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	535049	A. BUILDING _____ B. WING _____	C 10/17/2024

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LIFE CARE CENTER OF CASPER	**4041 SOUTH POPLAR STREET CASPER, WY 82601**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/14/24 to 10/17/24. Also reviewed in the course of the survey were complaint intakes WY00003895, WY00003896, and WY00003983. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		12/6/24

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

Electronically Signed | 11/07/2024

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, grievance review, and policy and procedure review, the facility failed to ensure residents were treated with dignity and respect on 1 of 2 resident units (unit 1). The census was 81. The findings were: 1. Interview with 9 residents during resident council on 10/15/24 at 10:40 AM revealed at times residents had to wait between 45 minutes and 2 hours for call lights to be answered. The residents revealed they had observed staff walking by rooms or sitting at the nurses' station while call lights were sounding. Further interview revealed the number of staff answering call lights	F 550	Problem Statement: Based on observation, resident, and staff interviews, grievance review, and policy and procedure review, the facility allegedly failed to ensure residents were treated with dignity and respect on 1 of 2 residents(unit 1) related to extended wait periods in response to call light wait times. Corrective Action: all Staff were educated to specifically address Residents #20, #72, regarding "Resident's Rights" Policy and Procedure regarding call lights must be answered and care must be provided in a timely manner. Identifications of others: The Executive	

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F 550	Continued From page 2 during the survey was increased compared to the number of staff who normally answered call lights. 2. Observation on 10/16/24 at 9:35 AM showed the call light for resident #20 was turned on. Continued observation until 9:48 AM showed 18 staff members passed by the resident's room. The staff included 3 activities staff members, 4 CNAs, an LPN, and 2 laundry staff members which walked past the resident's room a total of 18 times without entering the resident's room or offering assistance. At 9:49 AM LPN #1 entered the resident's room to answer the call light and asked if she could assist the resident. At that time, the resident stated "they forgot to shut it off." 3. Observation on 10/16/24 showed the call light for resident #72 was turned on for 42 minutes from 9:55 AM to 10:37 AM. Further observation showed staff walked past the resident's room without entering to assist the resident. 4. Review of a "Concern & Comment Form" dated 3/20/24 showed resident #11 reported on 3/19/24 his/her call light was on from 6:45 AM to 9 AM and the resident "expressed frustration with call light times (outside of this one event)." Review of a "Concern & Comment Form" dated 5/18/24 showed the resident reported "Call lights taking too long to be answered." Review of a "Concern & Comment Form" dated 7/15/24 showed the resident "reports frustration with call light response times. [S/He] states they are taking 1 to 1 1/2 hours to be answered, especially around 6:30 AM. Reports nursing won't help answer them and defer to the aide to need to help instead. Reports [s/he] filled out a previous card	F 550	Director/Designee interviewed residents that were able to be interviewed regarding call light response times. Any issue identified was corrected at the time of discovery Systemic Measures: Staff Development Coordinator/Designee will educate staff on the Facility's "Resident's Rights" Policy and Procedure, specifically that residents call lights must be answered and care must be provided in a timely manner, New staff will be educated upon orientation on the facility's "Residents Right's" policy and procedure, specifically that residents call light must be answered and must be provided in a timely manner. Monitoring: The Executive Director/Designee will perform 5 call light audits weekly to ensure call lights are being answered and cares are provided timely for the next 90 days or until substantial compliance is met. the results of these observations will be documented on an audit tool The Executive Director/Designee will track and trend results of the audits for the next 90 days or until substantial compliance is met and present the results to Quality Assurance Performance Improvement Committee monthly for input and review	

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F 550	Continued From page 3 re: [regarding] this with no improvement." 5. Interview with the DON on 10/17/24 at 10:19 AM revealed everyone was expected to answer call lights and the lights should be answered between 3 and 5 minutes for an emergency light or 5 and 7 minutes for a regular light. 6. Review of the policy titled "Resident Call System", last revised 1/4/2023, showed "...Procedure: 1. Facility associates should always be aware of call lights. 2. Associates should answer call lights whether they are assigned to provide care to that resident..."	F 550		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 1 of 18 (#35) sample residents. The findings were:	F 637	Problem Statement: Based on Medical record Review, staff interview, and MDS 3.0 RAI(resident assessment Instrument) manual, the facility allegedly failed to ensure a significant change assessment was completed for 1 of 18(#35) sample.	12/7/24

