| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106097 | A. Building<br>B. Wing | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hidden Lakes Senior Living Community | 1006 33rd St<br>Vero Beach, FL 32960 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38212<br><br>Based on observation and interview, the facility failed to ensure a clean, comfortable and homelike environment related to dirty carpet in 3 of 18 resident rooms (room [ROOM NUMBER], #9 and #14) and 1 of 24 bedside tables having 1 of 4 bolts missing from the table's surface (room [ROOM NUMBER]).<br><br>The findings included:<br><br>During the initial tour of the facility on 08/11/24 at approximately 9:30 AM, the following concerns were observed by the survey team:<br><br>1) room [ROOM NUMBER] was missing a large bolt from the bedside table. The carpet had multiple stains.<br><br>2) room [ROOM NUMBER] had multiple stains on the carpet.<br><br>3) room [ROOM NUMBER] had a large stain on the carpet at the end of the bed.<br><br>(Photographic evidence obtained)<br><br>On 08/14/24 at 10:15 AM, the Housekeeping Supervisor was asked about the carpets. She stated the facility was going to rip the carpet out, and she believed the Executive Director had received some quotes for it. She stated the carpet is made up of squares and each one can be individually removed and replaced with a new one.<br><br>On 08/14/24 at 10:30 AM, an interview and a tour were conducted with the Executive Director. He stated it is his goal to replace the carpet with hard flooring, but he has not started to get any quotes for a new floor. He also stated that each square of carpeting can be removed and replaced with a new carpet piece. During the tour with the Executive Director, he was shown the dirty carpets in Rooms #5, #9 and #14, and the missing bolt from the bedside table in room [ROOM NUMBER]. He confirmed the presence of the dirty carpets and the missing bolt for the bedside table. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment for 1 of 5 sampled residents, related to the medication usage of Resident #9.<br><br>The findings included:<br><br>Review of the record revealed Resident #9 was admitted to the facility on [DATE].<br><br>Review of the current MDS assessment dated [DATE] documented Resident #9 was taking an antidepressant medication during the seven-day look-back period of 05/08/24 through 05/14/24. Review of the corresponding Medication Administration Record (MAR) for the month of May 2024 lacked any provision of an antidepressant.<br><br>Further review of the May 2024 MAR revealed Resident #9 received the antiplatelet medication Clopidogrel (plavix) 75 milligrams (mg) daily during that timeframe, along with the antianxiety medication Buspirone 5 mg daily. Further review of the MDS lacked the indication that the resident received these two additional categories of medications.<br><br>During an interview and side-by-side record review on 08/14/24 at 12:59 PM, the MDS Coordinator agreed with the inaccuracy of the MDS. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078<br><br>Based on observation, interviews, and record review, the facility failed to:<br><br>a) provide showers per resident schedule and/or resident choice for 3 of 3 sampled residents reviewed for Activities of Daily Living (ADL) care (Resident #122, #72, and #14); and<br><br>b) provide timely nail care to 1 of 1 sampled residents reviewed for ADL's related to nail care (Resident #122)<br><br>The findings included:<br><br>The Activities of Daily Living Policy and Procedure, dated 06/26/22, states:<br><br>2. This [procedure] included the facility ensuring that:<br><br>a. A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified below:<br><br>i. Hygiene - bathing, dressing, grooming and oral care .<br><br>4. The facility will ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition , grooming, and personal and oral hygiene.<br><br>1) During observation and resident interview on 08/11/24 at 10:43 AM, Resident #122 stated she had not had a shower since being admitted , and she would really like a shower. Resident #122's hair appeared oily and her nails were ragged and chipped with a brown substance observed underneath her nails. Also, when leaning close to Resident #122 to better hear her, an unpleasant body odor was detected.<br><br>On 08/13/24 at 9:42 AM, a Certified Nurse's Aide (CNA) was observed entering the resident's room to provide care to the resident.<br><br>On 08/13/24 at 10:23 AM, Resident #122 stated she felt better today, as she had just had a bed bath, but she had still not received a shower. Resident #122 again stated, I would really like to have a shower. The resident's nails were still chipped and jagged, with dark discoloration underneath her nails.