| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 1 of 3 residents (Resident #32) reviewed for beneficiary notification. The findings included: Resident #32 was admitted to the facility on [DATE] and Medicare Part A services began on 12/20/24. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 3/02/25 to Resident #32 which explained Medicare Part A coverage for skilled services would end on 3/04/25. Resident #32 remained in the facility. A review of the medical record revealed a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (ABN) was not provided to Resident #32. An interview conducted with the Business Office Manager (BOM) on 8/05/25 at 1:10 PM revealed she was responsible for issuing the CMS-10055 ABN and CMS-10123 NOMNC when a resident's Medicare Part A benefit was ending. She stated her employment at the facility did not begin until 3/10/25 and the Former Social Worker was issuing the ABN and NOMNC forms when Resident #32's Part A benefit ended. The BOM stated Resident #32 was issued the CMS-10123 NOMNC but not the CMS-10055 ABN. She revealed because Resident #32 remained in the facility both the CMS-10123 NOMNC and CMS-10055 ABN should have been issued. A phone interview with the Former Social Worker on 8/07/25 at 10:53 AM indicated while employed at the facility, the BOM was responsible for issuing the CMS-10123 NOMNC and CMS-10055 ABN when Medicare Part A benefits were ending and he did not recall a time when he was responsible for issuing the forms. During an interview with the Administrator on 8/07/25 at 3:27 PM she stated at the beginning of March 2025 they were in the process of hiring a new BOM and the Former Social Worker was responsible for issuing beneficiary notifications. The Administrator indicated when a resident's Medicare Part A benefit was ending, and they remained in the facility, both the CMS-10123 NOMNC and CMS-10055 ABN should be issued. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to revise a resident's care plan with current cardiopulmonary resuscitation code status for 1 of 21 residents (Resident #64) reviewed for care plans. The findings included:Resident #64 was admitted to the facility on [DATE]. Her diagnoses included myasthenia gravis, diabetes mellitus, and essential primary hypertension. A review of Resident #64's care plan last revised on [DATE] indicated cardiopulmonary resuscitation (CPR)/Full Code status with a goal initiation date of [DATE], a goal revision date of [DATE] and a goal target date of [DATE]. Resident #64's most recent quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and revealed she was cognitively intact. A review of Resident #64's electronic medical record (EMR) social work progress note dated [DATE] revealed the Social Worker (SW) reviewed Resident #64's advanced directives with her and her code status was changed from a CPR/Full Code to Do Not Resuscitate (DNR) on the same date.A review of Resident #64's physical Medical Orders for Scope of Treatment (MOST) form, indicating DNR status, revealed the form was signed on [DATE]. An interview with the SW occurred on [DATE] at 12:36 PM. The SW explained Resident #64 indicated in a conversation about advanced directives that she wanted to change her code status from a CPR/Full Code to DNR. The SW recalled Resident #64 had two different MOST forms on file and she verified Resident #64's code status in the conversation. The SW stated code status changes were discussed during the facility's morning standup meeting and the MDS Nurse was tasked with making changes in the care plan.An interview was completed with the MDS Nurse on [DATE] at 12:44 PM. The MDS Nurse revealed she did not know Resident #64's code status from CPR/Full Code to DNR had changed. The MDS Nurse stated code status changes were typically discussed in clinical or standup meetings and the change in code status must have fallen through the cracks. The MDS Nurse indicated she would update the care plan with the correct code status.An interview with the Director of Nursing (DON) on [DATE] at 1:03 PM revealed Resident #64's code status change from CPR/Full Code to DNR should have been discussed in the morning standup meeting and the care plan should have been updated. The DON stated she was unsure why the code status change was not discussed in the morning stand up meeting.An interview with the Administrator on [DATE] at 1:17 PM revealed code status changes were discussed in their daily clinical meetings and discussed in their weekly risk management meetings. The Administrator was unsure how Resident #64's code status from CPR/Full Code to DNR was missed but she expected Resident #64's care plan to be updated timely. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, record review and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 opportunities resulting in a medication error rate of 8% for 1 of 5 residents observed during medication administration observation (Resident #6). Findings included: On 08/06/2025 at 9:07 AM, Nurse #3 was observed and interviewed as he prepared to administer medication to Resident #8. He stated Resident #8 had a gastrostomy tube (g-tube) as indicated on his medication sheet located on the top of the medication cart. Nurse #3 obtained the medication aspirin 81 milligrams (mg) and losartan 50mg from the medication cart and proceeded to crush the medication and place it into a cup. Upon entrance into the resident room, Resident #8 was observed lying in bed as well as her roommate Resident #6. Resident #8 did not have a g-tube, and Resident #6 did have a g-tube. Nurse #3 was observed administering the medication prescribed to Resident #8 to Resident #6 during the medication pass observation. A review of Resident #8's medication orders revealed the resident had a current order initiated on 04/17/25 for losartan potassium oral tablet 50 mg give one tablet by mouth one time a day related to hypertension. Resident #8 also had an order initiated on 04/17/25 for aspirin oral tablet 81 mg by mouth one time a day related to hemiplegia (muscle weakness or partial paralysis on one side of the body). The medication error was identified during the surveyor's record review immediately following administration of the medication. On 08/06/25 at 9:55 AM an interview was conducted with Nurse #3. During the interview the surveyor notified Nurse #3 that he had administered Resident #8's medication to Resident #6. Nurse #3 immediately reviewed his medication sheet located on the top of the medication cart and showed the surveyor the sheet had Resident #8 as having a g-tube. He stated, I accidently got the two residents mixed up. Nurse #3 stated he had not realized he had made a medication error until the surveyor notified him. The interview revealed Nurse #3 was agency staff and did not work in the facility very often. He stated he was not familiar with the residents and had never worked on the assigned hall before. Nurse #3 immediately checked on Resident #6 and went to notify Nurse Practitioner #1. Nurse #3 stated after administering medication to Resident #6 he was then called to another room down the hall to administer medication and he had not administered any medication to Resident #8. On 08/06/25 at 11:00 AM an interview was conducted with Unit Manager #1. During the interview she stated Nurse #3 had come to her and notified her of the situation. Unit Manager #1 stated she had notified Nurse Practitioner #1 who was on her way to the facility, the Medical Director and Resident #6's Responsible Party (RP). On 08/06/25 at 11:14 AM an interview was conducted with Nurse Practitioner (NP)# 1. During the interview she stated she was notified by Unit Manager #1 that Nurse #3 had administered the incorrect medication to Resident #6. NP #1 stated anytime a resident received the wrong medication it was an issue however after her assessment of Resident #6 she was not experiencing any adverse reaction to the medication so far. She stated she gave the facility orders to obtain the residents blood pressure every 2 hours for a duration of 24 hours. The interview revealed she typically did not receive calls from the facility stating medication errors had occurred, so it was an unusual situation. NP #1 explained Resident #6 had received all of her scheduled medications following identification of the medication error and her medications included midodrine HCL oral tablet 5 mg ordered on 06/10/25 for low blood pressure. She stated because Resident #6 had received Resident #8's blood pressure medication there was a chance her blood pressure could drop, however Resident #6 was already prescribed a medication to help keep her blood pressure stable. On 08/06/25 at 11:26 AM a follow up interview was conducted with Nurse #3. During the interview he stated after realizing he had administered the wrong medication to Resident #6 he went to the nurse's station and told Unit Manager #1 who then called Nurse Practitioner #1 and the Medical Director. The interview revealed Resident #6's blood pressure was 92/60 and he received orders to check it every 2 hours. Nurse #3 stated he felt terrible about the situation, but it was hard because he didn't know the residents well in the facility and he saw g-tube listed by her name on the medication sheet located on the top of the medication cart, so he followed it. On 08/07/25 at 3:09 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated all nurses in the facility should be following the 6 rights of medication administration including right patient, right medication, right dose, right route, right time and right documentation. The DON stated the nurses on the hall had created a report sheet as a guide for agency staff and they had updated it as needed. Resident #8 had a g-tube at one time however it had been removed and the only resident in the room with a g-tube was Resident #6. She stated regardless of the paper on the top of the medication cart Nurse #3 should have |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews with Registered Dietitian, Speech Therapist, and staff, the facility failed to modify a resident's diet order to meet her individual needs for 1 of 5 residents reviewed for nutrition (Resident #47).Findings included:Resident #47 was admitted to the facility 02/20/25 with a diagnosis including malnutrition. Hospital records revealed Resident #47 had a hospital stay on 03/30/25 due to shortness of breath. She was discharged back to the facility on [DATE].Review of Resident #47's physician orders revealed an order dated 04/07/25 for a regular diet. A Nurse Practitioner