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F 637	Continued From page 4 1. Review of the medical record for resident #35 showed s/he had fallen on 3/20/24 which resulted in a fractured hip. Review of the 3/26/24 significant change MDS assessment showed the resident was coded as dependent for toileting hygiene, lower body dressing, putting on and taking off footwear, toilet transfers, and tub/shower transfers. The resident was coded as requiring substantial/maximal assistance for showering or bathing self, personal hygiene, rolling left to right, sitting to lying, sitting to standing, and chair/bed-to-chair transfers. In addition, the resident was coded as requiring partial/moderate assistance for eating, oral hygiene, upper body dressing, lying to sitting, and moving a manual wheelchair. The resident was not assessed for walking due to safety reasons. 2. Review of the 9/11/24 quarterly MDS assessment showed the resident was coded as being independent with moving his/her manual wheelchair and rolling left and right. The resident required setup or clean-up assistance for eating, oral hygiene, toileting hygiene, and personal hygiene. The resident was coded as requiring supervision or touching assistance for upper body dressing, sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transfers, and could walk for 150 feet. 3. Interview with MDS coordinator on 10/17/24 at 10:07 AM confirmed a significant change assessment had not been completed. 4. Review of the "CMS RAI 3.0 User's Manual, October 2023, showed "...03. Significant change in status assessment (SCSA) (A0310A=04) The SCSA is a comprehensive assessment for a	F 637	Corrective Action: MDS Regulations MDS was not able to correct the identified issue as it was out of the allotted timeframe to do so. Identification Others:11/8/24 the MDS Coordinator/Designee in conjunction with the IDT Reviewed Community Member's to determine any significant improvements or declines in the Community Member's status over the last 14 days that 1)will not resolve itself without intervention by staff or by implementing standard standard disease related clinical interventions the decline is not considered limiting. 2) Impacts more that one area of the Community Member's health status. 3) Requiring interdisciplinary review and/or revision of the care plan to ensure a Significant change was completed in the MDS, if indicated, Any issues identified were corrected at the time of discovery. 11/8/24 the Director of Nursing educated the MDS Coordinator that a Significant change of Condition must be completed if a Community Member has any significant improvement or decline in the resident's status over the last 14 days(per the RAI manual) that:1)will not resolve itself without intervention by staff or by implementing standard standard disease related clinical interventions the decline is not considered limiting. 2) Impacts more that one area of the Community Member's health status. 3) Requiring interdisciplinary review and/or revision of the care plan to ensure a Significant change was completed in the MDS, if indicated, Any issues identified were corrected at the time of discovery.	

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F 637	Continued From page 5 resident that must be completed when the IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either major improvement or decline...An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement...Improvement in two or more of the following: Any improvement in an ADL (activities of daily living) where a resident is newly coded as Independent, setup or clean-up assistance, or supervision or touching assistance which last assessment and does not reflect normal fluctuations in that individual's functioning..."	F 637	New MDS associates will be educated upon orientation that a Sig change must be completed if a resident has any significant improvement or decline in the Community Member's status over the last 14 days(per the RAI manual) that:1)will not resolve itself without intervention by staff or by implementing standard standard disease related clinical interventions the decline is not considered limiting. 2) Impacts more that one area of the Community Member's health status. 3) Requiring interdisciplinary review and/or revision of the care plan to ensure a Significant change was completed in the MDS, if indicated, Any issues identified were corrected at the time of discovery. Monitoring: The Director of Nursing/Designee will review 5 resident's weekly for the next 90 days to determine if a sig change was necessary, per the RAI manual and if so, was it completed. The results of these reviews will be documented on an audit tool. The Director of Nursing will Track and Trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review,	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		12/6/24

