| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155170 | A. Building<br>B. Wing | 06/18/2025 |

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| Westminster Village Muncie Inc | 5801 W Bethel Ave<br>Muncie, IN 47304 |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on record review and interview, the facility failed to have a system in place to respond to and promptly resolve resident council concerns.<br><br>Finding includes:<br><br>Review of the facility's Resident Council Minutes, on 6/16/25 at 9:36 a.m., included the following Resident Council concerns:<br><br>On 4/17/25 at 10:30 am., six residents attended the resident council meeting. A concern in the minutes under dietary indicated the hot foods not. The Resident Council Action Form was left blank. The form had areas for the reported concern, date the form was due back to resident council, staff response and action plan, and staff signature and title.<br><br>On 5/15/25 at 11:00 a.m., seven residents attended the resident council meeting. The Old Business section was left blank. A concern under dietary indicated some residents reported the food was cold sometimes. The minutes lacked a Resident Council Action Form.<br><br>During an interview on 6/16/25 at 10:03 a.m., Life Enrichment Director 12 indicated she did not have additional follow-up/action information to provide regarding the concerns brought to her attention during Resident Council meetings. She typically took minutes during the meetings and handled any concerns brought up verbally with the different departments. The facility did not have a record of those interactions. She did not know how one would know when/if a concern was addressed or resolved for response to the resident group.<br><br>During a resident group interview on 6/16/25 at 11:06 a.m., two of two residents in attendance indicated they were uncertain if anyone responded to the resident council concerns discussed during the monthly meetings.<br><br>On 6/16/25 at 11:30 a.m., Life Enrichment Director 12 indicated she had taken the minutes in the resident council meetings for April and May 2025. In both April and May 2025, the Resident Council group had reported concerns with foods being cool, rather than hot, when it was served. She was unable to provide information or follow up on the concerns to show what had been done to correct the resident group concerns for April and May 2025. Life Enrichment Director 12 indicated she should have completed the Resident Council Action Form for each concern and followed up with the Resident Council group.<br><br>On 6/16/25 at 2:36 p.m., Dietary Aide 14 indicated dietary management staff typically informed them if there were concerns regarding the food temperatures. She was unaware of any food temperature<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | complaints for several months. She was unaware of any new processes put into place to ensure the resident's food was delivered warm.<br><br>On 6/16/25 at 2:51 p.m., the Food Services Director denied knowledge of food temperature concerns brought to his attention from the Resident Council meeting concerns. He received information regarding a concern about the food being cold from management staff during a care plan meeting on 6/11/25.<br><br>On 6/16/25 at 3:14 p.m., Administrator 1 indicated the Resident Council Action Form was not completed in April 2025 and May 2025 when food temperature concerns were reported in the Resident Council minutes. She was unable to provide additional information.<br><br>On 6/16/25 at 3:17 p.m., Life Enrichment Director 15 indicated responses to the Resident Council group concerns should have been documented on the Resident Council Action Form. Without the Resident Council Action Forms for follow-up, one would not know if the concerns had been addressed. Further information was not provided.<br><br>A current facility policy, revised on 5/14/25, titled Resident Council Meetings, provided by the facility on 6/16/25 at 1:31 p.m., indicated the following: Policy: This facility supports the rights of residents to organize and participate in resident groups, including a Resident Council . Policy Explanation and Compliance Guidelines: . 6. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council<br><br>3.1-3(l) |

