STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431805, IN00432283, and IN00434490. Complaint IN00431805 - No deficiencies related to the allegations are cited. Complaint IN00432283 - Federal/State deficiencies related to the allegations are cited at F557, F677, F684, and F689. Complaint IN00434490 - Federal/State deficiencies related to the allegations are cited at F684 and F689. Unrelated deficiency is cited. Survey dates: May 28 & 29, 2024 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 2 Medicaid: 65 Other: 19 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/4/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dilane Knights	Administrator	06/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, record review, and interview, the facility failed to ensure a resident was treated with respect and dignity related to not assisting the resident to the bathroom upon request, for 1 of 6 residents reviewed for respect and dignity. (Resident G) Finding includes: During an observation on 5/29/24 at 8:02 a.m., Resident G had activated the call light. On 5/29/24 at 8:09 the call light was observed not on. During an observation and interview on 5/29/24 at 8:12 a.m., Resident G had activated the call light. The resident was sitting on the side of the bed and the wheelchair was next to the bed. She indicated she needed to use the bathroom. Human Resources entered the room and asked the resident if she needed help and was informed by the resident she needed to use the bathroom. Human Resources left the call light on and informed the resident she would get a staff member to help her and left the room. The resident then indicated a man had came into her room earlier and she informed him she needed to use the bathroom. He had informed her she would have to wait because they were passing breakfast trays and turned the call light off. She indicated	F 0557	Casa of Hobart Complaint Survey: 5/29/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F557 Respect, Dignity/Right to have Personal Property What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident (G) remains in the facility and staff continue to provide assistance with ADL and toileting needs as needed and upon request. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring assistance with toileting have the potential to	06/20/2024

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	she had not wanted to make a mess in the bed and had tried to get into the chair by herself and fell back onto the bed. At 8:17 a.m., Restorative CNA 3 entered the room and assisted the resident to the wheelchair with minimal assistance and assisted the resident to the bathroom. During an interview on 5/29/24 at 8:22 a.m., the Director of Nursing indicated the resident should have been assisted to the bathroom when she first requested assistance. Resident G's record was reviewed on 5/29/24. The diagnoses included, but were not limited to, stroke. The Baseline Care Plan, dated 5/24/24, indicated one staff member was required for transfers and toilet use. The resident was alert and cognitively intact and was always continent of bowel and bladder. An Occupational Therapy Progress Note, dated 5/28/24, indicated moderate assistance was required for toileting and the sitting and standing balance was fair. This citation relates to Complaint IN00432283. 3.1-3(t)		be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on the importance of providing residents with assistance upon answering the call light and to not turn off the call light until the resident's needs have been met and all requested tasks have been completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. DON/Designee will Audit 5 residents weekly, to ensure assistance with toileting is being provided with a focus on incontinence care/toileting. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed:	

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			6/20/2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) 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; Based on observation, record review, and interview, the facility failed to ensure a resident who required maximum to dependent care received incontinent care in a timely manner, for 1 of 3 residents reviewed for incontinent care. (Resident D) Finding includes: During an observation and interview with Resident D on 5/28/24 at 8:27 a.m., she was lying on her back in bed wearing a hospital gown. The head of the bed was elevated. She indicated the facility staff checked her 2-3 times a day for incontinence of bowel and bladder. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, vascular dementia and bilateral above the knee amputations. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers, required maximum assistance for toileting, and was always incontinent of bowel and bladder. A Care Plan, revised on 1/22/24, indicated the resident had bowel and bladder incontinence. The interventions indicated the resident would be	F 0677	Casa of Hobart Complaint Survey: 5/29/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident G was assisted with incontinence care. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring assistance with Activities of Daily Living have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the	06/20/2024

