STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145384	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Village Care Center	400 South Station Road Glen Carbon, IL 62034

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49578 Based on interview, observation and record review, the facility failed to ensure the resident's sink water temperature was at a comfortable level for hand or facial washing for 4 of 4 residents (R36, R258, R27, R7) reviewed for safe, clean and comfortable environment in the sample of 25. Findings include: On 3/19/2024 at 9:15 AM, R36 reported there was no hot water in the bathroom since 2021. R36 stated she reported it to staff (unknown) with no results. The water in R36's bathroom sink was observed after running the hot water for 15 minutes, the temperature measured at 40 degrees Fahrenheit. 3/19/24 10:30 AM, R27 Alert and oriented x1, not able to interview. No hot water at the bathroom sink, cold to touch after 15 minutes of running hot water. 3/19/24 11:12 AM, R7 Alert and oriented x1. Not able to interview. No hot water at the bathroom sink, very cold to touch after 15 minutes of running hot water. On 3/20/2024 at 11:30 AM, V11, Director of Facility Services, stated that the water valve is broken, and he called the plumber to replace it and is just waiting on them to come and do it. V11 stated there's no hot water on 600 hall, so they will probably move those residents off the hall. On 3/21/2024 at 8:55 AM, the water temperature recordings were reviewed with no temperature's documented on 3/19/24, 3/20/24 or 3/21/24. On 3/21/2024 at 9:30 AM, V11, Director of Facility Services, stated he hasn't checked the water temperature today. V11 stated he will usually check a couple of times a week. V11 stated he thought it was the water valve yesterday, but the water pump went out. V11 stated they have been having problems for a little while, so hopefully the plumber will get it fixed by this Friday 3/22/2024. On 3/21/2024 at 9:45 AM, V11, Director of Facility Services, was observed going into bathrooms on Hall 600 to check the temperatures of the bathroom sink water. Temperatures were checked at the bathroom sink of R36, recording the water temperature at 68 degrees Fahrenheit after 15 minutes. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/24 at 10:05 AM, V11, Director of Facility Services, was observed checking the water temperature in R258's bathroom sink, recording the water temperature at 70 degrees Fahrenheit after 15 minutes. On 3/21/24 at 11:55 AM, V4, LPN (Licensed Practical Nurse) reported he knew that maybe sometimes they (maintenance) will work on the water heater for the halls. On 3/21/24 at 12:00 PM, V10, CNA (Certified Nursing Aide) reported when he works hall 600, he will get his water to wash residents on hall 600 from the breakroom. On 3/21/24 at 12:20 PM, V2, Director of Nurses, stated they don't have a policy for water temperatures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on observation, interview and record review, the Facility failed to supervise residents, properly tranfer residents, and ensure progressive fall interventions were implemented in 4 of 10 residents (R12, R34, R41, R44) reviewed for accidents and hazards in the sample of 25. Findings include: 1. R12's Face Sheet documents R12 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, Parkinson's disease, type 2 diabetes mellitus, psychotic disorder with hallucinations, post-traumatic stress disorder, difficulty in walking, and history of falling. R12's Minimum Data Set (MDS) dated [DATE] documented R12 was severely cognitively impaired and required substantial assistance with rolling from side to side, sitting to standing, and transfer. R12's Care Plan revised 3/11/24 documents R12 is at risk for falls due to Parkinson's disease, periods of confusion, and history of falls. R12's Fall Risk assessment dated [DATE] documents R12 is at high risk of falls. R12's Progress Note dated 10/30/23 at 1:30 AM documents R12 was found on the floor in his room with buttocks in the air, face on the ground and most of his weight on his left side. The incontinence pad was next to the bed. R12's left eye was puffy and discolored purple/blue, his nose was puffy, his left side and left foot were reddened, and his left knee had small abrasion. R12's Fall Report dated 10/29/23 documents R12 was found lying on the floor