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| F 0574<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | The resident has the right to receive notices in a format and a language he or she understands.<br><br>Based on observation and interview, the facility failed to ensure the name and contact information for the State Long Term Care Ombudsman was posted and readily available for the resident and visitors. This deficiency had the potential to affect 57 of 57 residents in the facility.<br><br>Finding includes:<br><br>During an observation on 6/16/25 at 12:18 p.m., a tour of the skilled areas of the facility was completed. The State Ombudsman information was not posted and readily available for residents and visitors.<br><br>During an observation of the nursing home units of the facility, on 6/16/25 at 1:24 p.m., accompanied by the DON and Administrator 2, Administrator 2 indicated the State Ombudsman contact information was not located and should have been posted for the residents' access.<br><br>During an interview on 6/17/25 at 10:28 a.m., Administrator 2 indicated the facility did not have a policy regarding posting of resident advocacy numbers. They followed the Indiana Department of Health guidelines regarding posting of advocacy numbers.<br><br>3.1-4(j)(3) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide bed hold policy and transfer/discharge notifications to the resident/representative for 2 of 2 residents reviewed for hospitalizations. (Residents 1 & 17)<br><br>Findings include:<br><br>1. Resident 1's clinical record was reviewed on 6/17/25 at 11:41 a.m. Diagnoses included acute on chronic diastolic (congestive) heart failure, hypertensive heart disease with heart failure, and hypertension.<br><br>A 4/6/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.<br><br>A 5/31/25, discharge, MDS assessment indicated the resident discharged with a return anticipated.<br><br>A 5/31/25, progress note indicated the resident complained of pain in the right upper and lower quadrant of her chest, right side of her back, and under her right shoulder. The pain was getting worse and the resident requested to be sent to the emergency room. The ambulance arrived and all parties were notified.<br><br>The clinical record lacked indication of whether a transfer/discharge form and the bed hold policy were provided to the resident or their representative.<br><br>2. Resident 17's clinical record was reviewed on 6/16/25 at 11:16 a.m. Diagnoses included primary hemiplegia and hemiparesis following a cerebral infarction, hypertension, and oropharyngeal dysphagia.<br><br>A 5/18/25, quarterly, MDS assessment indicated the resident was severely cognitively impaired.<br><br>A 4/16/25, progress note indicated the resident had fallen and suffered a forehead laceration. The nurse practitioner recommended the resident be sent to the emergency room. 911 was called and a verbal report of the situation was given. The resident Power of Attorney (POA) was notified.<br><br>The clinical record lacked indication of whether a transfer/discharge form and the bed hold policy were provided to the resident or their representative.<br><br>During an interview, on 6/17/25 at 3:05 p.m., LPN 16 indicated she utilized a transfer/discharge checklist to ensure she did not miss any steps when discharging a resident. Once an order for the discharge was obtained, she called for transportation or 911 and gave a verbal report to the hospital. The resident's family would be notified. She printed out the resident's code status, diagnoses, orders, medications, and other documents related to the discharge or transfer. These papers would be given to the emergency medical technicians (EMT) as the left with the resident. She would fill in the transfer event in the electronic medical record (EMAR) and document in a progress note.<br><br>On 6/17/25 at 3:32 p.m., RN 9 indicated when a resident required a transfer or discharge to the hospital her first step was to contact the doctor and obtain an order to send the resident to the<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | emergency room. She called 911 or transportation and would call to give verbal report to the hospital. She notified the resident's family and printed out resident information for the EMTs. She printed the resident's face sheet, code status, diagnoses, medications, progress notes, and any other documents related to the resident's discharge. She gave the papers to the ambulance drivers or EMTs. She would document this information in a progress note in the resident's medical record.<br><br>On 6/18/25 at 10:16 a.m., the DON indicated the staff were required to call report to the receiving facility, complete the transfer/discharge form, fill out a bed hold form, print the resident's face sheet and orders, and the staff should have included in the clinical record information regarding who the information and copies of the above documents were given to. This information had not been done for Resident 1's discharge on [DATE] and Resident 17's discharge on [DATE]. She was unable to find transfer/discharge notifications or bed hold notifications for either of the above mentioned residents.<br><br>A current facility policy, dated 5/15/25 and titled, Bed Hold Notice, provided by the DON on 6/18/25 at 10:16 a.m., indicated the following: . 