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F 641	Continued From page 6 Based on medical record review, staff interview, and review of the RAI (resident assessment instrument) manual, the facility failed to ensure MDS assessments were accurately completed for 3 of 5 (#34, #35, #71) sample residents reviewed for falls. The findings were: 1. Review of a 5/4/24 Event Note showed resident #34 had a witnessed fall with bilateral knee soreness, pain to the right lateral thigh, and bruising to the left knee and right lateral thigh. Review of a 6/15/24 Event Note showed the resident had an unwitnessed fall and had no signs or symptoms of pain or distress. The following concerns were identified: a. Review of 5/15/24 and 8/13/24 quarterly MDS assessments showed the resident was coded as not having any falls since admission or the prior assessment. 2. Review of a 3/20/24 Event Note showed resident #35 had an unwitnessed fall and was transported to the emergency department for evaluation. Further review of the medical record showed the resident had fractured his/her left hip. The following concerns were identified: a. Review of the 3/26/24 significant change MDS assessment showed the resident was coded as not having any falls since admission or the prior assessment. 3. Review of the medical record showed resident #71 was admitted on 3/3/24. Review of Event Notes from 4/26/24, 6/23/24, and 8/27/24 showed the resident had unwitnessed falls with no injury noted. The following concerns were identified: a. Review of the 6/6/24 and 9/5/24 quarterly MDS assessments showed the resident was coded as not having any falls since admission or	F 641	Problem Statement: Based on medical record review, staff interview, and review of the RAI(resident assessment instrument) manual, the facility allegedly failed to ensure MDS assessments were accurately completed for 3 of 5(#34, #35,#71) of the sample residents reviewed for falls. Identified MDS assessments were modified to reflect accurate fall coding, Identification of Others: The MDS Coordinator/Designee reviewed residents to determine if falls were accurately coded on te most recent MDS assessment. Any issue identified was modified, at the time of discovery. Systemic Measure: on 11/7/24, the Director of Nursing educated the MDS Coordinator that the MDS assessments must reflect accurate information, to include; coding any falls since the admission entry, re-entry, or prior assessment per the RAI manual. New MDS associated will be educated upon orientation that the MDS assessment must reflect accurate information, to include, coding of any fall since the admission, re-entry, or prior assessment, per the RAI manual. Monitoring: the Director of Nursing/Designee will review 5 residents record weekly for the next 90 days to ensure the most recent MDS Assessment accurately reflects fall history, The Results of these will be reviewed on an Audit tool. The Director of Nursing will Tract and Trend results of the Audits for the next 90 days or until substantial compliance is met and present it to Quality Assurance	

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F 641	Continued From page 7 the prior assessment. 4. Interview with the MDS coordinator on 10/17/24 at 10:51 AM confirmed falls were incorrectly coded on the MDS assessments. 5. Review of the "CMS RAI 3.0 User's Manual, October 2023, showed "...Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury."	F 641	Performance Improvement Committee monthly for input and review	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		12/6/24

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F 758	Continued From page 8 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed (PRN) psychotropic medication was limited to 14 days or the physician provided a rationale for extended use for 1 of 5 sample residents (#43) reviewed for unnecessary medications. The findings were: 1. Review of the physician orders for resident #43 showed the resident had an order for lorazepam (antianxiety) 0.5 milligrams to be given every 2 hours as needed for anxiety and restlessness	F 758	Problem Statement: Based on medical record review, staff interview, and policy and procedure review, the facility allegedly failed to ensure as needed(PRN) psychotropic medication was limited to 14 days or the physician provided a rationale for the extended use for 1 or 5 sample residents(#43) reviewed for unnecessary medications. The facility obtained a rationale for the PRN psychotropic medication for Resident #43 Identification of Others: The Director of	

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F 758	Continued From page 9 related to end of life care ordered on 8/16/24 and no stop date. The following concerns were identified: a. Review of a progress note dated 10/17/24 and timed 9:33 AM showed "Per [RN name] with Dr. [name] re: [regarding] Lorazepam usage: The dx [diagnosis] palliative care for its use of Lorazepam is for [facility] comfort care and the behavior could occur at any time and so its [sic] for the benefit of the patient. The benefit outweighs the risk of continuing the medication for the life of resident." 2. Interview with the DON on 10/17/24 at 10:19 AM confirmed the facility did not have a stop date or rationale for the lorazepam prior to 10/17/24. 3. Review of the facility policy titled "Psychotropic Medication Use" last revised on 11/28/16 showed "...5. PRN orders for psychotropic drugs should be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the order to be extended beyond 14 days, he or she should document their rationale in the resident's record and indicate the duration for the PRN order..."	F 758	Nursing/Designee audited Community Member's with orders for PRN psychotropic medications to determine if they had a stop date or physician documented rationale for extended use. All issues were corrected at the time of discovery. Systemic Measures: The Staff Development Coordinator/Designee educated nurses that PRN psychotropic medications must have a stop date within 14 days of the order, or a physician documented rationale for extended use. New Nurses will be educated that PRN psychotropic medications must have a stop date within 14 days of the order, or a physician documented rationale for extended use. Monitoring: The Director of Nursing will review up to 5 resident with PRN psychotropic medication orders weekly to ensure they have a stop date within 14 days of being ordered or a physician documented rationale for extended use for the next 90 days or until substantial compliance is achieved. The results of these reviews will be documented on an audit tool. The Director of Nursing/Designee will track and Trend the results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee montly for input and review.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/6/24