in his room by staff. His left eye was puffy, purple, and blue, his left side and left foot were reddened, and his left knee had a small abrasion. R12 complained of pain everywhere at a 10 out of 10 rating. R12's Care Plan revised 3/11/24 documents low bed with floor mats as the intervention for R12's 10/29/23 fall. On 3/20/24 at 1:47 PM, V12, Certified Nursing Assistant (CNA), stated, (R12) is a fall risk, so when he is in bed we lower his bed to the floor and put pads (floor mats) down on each side. On 3/21/24 at 7:32 AM, R12 was resting in bed with a floor mat to his left side. There was no floor mat on his right side, but there was a floor mat propped against the wall. V15, CNA, entered the room and stated R12 normally has two floor mats, but he refused to get out of bed this morning and staff probably forgot to put it back down. 2. R44's Face Sheet documents R44 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, type 2 diabetes mellitus, need for assistance with personal care, muscle weakness, unspecified psychosis, and unspecified abnormalities of gait and mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44's MDS dated [DATE] documented R44 was severely cognitively impaired and used wheelchair, but was independent with rolling from side to side, lying to sitting, and sitting to standing. He required supervision with transfer and walking. R44's Care Plan dated 8/31/23 documents R44 is at risk for falls due to weakness, history of falls, attempts to self-transfer, impulsivity, quick movements, poor memory, and failure to use call light. R44's Fall Risk assessment dated [DATE] documents R44 is at high risk for falls. R44's Progress Note dated 10/26/23 documents R44 was found on his knees in dining room attempting to return to his wheelchair and stated he slid from his wheelchair while propelling himself. There were no injuries. The intervention was placement of a non-skid seat cushion in R44's wheelchair. R44's Fall Report dated 10/26/23 documents R44 had an unwitnessed fall in the dining room while propelling himself in his wheelchair. There were no injuries. A non-skid seat cushion was added to the seat of R44's wheelchair. R44's Care Plan revised 12/5/23 documents non-skid seat cushion as R44's 10/26/23 fall intervention. On 3/20/24 at 9:45 AM, R44 was sleeping in bed in his room. V10, CNA, stated R44 does not have a non-skid seat cushion. V10 lifted R44's wheelchair cushion from the seat of his wheelchair, and there was no non-skid seat cushion on the seat. On 3/20/24 at 1:47 PM, V12, CNA, stated she was unsure whether R44 was supposed to have a non-skid seat cushion in his wheelchair. On 3/20/24 at 3:38 PM, V13, CNA, stated she was unsure whether R44 had a non-skid seat cushion in his wheelchair. On 3/20/24 at 3:43 PM, V14, Licensed Practical Nurse (LPN), stated she was unsure whether R44 has a non-skid seat cushion in his chair. 44953 3. R34's Minimum Data Sheet (MDS) dated [DATE] documents V34 is cognitively intact but requires substantial/maximal assistance with personal hygiene, toilet transfer and tub/shower transfer. R34's Physician Order Summary (POS) undated documents Alzheimer's disease with late onset; Hereditary and idiopathic neuropathy, unspecified; Unsteadiness on feet; Osteoarthritis of knee, unspecified, bilateral; History of falling; Abnormal posture; Muscle weakness (generalized); Dependence on wheelchair; Need for assistance with personal care. R34's Admission Fall assessment dated [DATE] documents R34 is a HIgh Risk for Falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34's Fall Investigation dated 3/20/24 documents Resident is A&O X 3 with some forgetfulness and confusion noted at times. She requires assist with all ADLs and usses (sic) wheelchair for mobility. On this date staff went in to assist her in getting up. They changed and provided percare (sic) and assist her in getting dress. The they stood her with gait belt to transfer her to wheelchair they forgot to lock wheelchair brakes and w/c moved. Staff lowered her to the floor to prevent her from falling and injury. Staff was educated and reminded to always ensure that brakes are locked before transferring resident. R34's Care plan dated 4/4/23 documents R34 is at risk for falls due to history of falls at home, increased weakness, glaucoma/macular degeneration, neuropathy. I have reduced mobility at this time. Tends to lean forward slightly, when sitting in wheelchair with head down slightly. Poor standing balance. When standing, she has knees bent slightly making her leg muscles hold her up rather than bearing weight thru her bones. Interventions: I will continue to be assisted with transfers in the most safe and appropriate manner during this review period - Approach: Fall intervention 3/14/24; Staff reminded/re-educated to always make sure the w/c brakes are locked when transferring her. On 3/21/24 at 9:45 AM, R34 stated she did not fall she just slid to the floor. 