<br><br>Record review revealed, Resident #122 was admitted to the facility on [DATE] with diagnoses which included Metabolic Encephalopathy, Congestive Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Other Cardiomyopathies, Chronic Pulmonary Edema, Obesity, and Muscle Weakness. Resident went out to the hospital on 07/29/24 due to the resident exhibiting stroke-like symptoms and returned back to the facility on [DATE]. Resident #122 was assessed at the time of admission and re-admission as having a Brief Initial Mental Status score of 12 out of 15, which in indicated moderately impaired cognition.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the shower schedule for Resident #122 showed resident was scheduled to have showers on Monday and Thursdays. A review of the shower book revealed only one bed bath had been given since re-admission on 08/05/24; that bed bath was provided on 08/12/24. No showers had been provided to the resident since admission on 07/22/24.<br><br>On 08/13/24 at 10:50 AM, an interview was conducted with Staff B (CNA). She stated, I work as needed, and last Monday I was not scheduled to work in the nursing home. A Resident's shower schedule is either posted on the wall or in the shower book. All showers and bed baths are put in the shower book. It is the Resident's choice as to the time of day they want a shower. If a resident requests a shower on a day that is not scheduled, we will try to arrange a shower on that day.<br><br>On 08/14/24 at 9:43 AM, during an interview with the Director of Nursing, she stated, Showers and Bed Baths are to be recorded in the shower book. [Resident #122] came back from the hospital on Monday, 08/05/24, so she probably would have missed that shower day, but she should have had a shower on the following Thursday (08/08/24) and last Monday (08/12/24). All residents are able to get a shower whenever they request one.<br><br>On 08/14/24 at 9:55 AM, the DON confirmed, after reviewing the shower book, that Resident #122 had only received bed baths since admission. When asked why Resident #122 had not received a shower, the DON replied, She is a 2 person assist for showers. She would need 2 aides to be with her during her showers, and we only have 2 aides on the floor.<br><br>On 08/14/24 at 10:45 AM, the DON informed the surveyor that Resident #122 just had the best shower ever, and her nails have been cleaned and cut. I personally gave the resident her shower.<br><br>25404<br><br>2) Review of the record revealed Resident #14 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating moderate cognitive impairment. This same MDS documented it was somewhat important for the resident to choose between a bath and a shower.<br><br>During an interview on 08/11/24 at 10:14 AM, when asked if he had been receiving a bath or shower as he would like, Resident #14 stated he had not had a shower, and was not even sure if there was a shower at the facility. When asked if he had been offered a shower or was aware of any shower schedule, the resident stated no to both. When asked if he wanted a shower, Resident #14 explained that he could not stand and was not sure if they would want his wheelchair to get wet, but volunteered, I'd like to get some of this dead skin off. Resident #14 explained because of his lack of showers he had been using extra lotion on his skin, trying to get the dead skin off, while pointing to his bottle of lotion.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the shower binder identified at the nurse's station by staff revealed Resident #14 was scheduled for a shower on Tuesday and Friday during the 2 PM to 10 PM shift. This binder contained multiple pages of resident's documented showers or bed baths. Review of these pages revealed a shower was provided on 07/23/24, with bed baths provided on and unknown/not documented date, on 07/31/24, and on 08/06/24. Review of the Certified Nursing Assistant's (CNA's) documentation in the electronic medical record revealed only one shower in the past 30 days, on 07/26/24. The additional five scheduled shower days lacked any documentation for the provision or refusal of showers.<br><br>During an interview on 08/13/24 at 11:25 AM, when asked about the process for resident showers, the Director of Nursing (DON) pulled the shower binder from the nurse's station and revealed the shower schedule. The DON stated the previous DON started the shower book on her last day at the facility, three weeks ago. The DON explained staff were to document on the form the provision of a shower or bed bath for each resident. The DON stated if a resident refused bathing, the nurse would attempt to encourage the resident. The DON stated if the resident still refused, the form would be signed by the CNA, nurse, and the resident. The DON agreed the forms and system in place did not support effective documentation for the provision of showers.