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F 880	Continued From page 10 §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for 2 of 2 resident units. This failure affected resident #30, #50, #52, #67, and #73. The census was 81. The findings were: 1. Review of the 8/23/24 quarterly MDS assessment for resident #30 showed s/he had a	F 880	Problem Statement: on 10/17/2024 the Director of Nursing/Designee initiated Enhanced Barrier Precautions(EBP) on Residents #30, #50, #52, #67, and #73 r/t observation, medical record review, staff interview, and policy and procedure review the facility allegedly failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents units.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 10/17/2024

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F 880	Continued From page 12 suprapubic catheter and a diagnosis of neurogenic bladder. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP (enhanced barrier precautions) signage or PPE (personal protective equipment) was present. 2. Review of the 8/21/24 admission MDS assessment for resident #50 showed s/he had a suprapubic catheter with a diagnosis of progressive neurological conditions. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP signage or PPE was present. 3. Review of the "Order Summary Report" for resident #52 showed s/he had an indwelling catheter, a PICC (peripherally inserted central catheter) line for receiving antibiotics, and required wound care to his/her left heel. Observation on 10/14/24 at 2:17 PM, 10/15/24 at 9:23 AM, and 10/16/24 at 11:50 AM of the resident's room showed no EBP signage or PPE was present. 4. Review of the 9/20/24 admission MDS assessment for resident #67 showed the resident had a stage 3 decubitus ulcer to the coccyx which required routine wound care. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP signage or PPE was present. 5. Observation on 10/15/24 at 1:35 PM showed RN #1 was performing wound care on resident #73 using gloves; however, the RN was not wearing a gown. Further observation of the room showed EBP signage was on the wall and PPE was hanging on the inside of the resident's door; however, no gowns were present. 6. Interview with RN #1 on 10/15/24 at 2:02 PM	F 880	This failure affected resident #30, #50, #52, #67, and #73. The census was 81. Corrective Actions on 10/17/24 the Director of Nursing/Designee initiated Enhanced Barrier Precautions(EBP) for Residents #30, #50, #52, #67, and #73 Identification of Others: The Director of Nursing/Designee reviewed residents with MDRO's, wounds, and/or indwelling medical devices to ensure they were placed on EBP. Any issues identified were corrected at the time of discovery. Systemic Measures: The Director of Nursing/Designee educated nurses that EBP are indicated for residents with any of the following: 1. Infection or colonized with a CDC-Targeted MDRO when contact precautions do not otherwise apply, or 2.Wound or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. a.Wounds generally include, chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tear covered with an adhesive bandage(e.g. Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. b.Indwelling medical device examples include central lines, urinary catheter's, feeding tubes and tracheostomies. A peripheral intravenous line(not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. New Nurses will be educated upon	

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F 880	Continued From page 13 revealed resident #73 was no longer on EBP because his/her PICC line had been removed. In addition, EBP was only indicated for residents with Foley catheters, "lines", or wounds with multi drug resistant organisms (MDRO). 7. Interview with the infection preventionist (IP) on 10/15/24 at 2:06 PM revealed EBP were used when residents have Foley catheters, "lines", or MDRO wounds. Further, resident #73 was removed from EBP due to his/her PICC line being removed. An additional interview on 10/16/24 at 9:35 AM with the IP revealed residents on EBP were identified with a pink star on their room number/name plate, EBP signage should be present in the room, and PPE available. 8. Review of the policy and procedure "Enhanced Barrier Precautions", revised 3/21/24, showed " ...the indications for EBP are for residents with wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO."	F 880	orientation the EBP are indicated for the residents with any of the following:1. Infection or colonized with a CDC-Targeted MDRO when contact precautions do not otherwise apply, or 2.Wound or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. a.Wounds generally include, chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tear covered with an adhesive bandage(e.g. Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. b.Indwelling medical device examples include central lines, urinary catheter's, feeding tubes and tracheostomies. A peripheral intravenous line(not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. Monitoring: The Director of Nursing will review and observe up to 5 residents with an MDRO, wound, and/or indwelling medical device to ensure that they are on EBP for the next 90 days or until substantial compliance is met. The results of these reviews will be documented on an audit tool. The Director of Nursing/Designee will track and Trend results of the audits for the next 90 days or until substantial compliance is met and present it to the Quality Assurance Performance Improvement Committee monthly for input and review	

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