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or resident representative written information that specifies: a. The duration of the State bed-hold policy, of any, during which the resident is permitted to return and resume residence in the nursing facility . 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed hold policies to the resident and/or resident representative within 24 hours .<br><br>A current facility policy, dated 5/15/25, titled, Transfer and Discharge (including AMA), provided by the DON on 6/18/25 at 10:16 a.m., indicated the following: .3. The facility's transfer/discharge notice will be provided to the resident and resident's representatives in a language and manner in which they can understand . 10. Emergency Transfers to Acute Care . d. The original copies of the transfer or discharge form and advance directives will accompany the resident. Copies will be retained in the medical record . g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated .<br><br>3.1-12(a)(6)(A)(i) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interview and record review, the facility failed to ensure staff competency regarding narcotic administration and reconciliation for 2 of 3 residents reviewed for narcotic use. The deficiency had potential to impact 11 residents who received narcotic pain medication from the unit medication cart. (Resident 5 and Resident 263)<br><br>Findings include:<br><br>During a medication storage observation with LPN 6 on 6/13/25 at 12:58 p.m., the 50s hallway narcotic log indicated Resident 5 received as needed (PRN) doses of tramadol (a narcotic pain medication) on the following dates:<br><br>6/4/25 at 10:00 p.m.<br><br>6/5/25 at 9:00 p.m.<br><br>6/12/25 at 8:30 p.m., and signed by RN 7<br><br>6/6/25 at 8:00 p.m.<br><br>6/7/25 at 7:00 p.m.<br><br>6/8/25 at 7:12 p.m.<br><br>6/9/25 at 8:00 p.m.<br><br>6/10/25 at 7:30 p.m.<br><br>6/11/25 at 6:30 p.m.<br><br>6/12/25 at 8:30 p.m. and signed by RN 8<br><br>Resident 263 received PRN doses of oxycodone (narcotic pain medication) at the following dates and times:<br><br>5/28/25 at 9:44 p.m., 6/7/25 at 8:53 p.m., 6/9/25 at 12:30 a.m., and signed out by RN 8 and on 6/5/25 at 10:34 p.m., signed out by RN 7.<br><br>Resident 5's clinical record was reviewed on 6/16/25 at 8:32 a.m. Diagnoses included, infection of internal joint prosthesis and left above knee amputation.<br><br>Current physician orders included tramadol 50 milligram (mg) tablet, give one tablet for pain as needed (12/27/24).<br><br>The electronic medication administration record (EMAR) indicated she received PRN doses of tramadol on 6/1/25 at 11:30 p.m., 6/2/25 at 11:02 p.m., and 6/5/25 at 9:44 p.m.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The EMAR lacked documentation of administration and follow-up for doses given on 6/4, 6/6, 6/7, 6/8,6/9, 6/10, 6/11, or 6/12/25.<br><br>Resident 263's record was reviewed on 6/16/25 at 8:31 a.m. Diagnoses included, right humerus (upper arm bone) fracture, type two diabetes, and hypertension (high blood pressure).<br><br>Current physician orders included oxycodone (pain medication) 5 mg capsule orally every 6 hours as needed for pain greater than seven on a zero to ten scale (5/23/25).<br><br>The EMAR indicated the resident received PRN doses of oxycodone on the following dates and times:<br><br>5/28/25 at 11:07 a.m.<br><br>5/29/25 at 6:42 a.m. and 7:08 p.m.<br><br>5/30/25 at 11:06 p.m.<br><br>5/31/25 at 11:28 p.m.<br><br>6/2/25 at 1:52 a.m.<br><br>6/4/25 at 11:10 p.m.<br><br>6/5/25 at 10:58 a.m.,<br><br>6/6/25 at 7:55 a.m. and 8:25 p.m.<br><br>6/8/25 at 4:03 a.m., 10:12 a.m., and 4:56 p.m.<br><br>6/9/25 at 5:59 a.m.<br><br>6/10/25 at 10:35 a.m.<br><br>6/11/25 at 10:03 a.m.<br><br>6/12/25 at 6:42 a.m. and 8:18 p.m.<br><br>6/13/25 at 1:53 a.m. and 4:40 p.m.<br><br>6/14/25 at 3:40 a.m. and 6:03 p.m.<br><br>6/15/25 at 4:08 a.m.<br><br>6/16/25 at 5:35 a.m.<br><br>The EMAR lacked documentation of administration and follow-up for doses given 5/28/25 at 9:44 p.m., 6/5/25 at 10:34 p.m. , 6/7/25 at 8:53 p.m. and 8:53 p.m., and 6/9/25 at 12:30 a.m.<br><br>During an interview with RN 9 on 6/16/25 at 1:56 p.m., she indicated when narcotic pain medication<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was requested by a resident, the medication was signed out in the narcotic log book, given to the resident, then charted in the MAR. She indicated that it would never be appropriate to document in only the MAR or the log book.<br><br>During an interview with the DON on 6/16/25 at 2:03 p.m., she indicated staff should have documented the narcotic administration in both the MAR and the narcotic log book.