STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676363	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mustang Park Therapy and Living Center	4501 Plano Parkway Carrollton, TX 75010

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 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** 28637 Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or quality of life, recognizing each resident's individuality for 1 (Resident # 24) of 6 residents observed for resident rights. CNA A and CNA B failed to provide Resident #24 with full privacy while he was receiving incontinent care. This failure could place residents at risk of not being treated with dignity and respect. Findings included: Record review of Resident #24's Admission Record dated 1/6/25 reflected he was a [AGE] year old male admitted to the facility 4/22/19. Record review of Resident #24's Quarterly MDS assessment dated [DATE] reflected he had severely impaired cognition, he was dependent on staff for toileting, bathing and dressing and required maximum assistance for transfers. He had an indwelling catheter and was frequently incontinent of bowel. His diagnoses included hypertension (high blood pressure); urinary tract infection, stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body), anxiety disorder, depression, and personal history of urinary tract infections Record review of Resident #24's Care Plan reflected the following entry initiated 8/19/22 Focus: [Resident #24] has bowel incontinence . Goal: [Resident #24] will have no complications r/t bowel incontinence . Interventions: Check resident every two hours and assist with toileting as needed, provide pericare after each incontinent episode. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/6/25 at 2:15 PM, Resident #24 was observed in his wheelchair in his room. He was awake and answered questions mainly using yes and no responses. His catheter was observed with a privacy bag attached to his wheelchair. He was transferred to his bed via mechanical lift by CNA A and CNA B. Both CNAs washed their hands, donned gloves and masks and proceeded to provide incontinent care. Resident #24 was lying in bed, his pants and brief were removed leaving him exposed from the waist down. His bed was positioned close to the door to his room. There was no privacy curtain on his side of the room to prevent his exposure to the door. During his care, a knock was heard on the door on two occasions. Both times, the door was opened by unknown persons who leaned their heads into the room, paused, then retreated and closed the door. Neither CNA A or CNA B called out to stop whoever was knocking at the door from opening the door or verbally indicate they were providing care. Both CNA A and CNA B stated they did not know why there was no privacy curtain in the room. CNA B stated resident #24 had recently moved back to the room after being in isolation on another room on the hall. He noted the hooks present on the curtain track above Resident #24's bed and stated it had possibly been removed for cleaning. CNA A stated she typically worked another section of the hall and had not noticed the curtain was missing. Both stated the residents could be embarrassed if exposed during care. CNA A stated they should have asked housekeeping staff if a curtain was missing. During an interview on 1/6/25 at 4:13 PM, the DON stated she did not know why the privacy curtain was missing from Resident #24's room. She stated the curtains were typically replaced at the same time they are removed for cleaning. She stated the staff could have call out they were providing care when knocks were heard at the door and staff should wait for a response when knocking on a door before entering. She stated the risk was a violation of the resident's privacy. During an interview on 1/7/24 at 11:32 AM, the ADON stated privacy curtains were checked as part of weekly room inspections conducted by housekeeping. He stated he was unsure when the curtain had been removed and they were usually replaced at the same time they are removed for any reason. He stated Resident #24 had recently had a deep cleaning done on his room but was unsure of the exact date. The ADON stated, staff should always knock and wait for an answer before entering any room. He stated staff providing care should call out 'patient care' if someone knocked or attempted to enter a room during care. He stated the risk was a loss of the resident's privacy and dignity. During an interview on 1/7/25 at 12:05 PM, LVN C stated she worked the 6 AM to 2 PM shift. She stated she did not notice Resident #24's privacy curtain was missing and did not know when it had been removed. She stated she could not recall whether it had been there when she provided his care the day prior. She stated it caused a risk of privacy loss for the resident. During an interview on 1/8/24 at 9:10 AM, the Administrator stated she learned the housekeeping department had conducted a deep cleaning on Resident #24's room the week prior. She stated whomever removed a privacy curtain for any reason should have replaced it at the same time and she was unsure why that did not happen. The Administrator stated the risk to the resident was low as there was a door and a curtain was available between the roommates' beds. She stated the lack of a privacy curtain removed a layer of privacy for the resident between Resident #24's bed and the door. The Administrator stated she had been unable to locate a policy specific to privacy curtains and would continue to look. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/24 at 9:51 AM, the Housekeeping Supervisor stated he made general facility rounds daily. He stated privacy curtains were removed weekly and as needed for cleaning and were supposed to be replaced at the same time. He stated they keep a stock of clean curtains available at all times. The Housekeeping Supervisor stated he believed Resident #24's room was done the week prior because his hall was due that week. He stated he did not know why his curtain was not replaced at the same time and he had not noticed it missing during his rounds. He stated the risk to residents was embarrassment if the door was open and he was exposed to the hallway during care. During an interview on 1/8/25 at 3:56 PM, RN D stated she worked the 2 PM to 10 PM shift and cared for Resident #24. She stated she had worked with Resident #24 the week prior and felt sure he had a privacy curtain at the time. She stated she would have used the curtain while providing his catheter care. She stated the risk would have been a loss of his privacy. Record review of the facility's policy titled, Dressing and Undressing the Resident, Revision Date 6/1/12, reflected: Purpose: The purposes of this procedure are to assist the resident as necessary with dressing and undressing and to promote cleanliness .General Guidelines: 1. Allow the resident as much privacy as possible while he or she is dressing or undressing . Record review of the facility's policy, Residents' Rights Nursing Facilities, dated April 2019, reflected: .You have the right to: Be treated with dignity, courtesy, consideration and respect .Privacy, including privacy during visits, phone calls and while attending personal needs .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #24) of 3 residents reviewed for catheter care. The facility failed to ensure Resident #24 had a catheter stabilization device. These failures could place residents at risk of urinary tract infections and injury from trauma. Findings included: Record review of Resident #24's Admission Record dated 1/6/25 reflected he was a [AGE] year old male admitted to the facility 4/22/19. Record review of Resident #24's Quarterly MDS assessment dated [DATE] reflected he had severely impaired cognition, he was dependent on staff for toileting, bathing and dressing and required maximum assistance for transfers. He had an indwelling catheter and was frequently incontinent of bowel. His diagnoses included hypertension (high blood pressure); urinary tract infection, stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body), anxiety disorder, depression, and personal history of urinary tract infections. Record review of Resident #24's Order Summary Report dated 1/8/25 reflected: 10/14/24 Catheter: Ensure catheter securement device and privacy bag in place every shift. Record review of Resident #24's Care Plan reflected the following entry initiated 4/22/24 Focus: [Resident #24] has a chronic indwelling suprapubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) . Goal: [Resident #24] will remain free from catheter related trauma . Interventions: .Urinary catheter care Q shift. Record review of Resident #24's Treatment Administration Record dated January 2025 reflected: Catheter: Ensure catheter securement device and privacy bag in place every shift . The entry was initialed as completed by LVN C on 1/6/25 during the 6 AM to 2 PM shift. During an observation and interview on 1/6/25 at 2:15 PM, Resident #24 was observed in his wheelchair in his room. Enhanced Barrier Precautions signage was observed hanging outside his door and PPE supplies were observed outside his door. He was awake and answered questions mainly using yes and no responses. His catheter was observed with a privacy bag attached to his wheelchair. He was transferred to his bed via mechanical lift by CNA A and CNA B. Both CNAs washed their hands, donned gloves and masks and proceeded to provide incontinent care. Resident #24 had a suprapubic catheter in place. The tubing was not secured in any way to his body. CNA B stated the tubing was sometimes secured to his leg with a strap to keep it from moving around and he did not know why it was not at that time. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/6/25 at 4:13 PM, the DON stated she had spoken with LVN C, who was Resident #24's charge nurse during the day shift, about his catheter and the LVN had told her the resident had a shower that day and she had forgotten to replace the device. The DON showed the device used by the facility which was a clip attached to an adhesive patch that was to be placed on the resident's leg. The DON stated the risk of not securing catheter tubing was that the tube could become dislodged and cause bleeding. She stated she provided additional in service to LVN C after speaking with her. During an interview on 1/7/25 at 12:05 PM, LVN C stated she worked the 6 AM to 2 PM shift and she checked Resident #24's catheter every day. She stated she had changed his catheter bag on 1/6/25. She stated they checked his urine every shift because he was taking coumadin (a blood thinner) and they monitored him for bleeding. She stated she forgot to go back and change his strap after she changed his bag. She stated the risk for not securing his catheter was the tubing could slide out and cause bleeding. She stated Resident #24 used a wheelchair and a mechanical lift placing him at risk of getting his tubing caught. During an interview on 1/8/25 at 3:56 PM, RN D stated she worked the 2 PM to 10 PM shift and cared for Resident #24. She stated she provided catheter care for Resident #24 every shift which included cleaning the insertion site, monitoring for any bleeding or infection and ensuring the tubing was secured to his leg. She stated securing the tubing was important to reduce his risk of bleeding or the catheter becoming dislodged. Record review of the facility's policy titled, Catheter Care, Urinary, Revision Date 5/31/12, reflected: Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract .General Guidelines: .15. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.). 16. Report unsecured catheters to the supervisor. Be observant of skin irritation .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review, the facility failed to provide food that was palatable and attractive for two meals from the facility's only kitchen (lunch meals on 01/7/25 and 01/8/25) reviewed for food and nutrition services. The facility failed to deliver food with an appetizing taste for the lunch meal on 01/07/25 and 01/8/25. The deficient practice could place residents at risk of poor intake of nutrition, weight loss, and a decreased quality of life. Findings included: Observation on 01/7/25 at 12:00 PM revealed the 3 lunch test trays for a regular diet, a pureed diet, and a dysphagia altered diet was tasted by four state surveyors. The meal consisted of Swedish Meatballs, Sliced Glazed Carrots, Egg Noodles, [NAME] Dinner Roll, and spiced peaches. The state surveyors stated the glazed carrots, dinner roll, and noodles were tasteless. Surveyor observed kitchen staff plating the food using warmer plates and a cover. Observation on 01/8/25 at 12:00 PM revealed the 3 lunch test trays for a regular diet, a pureed diet, and a dysphagia altered diet was tasted by four state surveyors. The meal consisted of Open Faced Roast Pork Sandwich with brown gravy, Mashed Potatoes, Herbed [NAME] Beans, Lemon Cake. The mashed potatoes were bland tasting, the green beans had a strong vinegar taste. Surveyor observed kitchen staff plating the food using warmer plates and a cover. Dietary Manager stated she was suprised to hear about the taste of the food. During a confidential interview a resident stated the food was not all that great'. The resident stated they ate in their room and lunch and dinner were served cool. They stated it was so salty I can't eat it most of the time. The resident denied complaining to anyone about the food. During a confidential observation and interview a resident stated they ate some meals in the dining room and others in their room. The resident stated meals were often late on the weekends. The resident presented a small bag with what they stated was a piece of cake in it, the cake looked as though it had been squeezed and the resident stated that was the way it had been provided the evening before. They stated the cakes were often burned or undercooked and tasted like batter. The resident stated the cake should be served in a bowl and not a plastic bag. The resident stated the kitchen tended to put gravy on everything, even meatloaf and it made them angry. They stated they didn't complain because they felt there was no point. During a confidential interview it was stated the breakfast is good most of the time but lunch and dinner not so much. Resident stated the food is sometimes cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview, a resident stated they felt like the food generally tasted ok but was often served cold. They stated they mainly ate the dining room and foods like French fries were often cold. They stated, It tastes like they cook them first and leave them sitting there while they cook the other food so they're cold when they make it to the tables. During a Confidential interview, a resident stated the food is crappy. Resident said the food is sometimes cold when received, resident stated he eats in his room. During a confidential interview, a resident stated the food at the facility had improved since they moved there but it was cold more often that it's not. The resident stated they ate in their room more than the dining room and food was served cold in both areas. Interview on 1/6/2025 at 1:00 PM, Resident #22 stated the food is not good. It could be made better if they make sure the food is not cold. Interview on 01/08/25 at 4:45 PM, Dietitian stated the kitchen staff follows recipes in regard to seasoning the food. Surveyors tasted the mashed potatoes in the dinner meal lacking an appetizing flavor. Dietitian stated the green beans served at the dinner meal was seasoned with black pepper although the four surveyors tasted the green beans, and all four surveyors stated the green beans tasted strongly like vinegar. Interview on 01/08/25 at 4:40 PM, the Dietary Manager revealed from time of plating the meals to the meals arriving on the halls equals 10 15 minutes , within appropriate time frame. Dietary Manager was unaware of any resident complaints about the food. Dietary Manager showed surveyor recipe cards that are followed when preparing the food. Record review on 1/8/25 at 4:45 PM, of the Corporate Recipe Number: 4164 recipe card. Starch Potatoes revealed the ingredients of dry mashed potato, boiling water, and margarine. Record review on 1/8/25 at 4:45 PM, of the Corporate Recipe Number: 5349 recipe card. Vegetable revealed the ingredients of Cut frozen green beans, boiling water, dried Thyme leaf, margarine. On 1/6/25 at 2:52 PM review of the mealtimes revealed Breakfast in Dining room [ROOM NUMBER] AM, [NAME] Hall 7:15 AM, Recovery Hall 7:30 AM. Lunch in Dining room [ROOM NUMBER]:30 AM, [NAME] Hall 11:45 PM, Recovery Hall 12 PM. Dinner in Dining room [ROOM NUMBER]PM, [NAME] Hall 5:15 PM, Recovery Hall 5:30 PM. Review of the facility policy titled. Food Preparation Healthcare Services Group, Inc., and its subsidiaries Dining Services Policy and Procedure Manual, Original 5/2014, Revised 9/2017, 10/2022, 2/2023 Policy Statement All foods are prepared in accordance with the FDA Food Code. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater 41 degrees F and/or less than 135 degrees F, or per state regulation. Review of the facility policy titled. Food: Quality and Palatability Healthcare Services Group, Inc., and its subsidiaries Dining Services Policy and Procedure Manual, Original 5/2014, Revised 9/2017, 2/2023 Revealed: Policy Statement Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served in a manner, form, and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. Definitions Food attractiveness refers to the appearance of the food when served to the residents. Food palatability refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns. Procedures Procedures guidelines, and standardized recipes. 1. The dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production. 4. The Cook(s) prepare food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention. 47030 47161

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45053 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS fiscal year 2024 for the second quarter (January 1, 2024, to March 31, 2024) reviewed for Administration. The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for January 1, 2024, to March 31, 2024. This failure could place all residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings Included: Record review of an email sent to the Administrator on 01/07/25 at 10:28 AM, indicated the [NAME] 3 Report records from CMS revealed that the PBJ Data for Quarter 2 2024 (January 1,2024 - March 31, 2024) was not submitted. Record review of an email received from the Administrator on 01/07/25 at 12:14 PM, indicated the information on the [NAME] 3 Report for the PBJ Data for Quarter 2 2024 (January 1 - March 31) was most likely correct. That was with our old ownership, and I don't think they submitted it. Record review of the CMS PBJ Staffing Data Report (Payroll Based Staffing), CASPER Report (Certification and Survey Provider Enhanced Report) 1705 D FY Quarter 2 2024 (January 1 - March 31), dated 12/31/2024, indicated the following entry: Failed to Submit Data for the Quarter Triggered .Triggered=No Data Submitted for the Quarter. In an interview with the Administrator on 01/08/25 at 1:24 PM, she stated that the PBJ Staffing Data for Quarter 2 for the Fiscal Year 2024 would have been submitted to CMS by the previous owner of the company. She stated that the facility had been under new management since May 2024. She stated that the company's current Chief Operations Officer is responsible for submitting the PBJ Staffing Data. She reported that the current owners of the company do not have any access to any of the PBJ Staffing Data that was submitted during their ownership of the company. She stated that the current Chief Operations Officer had been submitting the PBJ Staffing Data since the Change of Ownership occurred at the facility in May 2024. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a telephone interview with the Chief Operations Officer on 01/08/25 at 3:05 PM, he confirmed that his job duties include submitting the PBJ Staffing Data to CMS. He reported that the facility's previous owners were bankrupt and did not pay their vendors. He stated that the current owners of the facility gained ownership of the facility at the end of May 2024. He reported that the current owner made several attempts to the previous owners' vendors to request records but were unsuccessful due to the previous owners having an unpaid balance with the vendors. He reported that the vendors requested to be paid and the account cleared, prior to releasing any requested information regarding the previous company. He reported that due to the circumstances, the current owners do not have any access to any information or data submissions to CMS. He stated he submits the data for the PBJ Staffing Report on the CMS website. He stated that the facility follows CMS guidelines for Direct-Care Staffing Information of the PBJ Data, a policy was not provided. Record review of an email sent to the Administrator on 01/08/25 at 5:12 PM, requesting the facility's policy regarding PBJ Staffing Data Submission. Record review of an email received from the Administrator on 01/08/25 at 5:17 PM, stated the facility did not have a policy regarding PBJ Staffing Data Submission. She stated that the facility used the PBJ Policy Manual provided by CMS as their policy manual. Record Review revealed the facility was unable to provide any policy regarding their failure to report the PBJ Data to CMS for the Quarter 2 2024 (January 1 - March 31). Record Review of the CMS, Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, Version 2.6, June 2022, section 1.2 Submission Timeliness and Accuracy, revealed Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Policy manual revealed, Deadline: Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.

