STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	4801 Randolph Road Charlotte, NC 28211

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000 Based on record review and staff interviews, the facility failed to have advanced directives accurate throughout the medial record for 2 of 3 residents (Resident #47 and Resident #45) reviewed for advanced directives. The findings included: 1. Resident #47 was admitted to the facility on [DATE]. A review of Resident #47's health directive Medical Orders for Scope of Treatment (MOST) revealed that on 5/13/24 Resident #47 wanted his health directive to change from a Full Code to a Do Not Resuscitate (DNR). The MOST form was signed by Resident #47 on 5/13/24 and in the health directive binder at the nurse's desk. The care plan with a revision date of 5/31/24 stated that Resident #47 health directive was a full code. An intervention was the health directive should be reviewed quarterly and as directed. An interview on 6/26/24 at 11:53 AM was conducted with the Social Services Director. She stated that she reviews health directives at admission, care plan meetings and re-admission from the hospital. The social services director reviews the current code status and if the resident would want to make any changes. If there were any changes to the health directive the social services director updates the care plan. The health directive for Resident #47 should be the same in the medical record, the care plan and health directive binder. In each of these areas the health directive should match. Resident #47's health directive was not matching in the 3 areas. An interview on 6/26/24 at 11:11 AM with the Administrator revealed that the staff are now doing a building wide audit to ensure all health directives are correct. The Administrator stated that a revision was made to Resident #47's health directive and the care plan is now showing he is a DNR. The Administrator stated that there was inconsistency in the health directive for Resident #47. 45272 2. A review of Resident #45's physician orders dated 3/1/24 revealed an order for Do Not Resuscitate (DNR) (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #45's care plan last revised on 1/2/24 revealed her advanced directive code status as Full Code. On 6/27/24 at 9:19 AM the Social Services Director (SSD) stated she was responsible for updating the advanced directive code status care plan for all residents. She stated Resident #45's care plan was not updated when Resident #45's code status was changed from Full Code to Do Not Resuscitate (DNR) on 3/1/24. The SSD stated she normally updated the care plans quarterly and during care plan meetings. Resident #45's quarterly care plan meeting was scheduled to be completed during the current month (June). The Administrator stated on 6/27/24 at 2:04 PM Resident #45's care plan should have been updated to indicate the change in advance directive code status when the code status was changed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record reviews, and interviews with staff, Hospice Nurse, Medical Director and Consultant Pharmacist, the facility failed to limit the duration of an antipsychotic medication (a drug that affects brain activities associated with mental processes and behaviors) ordered on an as needed (PRN) basis to 14 days and failed to monitor for abnormal involuntary movements on a resident receiving an antipsychotic medication (Resident #63) for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #63 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety disorder. Review of Resident #63's care plan revised 2/23/24 revealed Resident #63 had been care planned for psychotropic/ antipsychotic medication use. The care plan interventions included to monitor effects related to psychotropics. The quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #63 was cognitively impaired and coded for behaviors that included hallucinations. She had no rejection of care documented and was not coded as receiving antipsychotic medication. a. Review of Resident #63's active physician orders for June 2024 revealed: - An order dated 5/16/24 for Haloperidol (antipsychotic medication) oral tablet 0.5 milligram (mg) give one table by mouth every 6 hours for anxiety/ agitation okay to dissolve in 0.25 milliliters (ml) of water and give sublingual (SL). - An order dated 5/16/24 for Haloperidol oral tablet 0.5 mg give one tablet by mouth every 4 hours as needed (PRN) for anxiety/ agitation okay to dissolve in 0.25 ml of water and give SL. The PRN Haloperidol physician's order did not contain a stop date for the medication. A review of Resident #63's electronic Medication Administration Record (eMAR) for the months of June 2024 and May 2024 revealed she had not received a PRN dose of Haloperidol. An interview was performed with Nurse #1 on 6/25/24 at 1:16 PM. Nurse #1 stated she thought PRN antipsychotic and psychotropic medications did not need a stop date. She said she thought the PRN orders for antipsychotic medications were indefinite. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was performed with the Hospice Nurse on 6/25/24 at 1:25 PM. She stated that Resident #63's Haloperidol had been ordered by hospice. She stated that hospice would add a stop date to PRN antipsychotic medication orders if the facility required a stop date. She said if a PRN antipsychotic had a stop date, at the end of the stop date hospice would re-evaluate the need for the medication and write a new order for the medication if it was still needed. The Hospice Nurse stated she did not recall that the facility had asked for PRN antipsychotic medications to have a stop date. She stated she was the routine Hospice Nurse for the facility and would have been aware if the facility had made a request for stop dates to be included on PRN antipsychotic medication orders. A telephone interview was performed with the Consultant Pharmacist on 6/25/24 at 2:17 PM. She stated that if the PRN was an antipsychotic medication it had to have a stop date of 14 days and then the order would have to be rewritten. She stated that residents who received hospice services were not exempt from needing a 14 day stop date on PRN antipsychotic medications. She said a pharmacy review with recommendations had been completed for Resident #63 on 6/18/24. The Consultant Pharmacist stated that the recommendations included: Haloperidol should be limited to 14 days and asked for an AIMs assessment to be completed. She stated the Pharmacy recommendations had been sent to the facility on [DATE]. A review of pharmacy recommendations for Resident #63 was completed. A Pharmacy recommendation dated 6/18/24 read in part - Physician recommendation: PRN antipsychotics orders are limited to 14-day duration and cannot be renewed unless: 1) the prescriber evaluated the resident for the appropriateness of PRN antipsychotic administration and 2) a new order is generated to extend the PRN antipsychotic beyond 14 days. The pharmacy recommendation had not been completed by the provider. - Nurse recommendation: Please obtain an abnormal involuntary movement scale (AIMS) and place in the chart to monitor for side effects associated with antipsychotic drug therapy. The pharmacy recommendation had not yet been completed. A telephone interview was conducted on 6/25/24 at 3:30 PM with the Medical Director. He stated residents receiving hospice did not need a stop date for PRN antipsychotics because they were terminal. He said that if PRN antipsychotic medications had a stop date the medication would fall off the MAR and not be available when needed by the resident for terminal changes. b. Review of Resident #63's active physician orders for June 2024 revealed: - An order dated 5/16/24 for Haloperidol (antipsychotic medication) oral tablet 0.5 milligram (mg) give one table by mouth every 6 hours for anxiety/ agitation okay to dissolve in 0.25 milliliters (ml) of water and give sublingual (SL). - An order dated 5/16/24 for Haloperidol oral tablet 0.5 mg give one tablet by mouth every 4 hours as needed (PRN) for anxiety/ agitation okay to dissolve in 0.25 ml of water and give SL. The PRN Haloperidol physician's order did not contain a stop date for the medication. A review of resident #63's electronic medical record revealed an abnormal involuntary movement scale (AIMS) assessment (an assessment used to monitor for a movement disorder that sometimes develops as a side effect of antipsychotic medications) had not been completed for Resident #63. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 6/26/24 at 2:23 PM. She said PRN antipsychotic medications should have a stop date of 14 days. She stated that an AIMS assessment should be completed for residents who received routine and/or PRN antipsychotic medication when the medication was started and then every 3 months. She reviewed Resident #63's medical record and was unable to locate an AIMS assessment. The DON said Resident #63 should have had an AIMS assessment completed when she was started on Haloperidol in May. She said she was unsure why Resident #63 had not had an AIMS assessment completed, that it had been missed. She did not say who was responsible for completing the AIMs assessment. The DON stated that she had received the pharmacy recommendations for Resident #63 on 6/18/24. She stated she was working on the recommendations but had not yet completed them. An interview was conducted on 6/27/24 at 2:15 PM with the Administrator. The Administrator said she thought PRN antipsychotic medications had to be reviewed by the physician every 14 days but did not have to have a stop date part of the order. The Administrator stated she did not think residents who received hospice services needed a stop date due to terminal changes. The Administrator said she had been notified by the DON that Resident #63 had not had an AIMS assessment completed. She said Resident #63 should have had an AIMS assessment completed when she was started on the antipsychotic medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, staff, Nurse Practitioner (NP), and Pharmacist interviews the facility failed to maintain a medication error rate of less than 5% by having 2 errors out of 27 opportunities which resulted in an 7.41% medication error rate. This affected 1 of 3 residents observed for medication administration (Resident # 14). The findings included: Resident #14 was admitted to the facility on [DATE]. Her medical diagnoses included: hypertension (high blood pressure), history of transient ischemic attacks (mini stroke), cerebral infarction (stroke). Dry eye syndrome of bilateral lacrimal glands. a. A Physician's order dated 8/11/21 read please crush medications and administer in applesauce, every shift for difficulty swallowing. A physician's order dated 8/12/23 read Nifedipine (blood pressure medication) extended release (ER) 24-hour oral 30 milligram (mg) tablet, give one tablet by mouth one time a day for hypertension give with 90 mg tablet to equal total combined daily dose of 120 mg. A Physician's order dated 5/22/24 read please crush medications as appropriate. An observation and interview were made on 6/26/24 at 10:12 AM of Nurse #1 preparing Resident #14's medication. She removed one Nifedipine ER 90 mg tablet and one Nifedipine ER 30 mg tablet from Resident #14's blister card and placed them into the medication cup along with all of Resident #14's other prepared medications. Nurse #1 said Resident #14 wanted her medications crushed due to swallowing difficulty. She then proceeded to place all the medications from the medication cup into the clear plastic pill crushing pouch. Nurse #1 placed the pouch containing all of resident #14's medications into the slot of the pill crusher and lifted the handle of the pill crusher to bring it down to crush the medications. Nurse #1 was stopped and asked if all of Resident #14's medications could be crushed. Nurse #1 checked Resident #14's medication administration record (MAR) and then proceeded again to perform the motion of crushing Resident #14's medications. Nurse #1 was stopped again and asked if all the medications could be crushed. She again checked Resident #14's MAR and then proceeded for a third time to perform the motion of crushing Resident #14's medications. Nurse #1 was stopped and asked if Resident #14's ER medications were okay to be crushed. Nurse #1 stated ER medications could not be crushed. She reviewed Resident #14's MAR again and removed the Nifedipine ER 30 mg and 90 mg tablets from the pill crush pouch. Nurse #1 stated extended-release medications could not be crushed because they were supposed to be released slowly for absorption over 24-hours. She said if the ER medication were crushed all the medication would be released all at once. Nurse #1 said she had missed that the Nifedipine was an ER tab. A phone interview was conducted with the Pharmacist on 6/26/24 at 4:42 PM. The Pharmacist stated Nifedipine ER should not be crushed. She said Nifedipine ER was designed to be released over an extended time. The Pharmacist said if Nifedipine ER were crushed the medication would be released all at once. She said the medication being released all at once and Resident #14 not getting a steady release of the medication over 24-hours, could cause blood pressure issues for Resident #14. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 6/27/24 at 9:39 AM. The DON said ER medications should not be crushed. The DON said the provider should have been contacted to find an alternative medication that could be crushed. A phone interview was conducted with the NP on 6/27/24 at 1:56 PM. She stated if Nifedipine ER was crushed it could cause Resident #14's blood pressure to drop. She said she was not aware of any blood pressure issues for Resident #14. An interview was conducted with the Administrator on 6/27/24 at 2:08 PM. The Administrator said she had been notified by the DON of the Nifedipine ER medication error today (6/27/24). She said she thought Nurse #1 needed more education on medications that could or could not be crushed. b. A Physician's order dated 8/8/23 read Artificial Tears Ophthalmic solution 0.2-0.2-1% (Glycerin-Hypromellose-polyethylene glycol 400) instill one drop in both eyes three times a day for dry eyes. An observation and interview were made on 6/26/07 at 10:12 AM of Nurse #1 preparing and administering Resident #14's medications. Nurse #1 was unable to locate Resident #14's Artificial Tears on the medication cart. She left the cart to look for Resident #14's Artificial Tears, she returned to the cart with a box of Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) drops. Nurse #1 stated the Lubricating Plus drops were the same as the Artificial Tears ordered for Resident #14. Nurse #1 was observed to administer one drop of Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) into each of Resident #14's eyes. A telephone interview was conducted on 6/26/24 4:42 PM with the Pharmacist. She said Artificial Tears Ophthalmic solution 0.2-0.2-1% (Glycerin-Hypromellose-polyethylene glycol 400) and Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) were not the same medication. The Pharmacist stated that the medication in the two eye drops were different but served the same purpose of lubricating the eye and would not harm Resident #14. An interview was conducted with the Director of Nursing (DON) on 6/27/24 at 9:39 AM. She said Nurse #1 should have clarified if the eye drops were the same medications. A telephone interview was conducted on 