<br><br>3) Review of the record revealed Resident #72 was admitted to the facility on [DATE]. Review of the New Admission Evaluation dated 08/08/24 documented the resident preferred showers.<br><br>During an interview on 08/11/24 at 11:02 AM, Resident #72 explained she had been at the facility about three or four days. When asked if staff were helping her with a bath or shower as she would like, the resident stated she hadn't had a bath yet. When asked if she had been given a bed bath, she again stated not yet. When asked about a shower the resident stated, I hope to get one in a day or two.<br><br>Review of the shower schedule revealed Resident #72 was scheduled for a shower on Monday and Thursday during the 2 PM to 10 PM shift. Review of the shower binder lacked any documented showers. Review of the electronic record lacked any provision of showers. Resident #72 was scheduled for a shower on Monday 08/12/24 during the evening shift. Further review of the electronic record revealed she received a sponge bath on that day and time. The progress notes lacked any documented showers or refusals.<br><br>During the continued interview and side-by-side record review on 08/13/24 at 11:25 AM, the DON agreed with the concern. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review, documented monthly pharmacy reviews, and interviews, the consultant pharmacist failed to identify the lack of behavior monitoring for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #9).<br><br>The findings included:<br><br>Review of the record revealed Resident #9 was admitted to the facility on [DATE]. Review of the orders revealed the resident had been on the anti-anxiety medication Buspirone since 02/16/24, and the anti-psychotic medication Haloperidol since 02/05/24. Review of the record lacked any behavior monitoring for these medications. (Refer to F757 for details). The anti-anxiety medication Ativan had been added to the resident's regimen as of 07/28/24.<br><br>Review of the monthly pharmacy recommendations from February 2024 through July 2024 lacked any recommendation related to the lack of behavior monitoring.<br><br>During a phone interview on 08/14/24 at 3:05 PM, the consultant pharmacist was unable to review his records, but would check later. The consultant pharmacist was told of the concerns related to the lack of behavior monitoring for Resident #9 and was asked to provide any recommendations or information to the Director of Nursing. As of the exit conference, no additional information had been provided. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to ensure adequate monitoring of medications for 2 of 6 sampled residents. The facility failed to ensure behavior monitoring for psychotropic medication use for Resident #9, and failed to ensure appropriate antibiotic use for Resident #14.<br><br>The findings included:<br><br>1) Review of the record revealed Resident #9 was admitted to the facility on [DATE], with a diagnosis of Schizophrenia. Review of the orders revealed the resident had been on the anti-psychotic medication Haloperidol since 02/05/24, and the anti-anxiety medication Buspirone since 02/16/24. The anti-anxiety medication Ativan had been added to the resident's regimen as of 07/28/24.<br><br>Review of the current care plan initiated on 02/06/24 and revised 07/02/24 documented, I have anxious/restless behavior as evident by calling out for help loudly without a need. Resident has a history of providing false information to family and staff for attention seeking purposes.<br><br>Review of the monthly Medication Administration Records (MARs) from February 2024 through August 2024, along with the progress notes, lacked any documented behavior monitoring for Resident #9.<br><br>During an interview on 08/14/24 at 11:25 PM, the new Director of Nursing (DON), as of three weeks prior to the survey, was asked about the lack of behavior monitoring for Resident #9. The DON stated it was part of the documentation in the eMAR. When shown the lack of documentation of behavior monitoring for Resident #9, the DON was unsure and referred the question to the MDS (Minimum Data Set) Coordinator.<br><br>During an interview on 08/14/24 at 12:59 PM, when asked how staff document behavior monitoring at the facility, the MDS Coordinator explained it was part of a batch order set used when a resident was admitted or readmitted , which allowed the nurse to document behaviors on the eMAR. The MDS Coordinator stated the order set may have fallen off during one of the resident's readmissions and no one caught it.<br><br>2) Review of the record revealed Resident #14 was admitted to the facility on [DATE] with an indwelling urinary catheter. Further review revealed an order for a urinalysis to be completed on 07/29/24. An order for Cipro (an antibiotic) was written to begin on 07/30/24, to give 500 milligrams (mg) every 12 hours for 14 days.<br><br>Review of the urinalysis along with the culture and sensitivity, that was collected on 07/29/24 and reported to the facility on [DATE], revealed Resident #14 did have a urinary tract infection (UTI). Further review of the culture revealed the antibiotic Cipro was resistant to the organism, and thus was not appropriate as the treatment for this UTI.<br><br>Review of the corresponding Medication Administration Records (MARs) revealed Resident #14 was administered the Cipro starting on 07/30/24 at 8:00 AM, twice daily through 08/11/24, thus receiving 22 extra doses of the antibiotic after having been determined to be resistant, or ineffective, as per the laboratory results<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/13/24 at 1:38 PM, when asked about the failure to stop the Cipro on 07/31/24, upon receipt of the culture documenting the Cipro was resistant to the organism, the Administrator, who was also a Registered Nurse stated apparently no one looked at the culture and noticed the Cipro was resistant. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to complete physician ordered laboratory services timely for 2 of 5 sampled residents reviewed for unnecessary medications (Resident #9 and #72).<br><br>The findings included:<br><br>1) Review of the record revealed Resident #9 was admitted to the facility on [DATE]. Review of the orders revealed the need for a CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) to be drawn on 07/22/24. The record lacked any results for these labs.<br><br>During an interview on 08/14/24 at 12:36 PM, the Director of Nursing (DON) was asked to locate and provide the CBC and CMP results from 07/22/24. The DON was unable to do so. The DON looked on the laboratory's website and found that four other residents had labs drawn on 07/22/24, and one on 07/23/24, but was unable to locate any for Resident #9. The DON reviewed the laboratory service binder and could not find any requisition page for 07/22/24 or 07/23/24, thus was unable to determine why the labs were not drawn as per order.<br><br>2) Review of the record revealed Resident #72 was admitted to the facility on [DATE]. Further review revealed an order dated 08/07/24 for a urinalysis with a culture and sensitivity to be completed. A second order dated 08/07/24 documented a CBC (complete blood count) and CMP (comprehensive metabolic panel) was to be drawn on 08/09/24. The electronic record lacked any results for either of these orders. The progress notes lacked any reason the orders were not completed.<br><br>During an interview on 08/13/24 at 11:25 AM, when asked about laboratory results, the Director of Nursing (DON) stated they had been having issues with the results not automatically integrating into their electronic record, so they had been scanning the results into the record manually. The DON was asked about the ordered labs for Resident #72, and upon searching on the laboratory services website, the DON found the CBC and CMP was completed on 08/12/24, three days after the ordered date, but was unable to locate any results for the urinalysis. The DON looked in the laboratory binder and could not find any requisition for the urinalysis. During the interview Staff C, Registered Nurse (RN) joined the conversation. When asked the reason for the urinalysis, the RN stated for her behaviors. When asked if she knew why the urinalysis was not completed, the RN stated she did not know, but if the sample wasn't labeled correctly or was too old when the laboratory services arrived, it would be thrown out. |

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| F 0803<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>32078<br><br>Based on observation, interview, and record review, the facility failed to ensure an accurate and current menu was posted for residents who eat their meals at the facility.<br><br>The findings included:<br><br>On 08/11/24 (Sunday) at 9:00 AM, it was observed that the daily menu posted on the wall at the entrance to the dining room was labeled as being the menu for Monday. This menu documented that the lunch meal to be provided on this day was Cracker Crumb Cod, Potato Wedges, Broccoli, Roll, and Brownie, with the alternate meal being Chili with Beans and Baked Potato.<br><br>During the meal observation at 08/11/24 at 12:10 PM, the main entree served to the residents was Turkey Shepherd's Pie (Ground Turkey, mashed potatoes, peas/corn/carrots), Dinner Roll, and Cheesecake. The only other meal observed being served at this time was an always available grilled cheese sandwich, tomato soup, and fresh fruit.<br><br>Observation of a weekly menu posted on the bulletin board in the dining room showed the menu was for Week 1, which included the dates of 08/20/24 - 08/26/24. A search through all the weekly menus posted on the bulletin board did not contain a menu for any dates prior to 08/20/24.<br><br>While looking at the menus, the surveyor was approached by the significant other of Resident #2 who stated, If you can understand the logic of those menus posted, you are a better person than I am. That daily menu posted on the outside of the dining room has been there since last Monday. It would be nice to know what's being served.<br><br>An interview conducted with the Certified Dietary Manager on 08/14/24 at 10:08 AM revealed that she had been on vacation and this was her first day back. It seems the daily menus were not changed in my absence. I changed the menu this morning. She also stated that the weekly menus posted on the bulletin board in the dining room should have indicated the menu for Week 5, not Week 1. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>38212<br><br>Based on observation, interview and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 1 sampled resident with an indwelling catheter (Resident #14).<br><br>The findings included:<br><br>The policy titled Enhanced Barrier Precautions and implemented 04/01/2024 documents in part:<br><br>Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.<br><br>Policy Explanation and Compliance Guidelines:<br><br>a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precaution.<br><br>9. Enhanced Barrier Precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that places them at high risk.<br><br>On 05/18/24, Resident #14 was admitted to the facility with diagnosis to include:<br><br>Urinary Tract Infection, Cerebrovascular Disease, Hypotension, Dementia, and Gout.<br><br>Resident #14 has a BIMS (Brief Interview for Mental Status) of 11, which indicates moderately impaired mental status. The resident had an indwelling urinary catheter present.<br><br>On 08/11/24 at 10:24 AM, Resident #14's room was observed; no EBP sign was noted on the door and no gowns were available. Resident #14 has a urinary catheter due to obstructive uropathy. During an interview with Resident #14, he stated that the staff wear gloves but they don't wear gowns during care.<br><br>On 08/12/24 at 12:27 PM, Staff A, a CNA (Certified Nursing Assistant) was observed donning a gown to deliver a meal tray. The EBP sign was noted on the door with a contact isolation sign also on the door. She was asked why she had donned the gown, and she replied, They told me to put on a gown since I was opening an item on [Resident #14] meal tray.<br><br>On 08/13/24 at 10:01 AM, Staff B, a CNA, performed urinary catheter care and peri-care on Resident #14. The CNA donned gloves and a gown. The resident asked, I wonder when they will be taking the sign off my door. Staff B replied I think your last one [antibiotic] was yesterday or it may be today, but I just wanted to be on the safe side.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106097 | A. Building<br>B. Wing | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hidden Lakes Senior Living Community | 1006 33rd St<br>Vero Beach, FL 32960 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 08/13/24 at 10:50 AM, Staff B was asked why she had worn a gown during the care. She stated that the overnight nurse told her the antibiotic for his ESBL (Extended Spectrum Beta-Lactamase) was up yesterday, and today's nurse said she thought that it was up today, so I used the gown to be safe. When shown and asked about the EBP sign, the CNA read it over and stated, I guess I need to wear the gown. The CNA stated she did not know about the EBP or the need to wear PPE (Personal Protection Equipment) for a resident with a urinary catheter. Staff B further added, I don't think he had that sign or PPE when I worked last time, and he had the Foley.<br><br>On 08/13/24 at 9:30 AM, Staff C, an RN (Registered Nurse), was interviewed. She was asked why the PPE (Personal Protective Equipment) was on the door for Resident #14. She stated the precautions were for the ESBL in his urine. When shown the sign for EBP, the RN was unaware of the use of PPE during care. The RN stated that prior to his contact precautions, Resident #14 had not been on any type of precaution.<br><br>Review of the chart revealed no ESBL in the urine and no indication for contact isolation. No order was found for Enhanced Barrier Precautions for Resident #14 and his indwelling urinary catheter.<br><br>On 08/14/24 at 10:43 AM, the DON (Director of Nursing) was interviewed about the EBP and how the staff is made aware of the precautions for the residents. She stated the last update for the staff on EBP precautions was on 02/14/24. A new policy was initiated on 04/01/24 for EBP. She states no in-services were completed with staff following the implementation of the new policy which includes EBP for urinary catheters. |