2 CNAs were holding her up under her (V34) arms and her (V34) legs just gave away. (V34) did not recall if her wheelchair was locked. On 3/22/24 at 8:48 AM, V2, DON stated in-service training is provided to all staff periodically on the use of any transfer equipment. Therapy provides transfer education to all staff and all staff are encouraged to ask questions if needed. On 3/22/24 at 9:45 AM, V21 CNA stated she and another CNA were involved in the transfer of R34. V21 CNA stated we forgot to lock the wheelchair and yes we did have in-service training on the use of wheelchair. 4. R41's Minimum Data Set (MDS) dated [DATE] documents R41 has severe cognitive impairment, requires partial/moderate assistance with sit to stand, chair to bed transfer and toilet transfer. R41's Physician Order Summary (POS) undated documents pertinent medical diagnosis as history of falling; Unspecified fall, subsequent encounter; Need for assistance with personal care; Weakness R41's Admission Fall Risk assessment dated [DATE] documents he is high risk for falls R41's Fall investigation dated 2/1/24 documents, (R41) was on floor at 1450. He was assisted to bed at PM and inc care/brief was last changed at 1435. He was fully dressed with gripper socks on that time and when found at 1450 he had removed all clothing/socks except shirt. He was apparently trying to toilet self. Laceration to back of head requiring 5 staples in ER. Alert with confusion,forgetfulness. Weak s/tmultiple myeloma. On hospice. Has cognitive deficits. Diabetic with neuropathy. Poor safety awareness. Impulsive. Given a low bed with mats, alarm placed on bathroom door (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41's Fall Investigation dated 3/11/24 documents Resident is alert with confusion. diagnosis include multiple myeloma, cognitive communication deficit, muscle weakness, Hypertension, Diabetes Mellitus, and history of falls. He has poor insight to self deficits, poor memory, and poor safety awareness. He requires assist with transfers and uses a reclining wheelchair for mobility. Staff anticipates his needs. On this date he was up in reclining wheelchair in common area, staff were getting people up. When staff member came back to common area resident was on the floor, with the back wheels off the ground. The reclining wheelchair was propped up on leg rest and front wheels. Resident looked like he tried to stand up at the railing and went down to the foot rest, tipping over the chair. Resident states that he was trying to get a drink. A cup holder for his reclining wheelchair was ordered. On 3/21/24 at 1:45 PM, V2, DON stated R41's reclining wheelchair was provided by Hospice without operations manual. On 3/21/24 at 2:30 PM, V23 Restorative CNA stated she arrived at work around 6:00 AM , R41 was not in his reclining wheelchair chair in the hallway leading to common area upon her arrival. At approximately 6:30 AM she (V23) stated the residents were gathered around the coffee carafe for their morning cup of coffee. Upon her (V23)return (R41) was in the reclining wheelchair and parked to the right side of the hall near the hand rail. Upon her return to the area (R41) was found on the floor and his reclining wheelchair was resting on its front wheels and the hind wheels were up in the air near the the left side of the hall. At the time of the fall R41 stated he was trying to get something to drink. (V23) Restorative CNA stated (R41) was known to be restless at times. Cannot recall if other staff were in the area or if all other residents had been returned to their rooms. R41 was unable to be interviewed at this time as his illness had progressed and he (R41) was in the active stage of dying. On 3/21/24 at 2:36 PM, V18, Hospice RN stated her company did order a reclining wheelchair for (R41) from a medical supply company