6/27/24 1:56 PM with the NP. She said the Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) drops were a different lubricating eye drop than the Artificial Tears ordered for Resident #14. She said Nurse #1 would need to call her to get an order to use a different eye drop medication than what was ordered. An interview was conducted on 06/27/24 at 2:13 PM with the Administrator. She said she was not aware that the wrong eye drops had been administered to Resident #14. She stated Nurse #1 should have clarified if the Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) was the correct eye drop medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review and staff, Medical Director, Vascular Physician Assistant (PA), Nurse Practitioner (NP) interviews, the facility failed to prevent a significant medication error when a resident did not receive an antiplatelet medication as ordered. This deficient practice occurred for 1 of 1 resident (Resident #68) reviewed for significant medication errors. The findings included: Resident #68 was readmitted to the facility on [DATE]. Her medical diagnoses included: chronic ulcer of left heel, peripheral vascular disease/ severe peripheral arterial disease (decrease blood flow to the lower extremities), cerebral infarction (stroke). A review of Resident #68's hospital discharge summary dated 6/5/24 revealed she was hospitalized from 5/29/24 to 6/5/24 for peripheral arterial disease (PAD) with chronic heel ulcer. She was seen by vascular surgery during her hospitalization and had a drug coated balloon angioplasty (a procedure used to open an artery to re-establish blood flow to tissues) procedure performed on 5/31/24 to her left leg. Her discharge summary included she will continue Plavix and that she was at high risk for left lower extremity limb loss per vascular surgery. Review of the medication orders on the discharge summary revealed under New Mediations there was an order that read: Clopidogrel bisulfate (Plavix) 75 milligrams (mg) tablet, take one tablet (75 mg dose) by mouth daily, start date: 6/5/24; End date: 6/5/25. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #68 was cognitively impaired. She was coded for a diabetic foot ulcer. Resident #68 was not coded as receiving an antiplatelet medication. A review of Resident #68's active and inactive physician orders for June 2024 was completed. An order for Plavix was unable to be located. A review of Resident #68's medication administration record (MAR) for June 2024 revealed there was not an order for Plavix on the MAR. An interview was performed with Nurse #2 on 6/25/26 at 3:46 PM. Nurse #2 stated he worked the evening shift on 6/5/24 when Resident #68 was readmitted to the facility and had entered Resident #68's admission orders into the electronic computer system from her hospital discharge summary. He stated he remembered the Plavix order for Resident #68. Nurse #2 revealed he did not enter the Plavix order into the electronic computer system because when he had looked at the order the start date and stop date for the Plavix order were the same. He explained he had thought the Plavix had been a one-time order she had received at the hospital. Nurse #2 stated he did not see that the start date year and end date year were different. The interview further revealed Nurse #2 did not remember clarifying the Plavix order when he had verified the new admission orders with the provider. He stated new admission orders were supposed to be checked by two nurses and he was not sure who had checked Resident #68's admission orders after him. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An NP progress note dated 6/6/24 included in the note continues Plavix per vascular surgery she is at high risk for left lower extremity limb loss. A telephone interview was performed with the vascular surgery Clinical Supervisor on 6/25/26 at 2:51 PM. She stated Resident #68 had been seen in the office on 6/19/24 for a follow up appointment. She said the provider note from the visit stated Resident #68 had a strong multiphasic (having more than one phase or component) pulse to her left top foot and that she had an active order for Plavix on her medication profile. The Clinical Supervisor stated Resident #68 had an angioplasty procedure completed during her hospitalization and that Plavix was part of the standard protocol after an angioplasty. A telephone interview was performed with the Vascular PA on 6/25/24 at 3:00 PM. The PA stated that Resident #68 had a drug coated balloon angioplasty procedure to her left lower extremity during her hospital stay. She said Resident #68 did not have a stent (a small mesh tube typically used to hold open passages in the body, such as weak or narrowed blood vessels) placed during the procedure. She stated the drug coated balloon procedure was used to open the blood flow to the lower extremity. The PA stated that the blood vessel leading to the top of Resident #68's left foot was the only blood vessel that was able to be successfully opened by the procedure. She said the two blood vessels leading to Resident #68's left heel were unable to be opened during the angioplasty due to the occlusion being too hard to get the balloon through. The PA stated Resident #68 was supposed to be taking Plavix. She explained during the first 30 days after an angioplasty there was a risk of the blood vessel that had been opened re-occluding, and the Plavix helped to prevent that from happening. She stated when Resident #68 was seen in the office on 6/19/24 for her follow up visit she had a strong signal (pulse) to the top of her left foot, which indicated the blood vessel was still open. The PA explained in Resident #68's case the problem was that she did not have blood flow to the back of her left heel. She stated Resident #68 did not have blood flow to the back of her left heel to begin with because they had not been able to open the blood vessels leading to the back of her left heel during the procedure. The PA stated Resident #68's upcoming left leg amputation was due to the occlusion of the blood vessels leading to her left heel and that not having blood flow to her left heel prevented her wound from healing. The PA stated since Resident #68 never had blood flow to her left heel to begin with, her receiving or not receiving the Plavix would not have had an impact on her needing an amputation of the left leg. The PA stated unfortunately the blood flow re-established to the top of Resident #68's left heel was not enough for her wound to heel. The PA stated that Resident #68's left heel wound would never be able to heel due to the lack of blood flow to the back of her left heel and that was why she needed the amputation. A telephone interview was performed on 6/25/24 at 9:09 AM with the NP. She stated Resident #68 was scheduled for a left leg amputation on 7/1/24. The NP said she had seen Resident #68 yesterday (6/24/24) and that her left lower extremity was warm and she was able to feel a pedal pulse. The NP stated Plavix was prescribed after the balloon procedure to prevent post-op complications such as blood clots. She stated the presence or lack of presence of the Plavix would not make a significant impact for Resident #68. She stated the Plavix did not prevent the deterioration of the blood vessels. The NP stated the occlusion to Resident #68's left lower extremity was more from atherosclerosis (a buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) not a blood clot. The NP stated Resident #68 should have been started on Plavix when she returned to the facility from the hospital. She stated there was not an indication for it to be discontinued. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted on 6/25/24 at 3:30 PM with the Medical Director. He stated he was unaware that Resident #68 had not received the Plavix that had been ordered on her hospital discharge summary since she had been readmitted to the facility on [DATE]. The Medical Director said the Plavix order being missed was a significant medication error. An interview was performed with the Director of Nursing (DON) on 6/27/24 at 9:45 AM. The DON stated she had been notified by the Administrator on 6/26/24 of the Plavix error for Resident #68. The DON explained the process for new admission orders. She said the nurse would call and verify the new admission orders from the hospital discharge summary with the provider and then enter the orders into the electronic computer system. She stated then another nurse would perform a second order check by comparing the orders that had been entered into the electronic computer system against the hospital discharge summary orders. The DON further explained new admission orders were usually verified and entered by the charge nurse and then a floor nurse would perform the second check. She said she was unsure how the Plavix order for Resident #68 had been missed when she was readmitted to the facility. An interview was performed on 6/27/24 at 2:04 PM with the Administrator. The Administrator stated she had been notified of the Plavix error for Resident #68 by Nurse #2 on 6/25/24. The Administrator said she was unsure how the order for Plavix had been missed.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, staff, and Nurse Practitioner (NP) interview the facility failed to wear personal protective equipment (PPE) while providing wound care for a resident requiring Enhanced Barrier Precautions (EBP). This deficit practice occurred for 1 of 3 residents reviewed for EBP (Resident #68). The findings included: Review of the facility's policy and procedure revised on 3/1/2023, entitled Enhanced Barrier Precautions read in part: - It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. -Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities. -Initiation of EBP- An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. -Implementation of EBP- Make gowns and gloves available immediately near or outside of the residents room. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities. -High-contact resident care activities include- Dressing, Bathing, Transferring, providing hygiene, Changing Linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator, Wound care: any skin opening requiring a dressing. Resident #68 was readmitted to the facility on [DATE]. Her medical diagnoses included a chronic ulcer of left heel. An observation was completed on 6/24/26 at 10:36 AM and revealed Resident #68 had a dressing in place to her left foot. The dressing on her left foot had visible seepage of yellow/tan colored drainage on the outside of the dressing. Resident #68 had a pillow on the bed next to her left foot with approximately a 10-inch area of visible yellow/ tan colored drainage on the pillowcase. There were no PPE supplies observed in resident #68's room, in her bathroom, or outside of her door. No signage for EBP was present in Resident #68's room or on the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. Building B. Wing	06/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was performed on 6/25/23 at 10:00 AM of the Wound Care Nurse performing a dressing change to Resident #68's left foot. The Wound Care Nurse was observed at the foot of Resident #68's bed leaning over the foot board of the bed. The dressing to Resident 68's left foot was observed to be unwrapped. The Wound Care Nurse was observed to be holding up Resident #68's left foot and applying a new absorbent dressing pad to the ulcer on her left heel. The Wound Care Nurse was observed to be wearing gloves. The Wound Care Nurse lifted the absorbent dressing pad away from Resident #68's left heel ulcer for the wound to be visualized. The wound covered the surface area of Resident #68's entire heel and was open with areas of necrotic tissue visible. The Wound Care Nurse was not observed to be wearing a gown. An additional observation was completed on 6/26/24 at 9:20 AM of Resident #68's room. There was no PPE equipment present in her room, outside the room, or in the bathroom. No EBP signage was present. A follow up observation was completed on 6/27/24 at 11:16 AM of Resident 68's room. There was no PPE equipment present in her room, outside the room, or in the bathroom. No EBP signage was present. An observation was completed on 6/27/24 at 11:16 AM of the Wound Care Nurse performing wound care to Resident #68's left heel ulcer. The Wound Care Nurse performed hand hygiene and donned gloves and a gown before proceeding to provide wound care to Resident #68's left heel ulcer. There was a PPE cart observed in Resident #68's room and new EBP signage on Resident #68's door. There were no issues noted during the wound care procedure. An interview was conducted on 6/27/24 at 11:32 AM with the Wound Care Nurse. She stated she wore a gown today while performing Resident #68's wound care because she was on EBP. The Wound Care Nurse stated anyone who had a wound was supposed to have EBP in place. She said she was unsure why Resident #68 did not have PPE equipment or a sign on her door for EBP before today. The Wound Care Nurse verbalized Resident #68 did not have EBP in place or PPE equipment in her room on Tuesday (6/25/24) when she performed the wound care to her left heel ulcer. She stated Resident #68 should have had EBP in place due to her wound and that she should have worn gloves and a gown when she performed Resident #68's wound care on 6/25/24. An interview was conducted on 6/27/24 at 11:57 AM with the Infection Preventionist (IP). The IP stated that residents with wounds and indwelling medical devices should have EBP in place. The IP said staff should use EBP when performing high-contact care activities, using devices, or performing wound care. She stated EBP were not in place for Resident #68 before today because she did not realize she had a wound. The IP stated she did not have a good process for re-admissions needing EBP and it was missed. She stated that Resident #68 should have had EBP in place for her wound. The IP said that the Wound Care Nurse should have worn gloves and a gown when she performed Resident #68's wound care. An interview was performed with the Director of Nursing (DON) on 6/27/24 at 12:31 PM. The DON stated EBP were needed for residents with indwelling devices and wounds. She said staff should wear gloves and a gown when they were doing direct care with a resident who had EBP in place. She explained direct care would include dressing, transferring, bed changes, providing incontinent care, using the device, or changing wound dressings. The DON stated she was not aware Resident #68 did not have EBP in place until today. She said Resident #68 should have been on EBP for her wound. The DON said the Wound Care Nurse should have worn gloves and a gown when performing Resident #68's wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was performed on 6/27/24 at 1:53 PM with the NP. She said she was aware the facility used EBP. She stated EBP applied to residents with indwelling devices and wounds. The NP stated Resident #68 needed EBP and should have had EBP in place for her wound. An interview was performed on 6/27/24 at 2:18 AM with the Administrator. She stated residents with wounds and devices needed EBP. The Administrator stated EBP should have been in place for Resident #68 due to her wound. She said she was unsure how EBP not being in place for Resident #68 had been missed. The Administrator stated EBP was new and was hard to manage and maintain. She stated the facility needed to come up with a process to manage EBP.