

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER The Citadel Mooresville		STREET ADDRESS, CITY, STATE, ZIP CODE 550 Glenwood Drive Mooresville, NC 28115	

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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II was completed for two residents with new mental health diagnoses for 2 of 3 residents (Resident #18 and #61) reviewed for PASRR.</p> <p>The findings include:</p> <p>1. Review of Resident #18's medical record revealed the resident was admitted to the facility on [DATE]. PASRR level I was completed on 6/12/23 prior to Resident #18's admission with a recommendation to resubmit paperwork for a PASRR level II if Resident #18 received a new mental health diagnosis or if there was a significant change in condition.</p> <p>The electronic medical record revealed Resident #18 was diagnosed with bipolar disorder on 10/15/24 and major depressive disorder on 12/17/24. No PASRR level II was completed.</p> <p>An interview on 5/14/25 at 2:00 PM with Social Worker (SW) #1 revealed she was responsible for completing PASRR paperwork for residents. She stated she typically completed paperwork for PASRR level II when residents had a limited level II and their paperwork required them to be reviewed every 30 or 60 days or if a resident had a change in condition. SW #1 revealed she was not aware PASRR level II should be completed for residents with mental health diagnosis upon their admission or readmission or for residents who had received a new mental health diagnosis. SW #1 stated based on Resident #18's mental health diagnosis, a PASRR level II should have been completed.</p> <p>During an interview on 5/15/25 at 12:20 PM with the Administrator she revealed PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. She stated based on Resident #18's mental health diagnosis, PASRR level II should have been completed</p> <p>2. Review of Resident #61's medical record revealed the resident was admitted to the facility on [DATE]. PASRR level I was completed on 10/21/19 prior to Resident #61's admission with a recommendation to resubmit paperwork for a PASRR level II if Resident #61 received a new mental health diagnosis or if there was a significant change in condition.</p> <p>The electronic medical record revealed Resident #61 was diagnosed with bipolar disorder on 10/29/24 and major depressive disorder on 11/05/24. No PASRR level II was completed.</p> <p>(continued on next page)</p>

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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 5/14/25 at 2:00 PM with Social Worker (SW) #1 revealed she was responsible for completing PASRR paperwork for residents. She stated she typically completed paperwork for PASRR level II when residents had a limited level II and their paperwork required them to be reviewed every 30 or 60 days or if a resident had a change in condition. SW #1 revealed she was not aware PASRR level II should be completed for residents with mental health diagnosis upon their admission or readmission or for residents who had received a new mental health diagnosis. SW #1 stated based on Resident #61's mental health diagnosis, a PASRR level II should have been completed.</p> <p>During an interview on 5/15/25 at 12:20 PM with the Administrator she revealed PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. She stated based on Resident #61's mental health diagnosis, PASRR level II should have been completed.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff and Resident interviews, the facility failed to obtain an order for the size of a urinary catheter and change the catheter as ordered for 1 of 1 resident (Resident #87) reviewed for urinary catheters.</p> <p>The findings included:</p> <p>a. Resident #87 was admitted to the facility on [DATE] with diagnoses that included obstructive uropathy (a blockage or hinderance in the flow of urine from the kidneys through the ureters and into the bladder, and then out through the urethra).</p> <p>Review of Resident #87's Minimum Data Set assessment dated [DATE] revealed the Resident was cognitively intact and had an indwelling urinary catheter.</p> <p>Review of Resident #87's physician orders dated 4/04/25 revealed an order to change urinary catheter in the facility every 28 days. There was no order for the size of urinary catheter.</p> <p>Review of Resident #87's Medication Administration Record for 4/2025 indicated the Resident's urinary catheter was changed last on 4/04/25 by Nurse #4.