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	checked and incontinent care would be provided on care rounds and as needed. During an observation and interview on 5/28/24 at 1:25 p.m., the resident remained in bed, lying on her back. The head of the bed remained elevated. Resident D indicated no one had been in her room all day to check her for incontinence and she needed to go to the bathroom. She then activated the call light. The Wound Nurse entered the room and indicated he would need to find someone to assist him with here care, then turned the call light off and left the room. At 1:30 p.m., the facility staff had not returned to the room. A family member entered the room and the resident informed the family member she needed to go to the bathroom. The family member went to the door of the room and saw the Wound Nurse. He informed the family member he was still looking for someone to assist him. The Administrator was standing in the hallway outside the room and the family member informed her the Wound Nurse was looking for someone to help him with the resident's care. The Administrator indicated the CNA on the hallway was on break. The Wound Nurse and CNA 1 began the incontinent care at 1:33 p.m. Upon removing the cover sheet, there was dried bowel movement on the outside of the incontinent brief. There was dried yellow liquid on the bottom sheet, and on and under the cloth incontinent pad under the resident. The resident indicated again no one had been in to change her all day. After the incontinent care was completed, CNA 2 entered the room and identified herself as the resident's assigned CNA. She indicated she had checked the resident prior to the lunch being served. An Incontinence Policy, dated 2/12/21 and received from the Director of Nursing as current,		deficient practice does not recur; Staff were re-educated on providing residents with assistance with Activities of Daily Living (ADL's) per plan of care/preferences. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will Audit 5 residents weekly, to ensure assistance with ADL's is being provided with a focus on incontinence care/toileting. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 6/20/2024	

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	indicated a resident who was incontinent would receive appropriate treatment and services. This citation relates to Complaint IN00432283. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, related to a fracture after a fall not investigated thoroughly for 1 of 6 residents reviewed for quality of care. (Resident E) Finding includes: Resident E's record was reviewed on 5/29/24 at 8:39 a.m. The diagnoses included, but were not limited to fractured left femur 4/11/24 and falls. A Significant Change MDS assessment, dated 4/18/24, indicated a severely impaired cognitive status, required moderate assistance with bed mobility and maximum assistance with transfers, and had no falls since re-admission into the facility. A Nurse's Progress Note, dated 4/4/24 at 10:30	F 0684	Casa of Hobart Complaint Survey: 5/29/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident (E) Remains in the facility without further incident and receives care and services as outlined in the plan of care.	06/20/2024

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	p.m., indicated the resident was observed laying on the floor in front of the wheelchair. Emergency Medical Services (EMS) were notified. There were no obvious signs of injury. The level of consciousness was at baseline. The resident denied hitting her head. There was limited range of motion to the bilateral upper extremities and range of motion was tolerated to the bilateral lower extremities. The resident complained of pain to the left hip. There was no discoloration, bruising, swelling, shortening, rotation, or deformities observed. The Nurse Practitioner was notified and ordered diagnostic imaging of the left shoulder and hip. The resident refused to be transferred to the hospital. The X-Rays of the left shoulder and bilateral hips were completed on 4/5/24. There were no fractures observed. The Post Fall Follow-up assessments, dated 4/5/24 at 10:34 a.m. and 6:41 p.m., 4/6/24 at 10:01 a.m. and 8:02 p.m., 4/7/24 at 4:02 a.m. and 8:03 p.m., and 4/8/24 at 4:04 a.m., indicated there was no signs or symptoms of injury such as swelling or bruising, no change the activities of daily living status, and no change in the resident's mental status. A Nurse's Progress Note, dated 4/8/24 at 5:10 a.m., indicated the resident complained of pain to the left hip during incontinent care by the CNA. The Physician was notified and orders were received to X-Ray the left hip and leg. The X-Ray of the left hip was completed on 4/8/24 and indicated an acute impacted left hip fracture. A Nurse's Progress Note, dated 4/8/24 at 1:06 p.m., indicated the resident was transferred to the		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents at risk for falls have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The administrator and Don have been re-educated regarding the process for completing a thorough and complete investigation of all accidents and injuries. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. Administrator /Designee will review all incident reports specifically falls and injuries of unknown origin verifying a complete and thorough investigation was completed. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	hospital due to the left hip fracture. A CT scan (Computerized Tomography - medical imaging technique used to obtain detailed internal images of the body) report of the left hip from the hospital indicated an impacted fracture of the intertrochanteric region of the left femur, osteopenia, and moderate to severe osteoarthritis of both hips. The hospital left hip X-Ray indicated a left hip fracture and osteopenia. During an interview on 5/29/24 at 10:53 a.m., the Administrator indicated the fracture was from the fall on 4/4/24. She acknowledged the X-Ray on 4/5/24 was negative for a hip fracture and had not completed a further investigation to rule out other causes of injury or to support the finding of the fall causing the fracture after the X-Ray on 4/8/24 indicated a fractured left hip. A facility fall prevention policy, dated 9/1/20 and identified as current by the Director of Nursing, indicated a resident would be assessed for the risk of falls and appropriate interventions to provide necessary assistive devices would be implemented. This citation relates to Complaints IN00432283 and IN00434490. 3.1-37		Date by which systemic corrections will be completed: 6/20/2024	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure care planned interventions to prevent injuries due to a fall were in place, related to floor mats not in place next to the bed and anti-roll brakes not on the wheelchair. The facility also failed to ensure an intervention initiated to prevent further falls was completed related to a urinalysis not obtained, for 2 of 3 residents reviewed for falls. (Residents D and E) Findings include: 1. During observations on 5/28/24 at 8:27 a.m. and 1:25 p.m., Resident D was lying in bed with the head of the bed elevated. The bed was elevated approximately two and a half feet off the ground. There was no mat on floor next to the bed. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, vascular dementia and bilateral above the knee amputations. A fall risk assessment, dated 4/3/24, indicated a high risk for falls. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers and wheelchair mobility, and had no falls since the last assessment was completed. A Care Plan, revised on 1/22/24, indicated the resident has had falls and there was a risk for future falls. The interventions included, anti-roll	F 0689	Casa of Hobart Complaint Survey: 5/29/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fall interventions were immediately put in place for Resident D. Unable to make any corrective action for Resident E. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents at risk for falls have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were in-serviced on: • An assessment is completed	06/20/2024

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	back brakes were to be used on the wheelchair and on 5/2/24, a floor mat was to be placed on the open side of the bed due to a fall on 5/1/24. A Nurse's Progress Note, dated 5/1/24 at 3:31 a.m., indicated the resident was found sitting on the floor next to her bed. The resident indicated she thought it was 6 a.m. and had rolled out of bed to use the bathroom. An Interdisciplinary Team (IDT) Progress Note, dated 5/1/24 at 2:05 p.m., indicated the resident had intermittent confusion and had attempted to take herself to the bathroom. The root cause of the fall was due to a roll from the bed. The intervention initiated was a floor mat to be placed next to the bed. During an observation on 5/29/24 at 8:07 a.m., Resident D was sitting in a wheelchair in the Dining Room. There were no anti-roll brakes on the wheelchair. During an interview on 5/29/24 at 8:11 a.m., CNA 1 indicated there were no anti-roll brakes on the wheelchair. 2. Resident E's record was reviewed on 5/29/24 at 8:39 a.m. The diagnoses included, but were not limited to fractured left femur 4/11/24 and falls. A Significant Change MDS assessment, dated 4/18/24, indicated a severely impaired cognitive status, required moderate assistance with bed mobility and maximum assistance with transfers, and had no falls since re-admission into the facility. A Care Plan, revised on 4/26/24, indicated she was a risk for future falls. An intervention was added		post fall and documented in the medical record. • Ensuring fall interventions are in place as ordered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON /designee will audit 5 residents with fall interventions weekly to ensure fall interventions are in place as ordered. Audits will be completed weekly for 4 months. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date of Completion: 6/20/2024	

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	on 4/4/24 and indicated a urinalysis (UA) and culture and sensitivity (C&S) was to be obtained. A Post Fall Observation form, dated 4/4/24 at 10:30 p.m., indicated the resident had fallen from the wheelchair in her room. She indicated she had fallen asleep. An IDT Progress Note, dated 4/5/24 at 11:46 a.m., indicated the resident had fallen asleep in her chair and slid to the floor from the wheelchair. The intervention initiated indicated an urinalysis would be obtained. There was no documentation that indicated the UA had been obtained or ordered. There was no UA result located in the record. During an interview on 5/29/24 at 10 a.m., the Director of Nursing (DON) and the Corporate Nurse Consultant indicated the UA had not been completed. This citation relates to Complaints IN00432283 and IN00434490. 3.1-45(a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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.			