and they would have provided the paperwork upon delivery to the facility. She (V18) had no concerns regarding R41's care. (V18) stated she was notified of his fall but not that it was from the reclining wheelchair. V18 Hospice RN did know R41 to be occasionally restless and occasionally reaching for objects not within his immediate reach. On 3/21/24 at 2:40 PM, V20, Hospice Team Leader provided the operations manual of the reclining wheelchair supplied by the medical supply company. On 3/22/24 at 8:48 AM, V2, DON stated in-service training is provided to all staff periodically on the use of any mechanical equipment. However, there is no specific training for use of the reclining wheelchair. The wheel locks are the same as on other reclining wheelchairs. According to the CNA (V23) there were other residents in the area and a nurse (V26) was at the end of the hall who had the the area within sight. On 3/22/24 at 10:00 AM, efforts to reach V26 unsuccessful. On 3/22/24 at 10: 01 AM, V25, LPN stated in all of her [AGE] years of being a nurse she had never received in-service training on the use of a reclining wheelchair. The Operating Manual for the Centric Tilt Semi- Recliner documents 2.5.3 Location of Chair - Danger of Tipping or Falling Objects. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	We recommend that when a resident has been moved to their destination, the chair is placed where the resident cannot reach handrails or other objects, fixed or movable. This is to prevent the resident from pulling the chair over or pulling themselves off the seating surface and to prevent the resident from pulling movable objects onto the chair and themselves. We recommend that the chair be used in a supervised area to prevent untrained residents, caregivers, or third parties from unauthorized operation, movement, or unsafe actions such as sitting or leaning on the reclined back, elevated footrest, or the armrests. These actions, if not prevented, put the chair at risk of tipping or damage to the chair. Care Plan dated 3/12/24 documents Resident is at risk for falls due to weakness, decreased functional mobility, DM with neuropathy, history of cerebral infarct, multiple myeloma. Forgetful. Periods of confusion. Poor safety awareness. Decreased reasoning and safe judgement. Impulsive. Poor insight to his own deficits. Has tried to get up unassisted at times. Has tried to toilet self. Staff has found him in bathroom after he covered urine with paper towels. Does not use call light. Does not recall falling. Has worn gripper socks, but has removed them at random. INTERVENTIONS: Fall intervention 3/11/24; Because senior is usually c/o being thirsty therefore he is given a water bottle to keep with him on the reclining wheelchair for ready access to water. - Provide 2 assist with transfers. Reclining wheelchair for mobility with staff assist. Keep floor clean, dry. Keep bed brakes locked. Call light in reach at all times when he is in bed. Remind him to use it. 'Call don't fall' signs in room. Utilize 2 half side rails while in bed for bed mobility and repositioning. Gripper socks on at all times. - Fall intervention 2/19/24; low bed with mats now, alarm placed on bathroom door. - He will wear his glasses as needed. Make sure he is wearing his hearing aid so he can communicate better. Can be up in reclining wheelchair as tolerated. Keep in common areas when up in chair. 42636 On 3/22/24 at 8:45 AM V2, Director of Nurses (DON), stated when a resident falls the nurse will assess the resident, then the nurse and CNAs on the hall have a fall huddle to discuss the cause of the fall and will try something else to prevent future falls. V2 stated the the fall committee meets weekly to discuss the falls, causes, if the interventions are working or if something different needs to be done. V2 stated she will in-service the staff on the new interventions if it is something they are not familiar with. V2 stated the interventions for fall prevention are documented on the care plan, Kardex and on the incident report. The Fall Prevention Policy & Procedure, with a review date of 2/28/24, documents the interdisciplinary team shall review each resident's fall risk prevention plan at a minimum of quarterly and after a fall occurrence, during care conference and modify the plan as needed based upon the resident's functional status during the review process.