<br><br>During an interview with RN 7 on 6/16/25 at 6:44 p.m., he indicated when a resident requested pain medication he got a pain rating from the resident, performed the 5 rights of medication administration, counted the narcotics, signed them on the narcotic sheet, then checked the medication off on the MAR. He was unable to provide reasoning for the discrepancies.<br><br>During an interview with RN 8 on 6/17/25 at 2:28 p.m., she indicated when a resident requested pain medication, she looked to see which narcotic was available, signed it out on the narcotic log book, administered the medication, and documented it in the MAR. She noted she was not the best at documenting in both the narcotic log book and the MAR due to time constraints and there was not a place in the MAR to document a late administration or to amend administration time.<br><br>During an interview with the DON on 6/17/25 at 2:35 p.m., she indicated unit managers audited the narcotic count sheets on a monthly basis.<br><br>A current facility policy titled, Medication Administration, provided by the DON on 6/17/25 at 9:36 a.m. included the following: .20. Sign MAR after administered. 21. If medication is a controlled substance, sign narcotic book .<br><br>A current facility policy titled, Controlled Substance Administration & Accountability, provided by the DON on 6/17/25 at 1:02 PM included the following: .The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure .ii.All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form.iii. All specially compounded or non stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy. G. In all cases, the doses noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record(MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. j. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure shift to shift narcotic reconciliations were completed to account for controlled medications for 2 of 5 medication carts reviewed for medication storage. ([NAME] Court Unit and Bristol Court Unit) This deficient practice had the potential to affect 21 out of 57 residents who resided in the facility and received controlled medications from [NAME] Court Unit and Bristol Court Unit medication carts.<br><br>Findings include:<br><br>1. During a medication storage observation, accompanied by RN 10 on 6/13/25 at 11:40 a.m., the Narcotic Count Log for [NAME] Court Unit medication cart was reviewed and lacked a count or off-going staff signature when RN 10 took over the cart at the beginning of his shift at 6:00 a.m. on 6/13/25.<br><br>During an interview on 6/13/25 at 11:51 a.m., RN 10 indicated a shift to shift count had not been completed at the beginning of his shift because the off-going nurse left before the count was completed. Counts and signatures of both staff members were required at each exchange of the cart. The Narcotic Count Log for May and June 2025 had multiple dates lacking counts and signatures for the [NAME] Court medication cart. During a controlled medication reconciliation of [NAME] Court medication cart, RN 10 indicated there were two controlled medications in the narcotic drawer that did not have a Controlled Substances Record sheet in the narcotic binder which included: Resident 42's unopened 15 milliliter (ml) bottle of morphine sulfate (opiate pain medication) 20 mg/5 ml and Resident 20's tramadol (opiate pain medication) 50 milligrams (mg) with one tablet left in the card. The morphine had been pulled from the emergency drug kit, on the previous shift, for a resident that recently admitted to hospice. A Controlled Substance Record sheet for the morphine had not been started nor placed in the binder to show the amount of remaining medication for the shift to shift medication reconciliation. Since he had not done a shift to shift reconciliation of the controlled medications at the exchange of the cart, he had not identified the missing Controlled Substance Record sheets nor notified anyone of the discrepancies. This was an opportunity for potential drug diversion.<br><br>Review of the Narcotic Count Log records for [NAME] Court Unit medication cart, from 5/21/25 through 6/6/25, lacked shift to shift reconciliation of controlled substances for 37 out of 50 opportunities.<br><br>Resident 42's clinical record was reviewed on 6/17/25 at 11:03 a.m. Diagnoses included Parkinson's disease and anxiety.<br><br>Current orders included morphine solution 20 mg/5 ml- administer 0.25 ml by mouth every two hours as needed for pain, shortness of breath, or air hunger.<br><br>A 4/13/25, quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired.<br><br>Resident 20's clinical record was reviewed on 6/17/25 at 11:16 a.m. Diagnoses included osteoarthritis and spinal stenosis.<br><br>Current orders included tramadol 50 mg by mouth every six hours as needed for pain. 11/13/24<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 4/20/25, quarterly MDS assessment, indicated the resident was severely cognitively impaired.<br><br>2. During a medication storage observation of the Bristol 1 cart, accompanied by LPN 5, on 6/13/25 at 12:44 p.m., the Narcotic Count Log was reviewed and was missing the beginning card count and ending card count numbers for 6/8/25. LPN 5 indicated the narcotic sign in sheet was completed at the beginning and end of each shift. The nurse on the cart filled in the columns showing if any medication cards had been added or removed from the cart during their shift. Then the oncoming nurse and the offgoing nurse counted the narcotic cards in the narcotic box and signed the count log to show it was completed.<br><br>Review of the Bristol 1 cart Narcotic Count Log records from 5/21/25 through 6/8/15, lacked shift to shift reconciliation of controlled substances for 4 out of 45 opportunities.<br><br>During an interview, on 6/16/25 at 2:06 p.m. LPN 16 indicated the narcotic sign in sheet was to be completed at the beginning and ending of each shift. The outgoing nurse and the oncoming nurse count the narcotics on the cart and sign the log to show the count was correct and completed.<br><br>During an interview on 6/16/25 at 4:33 p.m., the DON indicated both staff were required to complete shift to shift controlled medication reconciliation with each exchange of the medication cart. During the reconciliations, both staff members were required to count the Controlled Substances Record sheets and the medications for identification of discrepancies.<br><br>A facility policy, dated 6/16/25, titled, Controlled Substance Administration & Accountability, provided by the DON on 6/18/25 at 10:16 a.m., indicated the following: . f. All controlled substances (Schedule II, III, IV, V) are accounted in one of the following ways . iii. All narcotic are to be counted by the nurse's/QMA's with a change of hands of narcotic cart keys. ALL narcotic counts are to be recorded on the narcotic count log. The nurse's/QMA's are to also count a total number of all narcotic medications (cards, bottles, bags of patches, narcan, and refrigerated items) with ever narcotic count. iv. All specially compounded or non stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplies with the medication or other designated form per facility policy . j. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify: .ii. Medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order .<br><br>3.1-25(b)(3) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155170 | A. Building<br>B. Wing | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westminster Village Muncie Inc | 5801 W Bethel Ave<br>Muncie, IN 47304 |

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 | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP) during catheter care for 1 of 3 residents reviewed for EBP. (Resident 255)<br><br>Finding includes:<br><br>During an observation on 6/11/25 at 3:49 PM, EBP signage was observed to the left of resident 255's door and indicated the following: Stop. Enhanced barrier precautions. Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities. Dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing.<br><br>During a catheter care observation on 6/17/25 at 1:17 PM, LPN 5 performed hand hygiene and donned gloves, but not a gown prior to entry into Resident 255's room. She knocked on the door, announced herself, and explained the procedure to the resident. LPN 5 prepared wet and dry wash cloths, then pulled the resident's blankets down and wiped his penis and the catheter tubing with a wet washcloth. A new dry washcloth was used to dry the aforementioned areas. She then removed her gloves, performed HHG, and exited the room.<br><br>During an interview, immediately following the observation, LPN 5 indicated she had not worn a gown while performing catheter care. She indicated gowns and gloves should be worn when performing high contact resident care procedures, but she forgot to don a gown.<br><br>Resident 255's record was reviewed on 6/13/25 at 11:58 AM. Current diagnoses included hypertension (high blood pressure), type two diabetes mellitus, unspecified dementia, and stage three chronic kidney disease.<br><br>Current physician orders included the following: EBP for indwelling catheter twice a day (6/4/25), catheter care every shift (5/30/25), and change catheter bag monthly (5/30/25).<br><br>A current facility policy titled, Enhanced Barrier Precautions, and provided by the DON on 6/16/25 at 2:33 p.m. indicated the following: .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .4. High-contact resident care activities include: f. Changing briefs or assisting with toileting. G. Device care or use: central lines, urinary catheters,<br><br>3.1-18(l) |