen. She said no one updated his order from 2L to 4L. She said she did notice the discrepancy between what Resident #15 was receiving versus what was ordered but did not update the order because the MD had to verify it. She said there was no bad risk to the resident receiving a different amount than what was ordered. She said the DON and ADON were responsible for ensuring the order matched what the resident was receiving. She said she would update his oxygen order to 4L. Interview on 8/21/24 at 9:47 a.m., the DON said the MD prescribed a batch order for oxygen which included the level of 2L but the resident had been on 4L of oxygen. She said someone dropped the ball on that. She said nurses should monitor for the correct liter when they round on the resident. She said physician orders should match what the resident is receiving and if not, respiratory issues could happen. She said all nurses were responsible for ensuring the order matched what the resident received. She said nurses were trained to verify orders with the MD. Record review of the facility's Administering Medications policy dated December 2012 read in part, Medications shall be administered in a safe and timely manner, and as prescribed .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review, the facility failed to assess the resident for risk of entrapment, reviewed the benefits of bed rails with resident and resident representative, obtained Physician consent prior to use for 2 of 8 residents (Resident #11 and Resident #3) reviewed for bed rails. -The facility failed to obtain a physician's order, assess the need for, and consent for Resident #11's bed rails. -The facility failed to obtain a physician's order and consent for Resident #3's bed rails. This failure could place residents with bed rails at risk of restricted movement, entrapment, decline in ADLs function, and psychological distress. The findings include: Resident #11 -Record review of Resident #11's undated face sheet revealed she was a [AGE] year-old female admitted [DATE], with an original admitted [DATE]. She had diagnoses of fracture of T7-T8 vertebra (fracture of the vertebra in the mid-back), muscle weakness, and osteoporosis (bone mineral density and bone mass decreases). Record review of Resident #11's Admission MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15 which indicated normal cognition. The MDS revealed she had a fracture of her T7 and T8 and had spinal surgery involving fusion of spinal bones (surgery to connect bones in part of the spine). The MDS did not mention her having bed rails. Record review of Resident #11's Care Plan dated 7/11/24, had a Focus: Resident has an ADL self-care performance deficit and limited mobility (Initiated: 7/24/24, Revised: 7/24/24). Goal: Resident will improve in ADL functional status by next review date (Initiated: 7/24/24, Revised: 8/20/24, Target: 9/30/24). Interventions: Resident needs assist with ADLs. Focus: Resident has potential for injury secondary to bed rail use (Initiated: 8/20/24, Revised: 8/20/24). Goal: Resident will not sustain injury related to bed rail use (Initiated: 8/20/24, Revised: 8/20/24, Target: 9/30/24). Interventions: Complete bed rail assessment. Obtain physician order for bed rail use. Obtain resident and/or representative consent for bed rails. The focus for bed rails was added to the care plan after facility found out. Record review of Resident #11's August 2024 Physician Orders revealed the following orders from MD E, read in part . (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor bed rail safety q-shift; if safety concerns observed, lower side rail, notify the Director of Nursing, and complete a new bed rail assessment, every shift for side rails in use. Ordered on 8/20/24. -Use of bed rails authorized per bed rail assessment for 2 swing side rail(s) related to resident's safety and security, every shift. Ordered on 8/21/24 . Record review of Resident #11's chart revealed a bed rail assessment filled out by the DON on 8/20/24 at 5:07 p.m. Record review of Resident #11's August 2024 MAR-TAR revealed the orders for bed rails started 8/20/24 on the night shift and were not signed off for any other date in August 2024. In an observation of Resident #11 on 8/18/24 at 10:37 a.m., she was sitting in a wheelchair in her room. Her bed had siderails on both sides of the bed. In an observation of Resident #11 on 8/19/24 at 11:48 p.m., she was asleep in bed with side rails up on both sides of the bed. Interview and observation of Resident #11 on 8/20/24 at 11:46 a.m., she said she received the bed rails the first day she got to the facility and needed them to help turn in bed. Resident #3 Record review of Resident #3's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE], with diagnoses of peripheral vascular disease (narrowing/blockage in the blood vessels), muscle weakness, vascular dementia (changes to memory, thinking, and behavior from conditions that affect blood vessels in the brain), unspecified psychosis (symptoms that happen when person is disconnected from reality), anxiety (feeling of fear, dread, and uneasiness), major depression (lasting sad, anxious, or empty mood), TIA (mini stroke), memory deficit, and cerebral infarction due to occlusion/stenosis of small artery (stroke due to blockage of the small artery). Record review of Resident #3's Admission MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 which indicated normal cognition. The MDS revealed the resident was completely dependent with all ADLs. According to the MDS, the resident had major surgery in the 100 days prior to admission and required active care during the SNF stay. Bed rails were not checked off on the MDS. Record review of Resident #3's Care Plan dated 2/29/16, revealed a Focus: Resident has a potential for injury secondary to bed rail use (Initiated: 12/7/23 Revised: 6/18/24). Goal: Resident will not sustain injury related to bed rail use (Initiated: 12/7/23 Revised: 8/20/24). Interventions: Complete bed rail assessment for bed rail use upon initial use. Obtain physician order for bed rail use. Obtain resident and/or RP consent for bed rails. Record review of Resident #3's chart revealed a bed rail assessment from 4/29/24 at 2:51 p.m. by the DON. Record review of Resident #3's Physician Orders on 8/20/24 from MD D, revealed no orders for bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation of Resident #3 on 8/18/24 at 10:45 a.m., she was asleep in bed with side rails up on both sides of the bed. In an observation of Resident #3 on 8/19/24 at 11:48 p.m., the resident was asleep in bed with both side rails up on the bed. Interview with LVN W on 8/20/24 at 12:03 p.m., she said bed rails must have an assessment, physician's order, and a physical consent. She said those things were necessary to ensure the resident needed them. Interview with the DON on 8/21/24 at 9:34 a.m., she said bed rails must have an assessment, a physician order, a consent, and it must be on the care plan. She said the reason for those things was to ensure the resident/RP knew the advantages and disadvantages of the bed rails. Record review of the facility's policy and procedure on Bed Safety (Revised December 2007) read in part: .If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. After appropriate review and consent as specified above, side rails may be used at the resident's request to increase the resident's sense of security .Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38644 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in accordance with professional standards for food safety in 1 of 1 facility kitchen . -The facility failed to ensure [NAME] A wore a hair restraint while preparing meals in the kitchen. This failure could place residents receiving food from the facility kitchen at risk for cross contamination. The findings included: During an observation on 8/18/24 at 9:11 a.m., in the cooking area of the kitchen revealed [NAME] A was standing over a pan of rice, sampling it. He did not have on a hair restraint. Interview on 8/18/24 at 9:20 a.m., [NAME] B said it was a mistake that [NAME] A did not have on a hair restraint. He said [NAME] A normally wore a hair net but was unsure what happened this time. He said the purpose of a hair restraint was to protect the food from having hair in it. He said he normally provided reminders to the staff to wear a hair restraint. Interview on 8/18/24 at 9:23 a.m., [NAME] A said he normally wore a hat but forgot it at home. He said he was supposed to wear a hair net because of cross contamination and to prevent hair from getting into the residents' food. Interview on 8/21/24 at 9:00 a.m., the Administrator said anyone in the service prep area of the kitchen should wear a hair covering to ensure food sanitation. He said if a hair net was not worn it could compromise the integrity of the food sanitation. He said this year staff were trained quarterly on wearing hairnets and said [NAME] B was responsible for ensuring staff wore hair nets. Record review of the facility's policy titled Personal Hygiene dated 9/4/2015 read in part, .Guidelines for personal hygiene to promote a safe and sanitary department must be followed . Procedure: .3. Head covering worn a. wear a clean hat or other hair restraint. Hair must be appropriately restrained or completely covered .