note dated 06/11/25 revealed Resident #47 was evaluated for a nursing request for medication and lab review. It was the Nurse Practitioner's initial encounter with Resident #47. Resident #47 expressed during the evaluation that she was concerned her dentures were missing. The Nurse Practitioner had a discussion with the Director of Nursing regarding the resident's lost dentures, and the DON was aware of the situation. Resident #47 went to the hospital with her dentures however when she returned the hospital did not send the dentures back with her. A dental examination note dated 06/23/25 revealed Resident #47 was evaluated on this date by the facility dentist. The note revealed Resident #47 did not have dentures at the time of the evaluation and the treatment plan included completing denture impressions on the next visit to the facility. Resident #47 was noted to have an atrophic lower ridge and was not a candidate for a lower denture. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was moderately cognitively impaired. No nutritional approaches were documented during the assessment period. Review of Resident #47's weights revealed the following:- 05/16/25: 128.2 pounds- 06/07/25: 130 pounds- 07/07/25: 124.6 pounds On 08/04/25 at 11:28 AM an interview was conducted with Resident #47. Resident #47 stated she had lost her upper dentures the month prior and was having a difficult time eating her meals at the facility. She stated the facility continued to serve her a regular diet which included corn on the cob. Resident #47 stated she could not eat a lot of the meals provided by the facility and had told staff members (name she could not recall) that she was having difficulty eating. An observation of Resident #47's lunch meal ticket on 08/05/25 at 12:45 PM revealed she was to receive a regular diet. An observation of Resident #47's meal tray at the same time and date revealed she received two large kielbasa sausages with cabbage, canned sliced peaches and a roll. Resident #47 was observed cutting the sausages into smaller bites and attempting to chew the meat. An observation of Resident #47's lunch meal ticket on 08/06/25 at 12:30 PM revealed she was to receive a regular diet. An observation of Resident #47's meal tray at the same time and date revealed she received a slice of ham, mashed potatoes, corn on the cob and a cookie. An interview was conducted with Resident #47 at the time of the observation. Resident #47 stated, See it happens every day, I get food a cannot eat because I have no teeth. She stated she had told staff members she was unable to eat corn on the cob however nobody would ever change anything. She stated, I don't understand why they couldn't give me creamed corn, it makes me feel stupid. On 08/06/25 at 12:35 PM an interview was conducted with Nurse #4. The surveyor explained Resident #47 wanted a substitute for corn on the cob served for the lunch meal. Nurse #4 stated she was agency staffing and it was her first day in the facility. She stated she was not familiar with the resident, nor did she know if the resident had dentures. Nurse #4 stated she would go to the kitchen to see if they had a substitute for the corn served. On 08/06/25 at 1:03 PM an observation was conducted of Resident #47 with a bowl of creamed corn. An interview conducted with Resident #47 at the same date and time revealed Nurse #4 had provided her with the bowl of corn. Resident #47 stated, It is so good, I don't understand why they can't do this all of the time. On 08/06/25 at 2:59 PM an interview was conducted with Nurse Aide #3. During the interview she stated she had never heard Resident #47 complain about not having dentures but had heard her complain once about her diet. NA #3 stated Resident #47 had said to her, look at my mouth, my diet should be puree its hard for me to eat. NA #3 stated she went to the kitchen to get the resident an alternative meal she could eat and told the Nurse on duty (whose name she could not recall). On 08/06/25 at 3:07 PM an interview was conducted with the Speech Therapist. During the interview she stated she had never worked with Resident #47 because nobody from the nursing staff had mentioned she was experiencing difficulty eating her prescribed diet. The Speech Therapist explained if a resident was having any issues eating the assigned diet nursing staff could downgrade the diet themselves or send a referral for therapy to see if the need for a diet change was there. On 08/07/25 at 2:46 PM an interview was conducted with the Dietitian. She stated she came into the building weekly on Thursdays and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when Nurse #2 did not doff her gloves, perform hand hygiene and don clean gloves prior to cleaning wound and applying new wound dressing to Resident #31's sacrum. Additionally, the facility failed to implement their policy for Enhanced Barrier Precautions (EBP) when Nurse #1 did not don a gown during a high contact care activity which included dressing Resident #31 who had a chronic wound and feeding tube. The deficient practice occurred for 2 of 5 staff members observed for infection control practices (Nurse #1 and Nurse #2).The findings included:<br><br>A. The Hand Hygiene policy without revision date, revealed hand hygiene means to clean one’s hands with either a sanitizer product or with soap and water and glove use was not a substitute for hand hygiene. The policy also revealed staff were to perform hand hygiene for the following:<br><br>- During all care activities and while working in all locations within the facility.