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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** 28637 Based on observations, interviews, and record reviews the facility failed to establish and 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 one (Resident #24) of four residents observed for infection control. CNA A and CNA B failed to follow Enhanced Barrier Precautions while providing incontinent care to Resident #24. These failures place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #24's Admission Record dated 1/6/25 reflected he was a [AGE] year-old male admitted to the facility 4/22/19. Record review of Resident #24's Quarterly MDS assessment dated [DATE] reflected he had severely impaired cognition, he was dependent on staff for toileting, bathing and dressing and required maximum assistance for transfers. He had an indwelling catheter and was frequently incontinent of bowel. His diagnoses included hypertension (high blood pressure); urinary tract infection, stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body), anxiety disorder, depression, and personal history of urinary tract infections. Record review of Resident #24's Order Summary Report dated 1/8/25 reflected: 10/14/24 Enhance Barrier Precautions for Foley Catheter. Record review of Resident #24's Care Plan reflected the following entry initiated 6/11/24: Focus: [Resident #24] is on enhanced barrier precautions D/T suprapubic catheter [a tube that drains urine from the bladder through a small incision in the lower abdomen] . Goal: [Resident #24] will remain in enhanced barrier precautions without complications through next review. Interventions: .Proper use of PPE to be observed, use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO; Staff to don and doff according to recommendations, which is before entering residents toom and before leaving room .These precautions to be observed by staff during high contact resident care like dressings, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676363	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mustang Park Therapy and Living Center	4501 Plano Parkway Carrollton, TX 75010

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/6/25 at 2:15 PM, Resident #24 was observed in his wheelchair in his room. Enhanced Barrier Precautions signage was observed hanging outside his door and PPE supplies were observed outside his door. He was awake and answered questions mainly using yes and no responses. His catheter was observed with a privacy bag attached to his wheelchair. He was transferred to his bed via mechanical lift by CNA A and CNA B. Both CNAs washed their hands, donned gloves and masks and proceeded to provide incontinent care. Neither CNA donned a gown. Resident #24 had a suprapubic catheter in place. The catheter insertion site and tubing were cleaned during care. Both CNAs performed hand hygiene and changed gloves during care. After care, when CNA A was shown the Enhanced Barrier Precaution sign outside the room, she stated she had received in-service training about the precautions. She stated she worked on another hall but had assisted with Resident #24 on occasion. She stated she was aware he had recently been on isolation for a urinary tract infection but he had since been cleared. She stated she thought the signs were left up by mistake from his previous isolation. CNA A stated she was unaware of the continued need to wear a gown due to his catheter. CNA B joined the conversation and stated he also thought Resident #24's precautions had been lifted. He stated he was unaware of the continued need for wearing a gown. Both CNAs stated the risk for not following proper infection control procedures was the spread of infections between residents and staff. During an interview on 1/6/25 at 4:13 PM, the DON stated CNA A and CNA B had informed her about the issues regarding following enhanced barrier precautions. The DON and the Corporate Nurse stated both had been in-serviced before and were just re-trainied on the procedures. The DON stated they may have gotten confused as Resident #24 had recently come off isolation precautions. They stated they were already in the process of re-training all staff related to enhanced barrier precautions and the need for proper PPE. The DON stated the risk of failing to wear proper PPE was cross contamination and spread of infection between residents and staff. During an interview on 1/7/25 at 11:32 AM, the ADON stated he discussed enhanced barrier precautions with the staff on an ongoing basis. He stated he reminds them to always pay attention to the types of isolation precautions in place for any given resident. He stated the risk to residents was infection transmission. During an interview on 1/7/24 at 12:05 PM, LVN C stated she was Resident #24's charge nurse during the day shift. She stated he was on enhanced barrier precautions due to his catheter because it was an indwelling device and artificial body opening. She stated a gown and gloves should be used for all direct care. She stated the risk to residents was infection transmission. During an interview on 1/8/24 at 8:45 AM, the Corporate Nurse stated the facility followed their policy and CDC guidelines related to Enhanced Barrier Precautions. Review of the CDC website on 1/8/24 reflected: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html reflected: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using Enhanced Barrier Precautions. .Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). .Assuming Contact Precautions do not otherwise apply, Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO . Record review of the facility's policy titled, Enhanced Barrier Precautions, dated 6/17/24, reflected: Enhanced Barrier Precautions shall be used at this facility per CDC requirements . The facility understands that EBP is used for the safety and protection of both staff and residents. EBP are indicated for residents with any of the following: .wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .