| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115687 | A. Building<br>B. Wing | 09/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Willowbrooke Court at Lanier Village Estates | 4145 Misty Morning Way<br>Gainesville, GA 30506 |

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 observations, staff interviews, and review of the facility policy titled, Guidelines for Isolation Precautions, the facility failed to follow Enhanced Barrier Precautions (EBP) for two of four residents (R) (R6 and R8) on EBP while providing high-contact care. This deficient practice had the potential to increase the spread of infection due to cross-contamination.Findings include:<br><br>A review of the facility policy, Guideline for Isolation Precautions revised 3/23/2023, revealed staff were required to use Enhanced Barrier Precautions (EBP), which included wearing gowns and gloves when performing high-contact care activities. A further review indicated that high-contact resident care activities encompassed, but were not limited to wound care, urinary catheter care, and hygiene care.<br><br>1. A review of R6's care plan revealed that the resident was care planned for EBP related to wound care.<br><br>An observation of R6's room on 9/20/2025 at 11:50 am revealed signage indicating the need for personal protective equipment (PPE) and Enhanced Barrier Precautions (EBP) was observed outside the R'6 door. The instructions on the signage directed all staff to wear gowns and gloves when providing direct care.<br><br>During an interview with the Infection Control Preventionist (ICP) on 9/20/2025 at 11:02 am, she stated that all staff members were trained on the proper use of PPE for residents on EBP. According to the facility's Infection Control Plan (ICP), a PPE cart was placed in front of the door for each resident on EBP, and staff were required to put on PPE before providing high-contact care, which included wound care. Education on EBP was provided annually, as well as during in-service training throughout the year.<br><br>During an observation of wound care on 9/20/2025 at 11:51 am, Registered Nurse (RN) CC provided wound care without using PPE in accordance with EBP.<br><br>During an interview with RN CC on 9/20/2025 at 12:06 pm, she acknowledged that she did not don (put on) PPE before providing wound care to R6. According to RN CC, R6 was on EBP, and she should have donned PPE; it was an oversight.<br><br>During an interview with the Director of Nursing (DON) on 9/20/2025 at 12:18 pm, she stated it was her expectation that staff should wear PPE for residents on EPA when providing high-contact care, including wound care.<br><br>2. Review of the admission Record for R4 revealed diagnoses included, but were not limited to, urinary retention and renal insufficiency.<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Annual MDS for R4, dated 7/19/2025, revealed in Section GG (Functional Abilities and Goals) R4 was dependent on staff for lower body dressing and toileting, and required substantial to maximal assistance for personal hygiene and chair to bed transfers. Section H (Health Conditions) documented that the resident had an indwelling urinary catheter.<br><br>Review of the care plan for R4 revealed a Focus, initiated 7/18/2024, of an indwelling catheter. Interventions included, but were not limited to, EBP, initiated 8/1/2024, and indwelling catheter care, CNA (Certified Nurse Aide) may perform.<br><br>Review of the physician's orders for R4 revealed an order dated 3/7/2025 for EBP two times a day for prevention of transmission of MDRO (multi-drug-resistant organism) infections. Further review revealed an order dated 3/7/2025 for indwelling urinary catheter care, CNA may perform two times a day for indwelling urinary catheter care maintenance.<br><br>Observation on 9/20/2025 at 11:45 am of CNA AA and CNA BB providing urinary catheter care for R8 revealed that CNA AA and BB performed hand hygiene, donned gloves, did not don gowns, transferred the resident to the bed, positioned R8, repositioned her pants, and removed her brief. CNA AA and BB provided catheter care, placed a clean brief on R4, repositioned her pants, and transferred R4 to her wheelchair. Observation revealed an EBP instructional sign, instructing staff to don gloves and gowns when providing high-contact care, and a cart with PPE supplies, including gowns, gloves, and masks, just outside of R4's room.<br><br>In an interview on 9/20/2025 at 12:05 pm, CNA BB verified the EBP signage and PPE supply cart outside of R8's door. She stated that she was aware R8 was on EBP, and she should have worn a gown while providing catheter care. She further stated that she had just forgotten to.<br><br>In an interview on 9/20/2025 at 12:10 pm, CNA AA verified the EBP signage and PPE supply cart outside of R8's door. She stated she always wore gloves but normally did not wear a gown while providing urinary catheter care or ADL care to residents on EBP. She stated she thought wearing gloves was all that was needed.<br><br>In an interview on 9/20/2025 at 12:15 pm, the DON stated nursing staff had received education on EBP, and she expected them to follow EBP when providing high-contact care to residents who were on EBP. |