<br><br>- Before and after wearing gloves.<br><br>- After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings.<br><br>An observation was conducted on 8/7/2025 at 10:59 AM while Resident #31 received wound care. Nurse #2 was observed entering Resident #31’ts room wearing a gown, then applied gel hand sanitizer, and donned gloves. Next Nurse #2 removed the soiled dressing from Resident #31’s sacrum and placed soiled dressing in the trash. Nurse # 2, without changing gloves cleaned the wound on Resident #31’s sacrum and placed a clean dressing on the wound. Nurse #2 cleaned the workstation, removed gloves and gown. Nurse #2 used gel hand sanitizer prior to exiting Resident #31’s room.<br><br>An interview was conducted on 8/7/2025 at 11:40 AM with Nurse #2. Nurse #2 stated she did not sanitize or wash her hands between removing the old dressing, cleaning the wound, and placing the new dressing on Resident #31’s wound because she had forgotten and stated, “maybe I could have double gloved and removed a pair of gloves after removing the dirty dressing.” The interview revealed that Nurse #2 completed wound care in the facility throughout the week for her assigned residents that required wound care.<br><br>An interview was conducted on 8/7/2025 at 2:28 PM with the Director of Nursing (DON). The DON stated she served as the Infection Control Nurse for the facility since April of 2022. The DON stated staff received education about infection control during orientation and annually. The DON reported that when staff performed wound care, they should wash their hands and change gloves before removing the old dressing and then perform hand hygiene and change gloves in between wound care steps because of the contact with body fluids and non-intact skin. The DON stated Nurse #2 should have changed gloves and performed hand hygiene after she removed the dirty dressing, after cleaning the wound, and before applying a new dressing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345304 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accordius Health at Midwood, LLC | 2727 Shamrock Drive<br>Charlotte, NC 28205 |

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 | B. The facility's policy for Enhanced Barrier Precautions (EBP) revised on 3/27/24 read in part: EBP refer to infection control interventions designed to reduce the transmission of multidrug-resistant organisms which employs targeted gown and gloves use during high contact resident care activities for residents with wounds and/or indwelling medical devices. 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 and tracheostomy, and wound care: any skin opening requiring a dressing.<br><br>An observation conducted on 8/04/25 at 11:33 AM revealed Resident #31 had personal protective equipment (PPE) including gowns and gloves available in a caddy hanging on the door to her room. Nurse Aide (NA) #1 and Nurse #1 were observed entering Resident #31’s room to reposition her in bed. NA #1 donned a gown and gloves and Nurse #1 donned gloves. Upon entering Resident #31’s room EBP signage was observed on the closet door instructing staff to wear a gown and gloves during high contact care activities which included bathing, dressing and transfers. Resident #31 was lying flat in bed covered with a sheet and had a feeding tube in place. NA #1 and Nurse #1 used a draw sheet to pull Resident #31 up in the bed and then elevated the head of the bed to approximately 45 degrees. Nurse #1 assisted NA #1 to dress Resident #31 in a shirt and then disposed of her gloves, performed hand hygiene and exited the room.<br><br>During a phone interview with Nurse #1 on 8/07/25 at 2:14 PM she revealed Resident #31 was on EBP due to having a wound and a feeding tube. Nurse #1 indicated she was unaware of the EBP signage posted in Resident #31’s room however the PPE caddy hanging on the room door indicated that EBP was in place. Nurse #1 revealed she wore a gown and gloves when providing care related to Resident #31’s wound or feeding tube. Nurse #1 stated she did not think a gown was required when putting Resident #31’s shirt on because it was not involving her wound or feeding tube.<br><br>An interview conducted with the Director of Nursing (DON) on 8/07/25 at 3:13 PM indicated she was also the facility's Infection Preventionist (IP). She stated EBP were implemented for residents with an open wound and/or indwelling medical device such as a feeding tube or urinary catheter. She revealed residents on EBP had a PPE caddy containing gowns and gloves hanging on their door and EBP signage was posted inside their room. She stated when staff provided high contact care for a resident on EBP which included bathing, dressing and transfers they should wear a gown and gloves.<br><br>During an interview with the Administrator on 8/07/25 at 3:20 PM she revealed staff providing high contact care for a resident on EBP such as bathing, dressing and transfers, should wear a gown and gloves. |