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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** 42636 Based on interview, observation and record review, the facility failed to ensure an indwelling urinary catheter drainage bag was placed below the level of the bladder to prevent back flow of urine into the bladder and proper drainage of urine in 1 of 1 residents (R2) reviewed for catheters in the sample of 25. Findings include: On 3/21/24 at 9:45 AM, R2 was observed in bed lying on her back with her feet and head slightly elevated with an indwelling urinary catheter in place. The drainage bag was full with urine, backing up in the tubing going into the urethra. The urine drainage leg bag was secured to the top of R2's left knee, not below the level of the bladder causing urine to back flow into the bladder and not allowing for proper drainage. Incontinent/Catheter care was observed with V10, CNA (Certified Nurses Assistant), and V5, CNA. After care was provided, R2 was covered up with her blanket and V10 and V5 left the room, leaving R2's urinary catheter bag in the same position, not below the level of the bladder. R2's Face Sheet, undated, documents R2 has a diagnosis, in part, of Multiple Sclerosis (MS), Need for Assistance with Personal Care, Full Bowel Incontinence, Chronic Obstructive Pyelonephritis, History of Urinary Tract Infections and Neuromuscular Dysfunction of the Bladder. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has severe cognitive impairment, has an indwelling urinary catheter and is incontinent of bowel. R2's Care Plan, dated 5/23/23, documents R2 requires an indwelling urinary catheter due to MS and Neurogenic Bladder with an intervention to provide catheter care every shift and as needed. Keep drainage system closed as much a possible. Keep collection bag below bladder level. Empty bag every shift. Continue to encourage fluids when possible. Remains on enhanced precautions per infection control policy. R2's Physician Order Sheet (POS), documents an order dated 7/8/22, to provide catheter care every shift. R2's POS, documents an order dated 8/4/23, for a urinary catheter due to a diagnosis of Neuromuscular Dysfunction of the Bladder. R2's Progress Note, dated 1/2/24 at 12:07 AM, documents the following: Resident c/o (complaining of) being cold and did not want to get up for her shower or supper, she did agree to a bed bath after supper. CNA (Certified Nurses Assistant) reported that the resident's catheter leaked. Resident's catheter had just been changed three days ago. Noted that staff had left resident's leg bag on while she was in bed all evening, which probably contributed to leaking Foley. Resident cleaned up and a large drainage bag was applied to the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Progress Note, dated, 1/30/24 at 12:50 AM, documents the following: Staff noted that when the leg bag is left on resident in bed, the catheter does not drain properly and instead the leaks. Staff teaching done again. R2's Progress Note, dated 1/30/24 at 2:05 AM, documents the following: CNA informed this writer that the resident's catheter was leaking as the bag was empty and her brief was saturated with urine. New catheter placed using sterile procedure and 16 French catheter. Received good urine return and resident tolerated procedure well. No s/s (signs/symptoms) of distress noted. On 3/22/24 at 8:45 AM V2, DON, stated residents with catheters that are laying down can have their leg bag on for a short time. If they are going to be in bed longer or at night then their leg bag is changed over to the bigger bag. V2 stated their leg bags resist back flow of urine. The Perineal Care/Catheter Care Policy & Procedure, with a review date of 2/28/24, documents for catheter care, at no time should the drainage bag be placed above the bladder; this prevents back flow of urine into the bladder which may cause infection.

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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** 42636 Based on observation, interview and record review, the facility failed to provide incontinent care utilizing infection control practices to prevent infection and use appropriate personal protective equipment on a resident that was on enhanced barrier precautions in 1 of 2 residents (R2) reviewed for catheters/urinary tract infections in the sample of 25. Findings include: On 3/21/24 at 9:45 AM, There was a sign on R2's door indicating R2 is on enhanced barrier precautions. R2 was observed in bed lying on her back with her feet and head slightly elevated. An indwelling urinary catheter in place. The urine drainage bag was contained in a leg bag that was secured to the top of R2's left knee, causing urine back flow into the bladder and improper drainage of urine. Incontinent/Catheter care was observed with V10, CNA (Certified Nurses Assistant), and V5, CNA, with the following noted: Neither V10 or V5 had a gown on due to resident being on enhanced barrier precautions. V10 put gloves on with no hand hygiene observed prior to. R2's depend was soiled with urine. V10 used pre-packaged wipes to clean R2's front perineum, then discarded the wipe, V10 then used his dirty hand to grab a clean wipe from the package and wiped R2 again. V10 did this several times without maintaining a clean/dirty field. V10 removed his gloves and donned new gloves without performing hand hygiene. R2 was then turned onto her left side, V10 took a wipe and wiped in a downward motion towards R2's urethra, noting resident had stool in the anal area. V10 then cleaned R2's buttock crease and buttocks without maintaining a clean/dirty field. V10 then changed gloves to apply a clean incontinence brief without performing hand hygiene. R2 was then covered up with her blanket and V10 and V5 left the room, leaving R2's urinary catheter bag in the same position causing back flow of urine into the bladder and improper drainage. R2's Face Sheet, undated, documents R2 has a diagnosis, in part, of Multiple Sclerosis (MS), Need for Assistance with Personal Care, Full Bowel Incontinence, Chronic Obstructive Pyelonephritis, History of Urinary Tract Infections and Neuromuscular Dysfunction of the Bladder. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has severe cognitive impairment, has an indwelling urinary catheter and is incontinent of bowel. R2's Care Plan, dated 5/23/23, documents R2 requires an indwelling urinary catheter due to MS and Neurogenic Bladder with an intervention to provide catheter care every shift and as needed. Keep drainage system closed as much a possible. Keep collection bag below bladder level. Empty bag every shift. Continue to encourage fluids when possible. Remains on enhanced precautions per infection control policy. R2's Physician Order Sheet (POS), documents an order dated 7/8/22, to provide catheter care every shift. R2's POS, documents an order dated 8/4/23, for a urinary catheter due to a diagnosis of Neuromuscular Dysfunction of the Bladder. (continued on next page)

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Eden Village Care Center	400 South Station Road Glen Carbon, IL 62034

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Progress Note, dated 12/24/23 at 1:04 PM, documents the following: Catheter in place & patent. Draining thick amber urine with foul odor & moderate amount of mucus. Fluids encouraged but she is a poor drinker. Appetite fair. Catheter care given. Resident denies pain or discomfort. R2's Progress Note, dated 1/2/24 at 12:07 AM, documents the following: Resident c/o (complaining of) being cold and did not want to get up for her shower or supper, she did agree to a bed bath after supper. CNA (Certified Nurses Assistant) reported that the resident's catheter leaked. Resident's catheter had just been changed three days ago. Noted that staff had left resident's leg bag on while she was in bed all evening, which probably contributed to leaking Foley. Resident cleaned up and a large drainage bag was applied to the catheter. R2's Progress Note, dated, 1/30/24 at 12:50 AM, documents the following: Staff noted that when the leg bag is left on resident in bed, the catheter does not drain properly and instead leaks. Staff teaching done again. R2's Progress Note, dated 1/30/24 at 2:05 AM, documents the following: CNA informed this writer that the resident's catheter was leaking as the bag was empty and her brief was saturated with urine. New catheter placed using sterile procedure and 16 French catheter. Received good urine return and resident tolerated procedure well. No s/s (signs/symptoms) of distress noted. R2's Urine Culture dated 5/21/23 documents the following bacteria was identified, Klebsiella Pneumoniae ESBL (extended spectrum beta-lactamase), Proteus Miribillis ESBL and Citrobacter Freundii Complex. On 3/22/24 at 8:45 AM V2, DON, stated residents with catheters that are laying down can have their leg bag on for a short time. If they are going to be in bed longer or at night then their leg bag is changed over to the bigger bag. V2 stated their leg bags resist back flow of urine. V2 stated when a resident is on enhanced barrier precautions for an MDRO (multi-drug resistant organism), staff are to wear a gown and gloves when providing incontinent care. V2 stated staff should perform hand hygiene before incontinent care, during and after care. The Perineal Care/Catheter Care Policy & Procedure, with a review date of 2/28/24, documents for catheter care, perform hand hygiene and apply gloves. At no time should the drainage bag be placed above the bladder; this prevents back flow of urine into the bladder which may cause infection. The Infection Control Policy, with a review date of 2/28/24, documents standard precautions apply to all residents, regardless of their diagnosis, shall use appropriate hand hygiene after touching blood, body fluids, excretions, secretions and contaminated items, regardless of whether gloves are worn. Hand hygiene immediately after gloves are removed and between tasks and procedures on the same resident to prevent cross contamination of body sites. Enhanced barrier precautions will be used for residents during high contact resident care activities that provide opportunities for a transfer of multi-drug resistant organisms which include ESBL. Under enhanced barriers staff will wear a clean, disposable, non-sterile gown and gloves when providing high contact resident care areas which include dressing, clothing, showering, transferring, changing linens and providing hygiene.