</p> <p>An interview was conducted with Nurse #4 on 5/14/25 at 5:02 PM. The Nurse explained that she had to change Resident #87's urinary catheter on 4/04/25 and there was no order for the size of the catheter, but Nurse #2 told her to use the same size of catheter that she removed from Resident #87 which was a size 16 French. Nurse #4 stated she had no problem changing the urinary catheter.</p> <p>During an interview with Nurse #2 on 5/14/25 at 3:45 PM the Nurse explained that she did not know what size catheter Resident #87 has ordered but she helped Nurse #4 gather the supplies for the catheter change on 4/04/25 and Nurse #4 told her that there was no order for a specific catheter size so Nurse #2 told Nurse #4 to use the same size catheter that she removed from Resident #87.</p> <p>During an interview with the Unit Manager on 5/15/25 at 9:00 AM the Unit Manager stated there should be an order for the size of the urinary catheter.</p> <p>An interview was conducted with the Medical Director on 5/14/25 at 11:51 AM who explained that there should be a specific order for the size of urinary catheter.</p> <p>On 5/15/25/at 11:42 AM during an interview with the interim Director of Nursing (DON), the DON stated her expectation was for there to be an order for the size of the urinary catheter and if there was no order then Nurse #4 should have obtained an order for the size of the catheter. The DON indicated an order for a size 16 French catheter had already been obtained from the physician.</p> <p>b. Resident #87 was admitted to the facility on [DATE] with diagnoses that included obstructive uropathy (a blockage or hinderance in the flow of urine from the kidneys through the ureters and into the bladder, and then out through the urethra).</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #87's Minimum Data Set assessment dated [DATE] revealed the Resident was cognitively intact and had an indwelling urinary catheter.</p> <p>Review of Resident #87's physician orders dated 4/04/25 revealed an order to change urinary catheter in the facility every 28 days in the evening.</p> <p>Review of Resident #87's 4/2025 Medication Administration Record revealed the last urinary catheter change was on 4/04/25.</p> <p>Review of Resident #87's Medication Administration Record (MAR) for 5/2025 revealed the catheter change was scheduled for 5/02/25. The scheduled change was initiated by a Medication Aide #1.</p> <p>An interview was conducted with Medication Aide (MA) #1 on 5/14/25 at 3:28 PM. The MA explained that if she initiated the MAR for the catheter change it was a mistake because that was not in her scope of practice to change urinary catheters. The MA stated it was the nurse's responsibility to change the urinary catheters.</p> <p>On 5/14/25 at 3:40 PM an interview was conducted with Resident #87. The Resident stated the last time his urinary catheter was changed was about a month ago and it was time for it to be changed again. He stated it was uncomfortable, but he tolerated it well.</p> <p>An interview was conducted with Nurse #2 on 5/14/25 at 3:45 PM. The Nurse confirmed that she worked on 5/02/25 from 3:00 PM to 7:00 PM but she did not change Resident #87's urinary catheter. Nurse #2 indicated she did not know that the catheter was scheduled to be changed.</p> <p>During an interview with Nurse #3 on 5/14/25 at 4:33 PM the Nurse confirmed that he worked on 5/02/25 from 7:00 PM to 11:00 PM on the hall that Resident #87 resided. The Nurse explained that he was not aware that Resident #87 was scheduled for a urinary catheter change during that shift and therefore he did not change the Resident's catheter. Nurse #3 stated the MA did not let him know that the Resident was due for a catheter change.</p> <p>An interview was conducted with the Unit Manager on 5/15/25 at 9:00 AM who explained that it was the responsibility of the nurse on duty to look at the residents' MARs to know what they needed to do during the shift and not the MAs responsibility to let the nurses know. The Unit Manager stated if Resident #87 was scheduled for a catheter change on 5/02/25 then there was no reason why the catheter should not have been changed.</p> <p>During an interview with the Medical Director (MD) on 03/14/25 at 11:51 AM the MD indicated if there was an order for a resident's catheter to be changed then his expectation was for the catheter to be changed per that order.</p> <p>An interview was conducted with the interim Director of Nursing (DON) on 05/15/25 at 11:32 AM. The DON explained that Resident #87's catheter should have been changed as scheduled and she would see that it was changed on 05/15/25.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** #2. Resident #46 was admitted to the facility on [DATE] with diagnoses that included dementia without behaviors, sleep apnea, and chronic respiratory failure.</p> <p>Review of Resident #46's quarterly Minimum Data Set assessment revealed she was cognitively impaired. Resident #46 was dependent on others for the completion of her activities of daily living and received oxygen therapy while admitted to the facility.</p> <p>Review of Resident #46's physician orders revealed the following physician order dated 12/22/25:</p> <p>- Rinse or replace oxygen filters on concentrator weekly and as needed. Remove concentrator from machine. Rinse filter with running water and allow to air dry before returning to concentrator. Every night shift, every Sunday.</p> <p>An observation completed of Resident #46's oxygen concentrator on 05/12/25 at 12:00 PM revealed it to be set to 2 liters per minute and had copious amounts of gray matter on the intake filter.</p> <p>An additional observation of Resident #46's oxygen concentrator on 05/14/25 at 2:17 PM revealed the concentrator to continue to be set to 2 liters per minute with additional gray and white matter on the intake filter.</p> <p>Review of Resident #46's medication administration record revealed Nurse #5 was the nurse responsible for ensuring that Resident #46's oxygen concentrator filter was cleaned on Sunday, 05/11/25 overnight.</p> <p>An interview with Nurse #5 on 05/15/25 at 2:17 PM via telephone revealed she had worked on Resident #46's hall on 03/11/25 and would have been responsible for cleaning Resident #46's oxygen concentrator filter. She indicated that she was busy that evening and was not certain she had time or stopped to change or clean Resident #46's oxygen concentrator filter. She verified that the order to clean the filter did show up on the medication administration record so she would see it when she was passing medications.</p> <p>During an interview with the Director of Nursing on 05/15/25 at 12:00 PM, she reported it was only her second day serving in the role of Director of Nursing and she was unsure about the facility's process for ensuring oxygen concentrators and filters were clean but indicated they should be clean and free from dust and debris.</p> <p>An interview with the Administrator on 05/15/25 at 12:01 PM revealed that oxygen concentrators and filters should be cleaned every Sunday on the overnight shift each week. He stated the order to clean the oxygen concentrators and filters should show up on the medication administration record and should be completed. She stated she expected her staff to clean the intake and filter to ensure it was free from dust and debris.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, record reviews, and staff interviews, the facility failed to post cautionary oxygen signage on 1 of 2 oxygen storage rooms where full portable oxygen cylinders were stored. The facility also failed to maintain a clean oxygen concentrator filter for 1 of 5 residents reviewed for respiratory care (Resident #46).</p> <p>Findings included:</p> <p>1. Observations of oxygen storage closet #1 located on the 300 hall on 05/14/25 at 10:48 AM, 1:34 PM, and 3:58 PM revealed closet #1 had a laminated sign labeled full tanks. There was no cautionary oxygen signage noted on the door. There were 48 full oxygen tanks stored in closet #1.</p> <p>An interview with the Interim Director of Nursing on 05/15/25 at 8:43 AM revealed that oxygen storage areas should be labeled with cautionary no smoking signage.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to label and date open food items and discard items that were beyond their expiration date in 1 of 1 walk-in refrigerator and 1 of 1 reach-in refrigerator in the kitchen.</p> <p>The findings included:</p> <p>An observation of the facility's kitchen completed on 5/12/25 at 10:31 AM revealed a small plate with six slices of tomato with no use by date and a carton of whole milk with a use by date of 4/14/25 located in the facility's reach-in refrigerator. Additional observations at this time of the facility's walk-in fridge revealed an open and undated package of diced ham, two open and undated packages of sliced ham, an open and undated package of sliced turkey breast, a pan of cooked alfredo pasta that was open and undated, an open and undated pan of sliced pork, and open and undated bag of white and orange shredded cheese, and open and undated package of sliced American cheese, and 16 premade peanut butter and jelly and ham and cheese sandwiches that were dated to be used by 4/05/25.