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	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 §483.70(e) 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, 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			

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	155469	A. BUILDING 00 B. WING	05/29/2024

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	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. Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and Wound Nurse), when providing care to a resident who was in Enhanced Barrier Precautions (EBP), and failed to remove soiled gloves before touching clean surfaces for 1 of 1 random observations for infection control. (Resident D) This had the potential to affect the residents on 4 of 5 Units (Cherry, Blueberry, Apple, and Cherry Lane) and 18 residents who received wound care where staff should use EBP. Finding includes: During an observation on 5/28/24 at 8:27 a.m., Resident D had a sign on the outside of the entry door to her room, which indicated Enhanced Barrier Precautions (EBP) were to be used when providing care. The sign indicated the EBP was to	F 0880	Casa of Hobart Compliant Survey: 5/29/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F880 Infection Prevention & Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Staff immediately donned the appropriate PPE for enhanced barrier precautions for resident D .	06/20/2024

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	be used for Bed 1 and 2. There was a storage cart with the PPE in the hallway outside of the entry door. Resident D's record was reviewed on 5/28/24 at 12:19 p.m. The diagnoses included, but were not limited to, end stage kidney disease with hemodialysis. A Quarterly Minimum Data Set (MDS) assessment, dated 4/8/24, indicated an intact cognition, no behaviors, impairment of the bilateral lower extremities, dependent for transfers, required maximum assistance for toileting, showers, hygiene, and was always incontinent of bowel and bladder. A Care Plan, revised on 1/22/24, indicated assistance was required for bed mobility, transfers, toileting, and bathing. The interventions indicated the staff would assist with all activities of daily living. During an observation and interview on 5/28/24 at 1:33 p.m., The Wound Nurse and CNA 1 donned gloves and were starting incontinent care. They were stopped prior to care beginning and asked about EBP precautions and the sign on the door. CNA 1 indicated a gown was required. CNA 1 and the Wound Nurse then donned a gown to provide care to the resident. The resident had been incontinent of bowel movement and had menstrual/uterine bleeding. CNA provided incontinent care. While still wearing the gloves used for the incontinent care, he began looking for a bottom sheet in the room and opened and closed the resident's closet, drawers, and touched the wheelchair handle with the soiled gloves. He then entered the roommate's area and was stopped before he touched any surface. He then		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents requiring enhance barrier precautions can be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated: • What Enhanced Barrier Precautions (EBP) are. • When/What Personal Protective Equipment (PPE) is to be used. • Who requires EBP. • Doffing PPE prior to moving to clean area of care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will observe 5 staff members per week providing care for a resident requiring Enhanced Barrier Precautions (EBP) to ensure PPE is donned and doffed, appropriately. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be	

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	doffed the gloves and gown, completed hand hygiene and exited the room to obtain linens for the bed change. During an interview on 5/28/24 at 2:10 p.m., the Director of Nursing (DON) indicated they room would be wiped down with disinfectant. She also indicated the staff had all been trained in EBP requirements. Review of the in-house trainings for EBP, dated 5/9/24 and 5/17/24 and received from the DON on 5/29/24 at 8:30 a.m., indicated the staff were educated on EBP, which included a gown and gloves were to be used during high-contact resident care activities. Signage would be on the door with the number of the bed who required EBP. The undated facility's EBP Guidelines, received as current from the DON on 5/29/24 at 8:30 a.m., indicated the use of gown and gloves during high-contact resident care activities was required. EBP was to be used with transfers or during bathing assistance and when close physical contact is present. 3.1-18(b)		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 6/20/2024	