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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** 47722 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #138) of 8 residents reviewed for infection control. -CNA B failed to wear appropriate PPE and change her gloves when she provided incontinence care to Resident #138, who was on Enhanced Barrier Precautions. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings include: Record review of Resident #138's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses cerebral infarction (stroke), acute endocarditis (inflammation/infection of the lining of the heart chambers and valves), muscle weakness, and lack of coordination. Record review of Resident #138's Admission MDS assessment dated [DATE] was not completed yet. Record review of Resident #138's Care Plan dated 8/14/24, revealed a Focus: Resident has actual or is at risk for possible endocarditis (inflammation/infection of the lining of the heart chambers and valves) (Initiated: 8/14/24). Goal: Resident will be free of infection (Initiated: 8/14/24 Target: 11/12/24). Interventions: Infection precautions per physician. IV per MD order. Notify Infection Preventionist. Observe for signs and symptoms of worsening infection. Record review of Resident #138's previous hospital records from 8/14/24 at 11:38 a.m., revealed the resident had blood cultures positive for Abiotrophia Defectiva (type of bacteria that causes endocarditis), he would need 6 weeks of IV antibiotic therapy, and he would receive a PICC (long tube inserted into vein in arm and passed through large veins near heart) line prior to transferring to the SNF. Record review of Resident #138's Physician Orders revealed the following orders from MD D, read in [NAME] . -Change PICC (long tube inserted into vein in arm and passed through large veins near heart) dressing PRN. Note any complications, every 24hrs as needed. Ordered 8/14/24. -Flush PICC (long tube inserted into vein in arm and passed through large veins near heart) catheter with 10ml NS before IV med administration & flush with 10ml NS after IV med administration, every shift. Ordered 8/15/24. -Flush unused PICC (long tube inserted into vein in arm and passed through large veins near heart) line lumen with 10ml NS qshift, every shift. Ordered 8/15/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: The Village at Gleannloch Farms		STREET ADDRESS, CITY, STATE, ZIP CODE: 9505 North Pointe Blvd Spring, TX 77379	

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe PICC (long tube inserted into vein in arm and passed through large veins near heart) site and document in progress notes as indicated; Every 2 hours during continuous therapy. Every shift. Ordered 8/15/24. -Vancomycin 2000mg/20ml (antibiotic), 2gm IV QHS for endocarditis. Ordered 8/15/24. -F/U with Infectious Diseases in two weeks re: Endocarditis. Ordered on 8/16/24. -Ceftriaxone 2gm (antibiotic), 1 application IV QD for endocarditis. Ordered 8/16/24 . Record review of Resident #138's Nursing Progress Notes revealed a note from 8/18/24 at 8:05 p.m., that said a new PICC (long tube inserted into vein in arm and passed through large veins near heart) line was placed to the LUA without any issues and IV antibiotics would resume. Interview with CNA C on 8/18/24 at 9:57 a.m., she said EBP were for resident's who had open wounds or lines. She said there would be an isolation cart outside of their room. CNA C said she only had to wear gloves for PPE in EBP. In an observation on 8/18/24 at 1:30 p.m., Resident #138 had an EBP isolation sign on his door. Interview and observation on 8/18/24 at 1:36 p.m., CNA B performed incontinence care on Resident #138. She entered the room and did not don any PPE when he was on EBP. She changed his soiled brief and threw it away in the trash can. She did not take off her dirty gloves and sanitize her hands and proceeded to put on his clean brief. After she was finished changing him, she touched his call bell, bed remote, and other items with her dirty gloves still on. CNA B said she forgot to change her gloves and it could cause infection control issues. She said EBP was when a resident had lines or a wound. She said she did not know what she was supposed to wear, and no one had ever told her what to do. There was an isolation cart and an isolation sign on the door, but the CNA said it did not signal anything to her. She said she knew the resident was on EBP, but she did not know she was supposed to wear anything. Interview on 8/20/24 at 12:03 p.m., LVN W said EBP was for any resident with an IV, peg tube (tube into stomach for nutrition), wounds, or a foley (tube into bladder to drain urine). She said before entering their room staff would have to don a gown, gloves, and a face mask and it was to prevent giving or getting something from the resident. She said if a staff member went to change a resident, they would need to wear PPE for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/21/24 at 9:34 a.m., the DON said EBP was for residents who had indwelling devices, wounds, or foleys (tube into bladder to drain urine). She said staff were expected to wear a gown and gloves with high contact care. The DON said an indwelling device includes a PICC line, catheter (tube into bladder to drain urine), or PEG tube (tube into stomach for nutrition). She said high contact care included peri care (washing genitals), showering, and transferring. She said EBP was to prevent the spread of germs from both parties and to prevent infection into a wound, PICC line (long tube inserted in vein in arm and passed through large veins near heart), and catheter (tube into bladder to drain urine). The DON said when a staff member is providing peri care (washing genitals) they should change gloves and perform hand hygiene, when they were done with the dirty part of the brief change. She said the hand hygiene and glove changing was to prevent cross contamination. She also said she performs in-services and training and all the staff had training on infection control and EBP, but they had started in-servicing again. Record review of the facility's policy and procedure on Handwashing/Hand Hygiene (Revised August 2015) read in part: The facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap .and water for the following situations: .Before and after direct contact with residents; Before moving from a contaminated body site to a clean body site during resident care; After contact with blood or bodily fluids; Before and after entering isolation precaution settings .The use of gloves does not replace hand washing/hand hygiene . Record review of the facility's policy and procedure on Enhanced Barrier Precautions (Revised 3/22/24) read in part: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied before performing the high-contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .providing hygiene .changing briefs or assisting with toileting . EBPs are indicated .for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available near or outside of the resident rooms .