</p> <p>During an interview with the Dietary Manager on 5/15/25 at 11:43 AM, she reported that she had been on vacation for 4 days prior to 5/13/25. She stated while she was out, the staff cooks oversaw the kitchen, and she reported that the cooks were aware of the facility's processes and procedures on how to store open or leftover food items. She stated she expected her staff to place an open date, along with a use by date that was no longer than seven days from the day of opening. The Dietary Manager reported she had no idea how the 16 premade sandwiches and the expired carton of milk were missed as she checked the refrigerators daily for out-of-date food.</p> <p>An interview with the Administrator on 05/12/25 at 11:33 AM revealed the Dietary Manager had been on vacation and reported that food items that are opened should be dated and stored appropriately, and expired food should be removed and disposed of.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>b. On 05/13/25 at 9:45 AM the Wound Nurse prepared to perform wound care on Resident #61 who had an Enhanced Barrier Precaution sign on his door. The sign indicated wearing gloves and a gown for high contact resident care activities which included wound care. The Wound Nurse washed her hands and applied her gloves then prepared the work field on the over bed table. She then positioned Resident #61 on his right side to expose the stage IV pressure ulcer on his left ischium (hip bone) which had no dressing on it. The Wound Nurse cleansed the wound then removed her gloves and applied clean gloves without washing her hands. The Wound Nurse then applied the ordered treatment and covered the wound with a border dressing to complete the wound care. The Wound Nurse did not don a gown per the Enhanced Barrier Precautions.</p> <p>An interview was conducted with the Wound Nurse on 05/14/25 at 2:34 PM. The Wound Nurse explained that she was aware of the Enhanced Barrier Precautions sign that was posted on Resident #61's door but she thought she only had to wear the gown if the wound had the potential to splash drainage on her. She stated she had been educated on infection control but that was her understanding of Enhanced Barrier Precautions.</p> <p>During an interview with the interim Director of Nursing (DON) on 05/14/25 at 2:49 PM the DON explained that Enhanced Barrier Precautions (gowns and gloves) were to be utilized on all wound care and the Wound Nurse should have washed her hands after she removed her gloves and before she donned new gloves to continue the procedure. The DON also stated the Wound Nurse should have worn a gown during the procedure as the sign directed.</p> <p>Based on observations, record reviews and staff interviews, the facility failed to implement their infection control policy when the Wound Nurse did not apply a gown when performing wound care for Resident #83 and Resident #61. In addition, the Wound Nurse failed to perform hand hygiene before applying clean gloves during wound care on Resident #61. This occurred for 1 of 2 staff members observed for infection control practices (Wound Nurse).</p> <p>Findings included:</p> <p>Review of the facility's undated infection control policy for Hand Hygiene revealed the staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub also known as alcohol-based hand rub. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.</p> <p>Review of the facility's Enhanced Barrier Precautions (EBP) dated 03/24 revealed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident activities. 2. Initiation of Enhanced Barrier Precautions: i. Wound care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. On 05/14/25 at 9:38 AM the Wound Care Nurse prepared to perform wound care to Resident #83 who had an Enhanced Barrier Precaution sign on door. The sign indicated staff should don gloves and a gown for high contact resident care activities which included wound care. The Wound Nurse performed hand hygiene, and donned gloves. The Wound Nurse did not don a gown per the Enhanced Barrier Precautions. Resident #83 was positioned to perform wound care to lower right leg. The dressing to area removed and had a small amount of drainage. The Wound Nurse performed hand hygiene, then donned new gloves. The wound site was cleansed with normal saline, ordered treatment was applied, and new 6 inch by 6-inch bordered gauze dressing applied to wound. The Wound Nurse discarded trash, removed gloves, and performed hand hygiene to complete the wound care.</p> <p>An interview with the Wound Nurse on 05/14/25 at 9:54 AM after wound care observation revealed she recently had been educated on EBP. She stated she believed the gown would only need to be worn if the wound was infected. She was not aware that a gown was needed during routine wound care.</p>		