

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/07/2024
NAME OF PROVIDER OR SUPPLIER  Willow Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  650 W. Alluvial Clovis, CA 93611	

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 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949</b></p> <p>Based on interview and record review, the facility failed to ensure the physician was notified for a change in condition for one of three residents (Resident 1) when on 5/14/24 Resident 1 was observed to have an acute change in mental status, an abrupt loss of in appetite, weakness, fatigue, and was difficult to arouse. CNA 4 communicated the changes of Resident 1 to the licensed nurse and the license nurse did not assess the resident, did not notify the physician and the Responsible Party (RP-a decisionmaker for the resident) regarding the change in condition.</p> <p>This failure resulted in a delay in physician notification of a change in condition that occurred on 5/14/24 and did not provide the physician the resident assessment to diagnose promptly to treat or transfer Resident 1 to a higher level of care. The delay in physician notification lead to a delay in transferring to a general acute care hospital where Resident 1 ' s CT (computerized tomography x-ray image) scan results were consistent with an acute ischemic stroke (when blood flow to the brain is blocked). The delay in physician notification lead to Resident 1 inability receive medication treatment for a stroke and decline in mental and physical abilities. This led the Responsible Party to place Resident 1 on hospice (care for people who are neat the end of life) and palliative care (care that focuses on providing relief from pain and symptoms of a serious illness).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included constipation, hypertension (high blood pressure), and muscle weakness, cardiac murmur (a blowing, whooshing, or rasping sound heard during a heartbeat), overactive bladder (a condition in which the bladder squeezes urine out at the wrong time).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/11/24, the MDS, indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15 ) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 1 was cognitively intact.</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 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's MDS assessment, dated 5/11/23, the MDS Section GG (Functional Abilities and Goals) indicated Resident 1 was a partial to moderate assistance (helper does 50% of assistance) with transfer, dressing and bathing.</p> <p>During an interview on 6/4/24 at 1:45 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she worked at the facility for more than two years. CNA 4 stated she took care of Resident 1 on a regular basis and was familiar with her care. CNA 4 stated she remember Resident 1 was her normal talkative self in the chair the morning of 5/14/24. CNA 4 stated in the afternoon of 5/14/24 Resident 1 was weak, less talkative and was out of it after lunch. CNA 4 stated Resident 1 ' s .eyes were stuck to the side . while looking out the window and responded slower to questions. CNA 4 stated she provided care for Resident 1 after lunch and noticed she was not as strong. CNA 4 stated Resident 1 looked tired and did not want to eat lunch on 5/14/24. CNA 4 stated she notified License Vocation Nurse (LVN) 2 regarding Resident 1 ' s condition. CNA 4 stated LVN 2 told her to offer extra fluids to Resident 1. CNA 4 stated when she returned to work on 5/15/24 Resident 1 was not eating, not talkative, not able to drink out of the straw and she was total assistance which indicated she was worse than 5/14/24. CNA 4 stated Resident 1 had eaten 25% of breakfast on 5/14/24 and refused breakfast on 5/15/24. CNA 4 stated it was unusual for Resident 1 to not eat.</p> <p>During an interview on 6/6/24 at 10:36 a.m. with LVN 1, LVN 1 stated she was a float (a work assignment that moves from one section of the healthcare facility to another) nurse and worked for the facility for six years. LVN 1 stated she was assigned to Resident 1 on 5/14/24 for the afternoon (pm) shift. LVN 1 stated she had received report (update) about a change in condition from LVN 2 for Resident 1. LVN 1 stated she was told in report LVN 2 and the Assistance Director of Nursing (ADON) 1 assessed Resident 1 for a change in condition. LVN 1 stated on 5/14/24 during her afternoon shift Resident 1 was tired and difficult to arouse (stay awake) and slow to respond when spoken to. LVN 1 stated when a resident is difficult to arouse it was considered a changed in condition. LVN 1 stated Resident 1 had a change in condition and LVN 2 was responsible to notify the physician on 5/14/24, the RP and revise the care plan (an individualized plan of care that is personalized for a person's health conditions and current treatments needed for their care). LVN 1 stated the facility has a communication form for nurses to monitor for decline in residents when there a change in condition and one was not completed for Resident 1 on 5/14/24.</p> <p>During a review of Progress Notes (PN) dated 5/14/24 at 10:05 p.m., the PN indicated, Writer [received] report from [morning charge nurse] that resident [Resident 1] presented with normal vitals[clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] however difficulty arousing on [morning] shift. ADON aware assess resident .Resident continue to exhibit difficulty arousing on [afternoon] shift .resident consumed less than 25% of dinner meal, intake 220 [milliliters- a unit of measurement for liquids] of fluids . There was no indication in the PN by LVN 1 that the doctor was notified regarding Resident 1 ' s change in condition.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 11:08 a.m. with LVN 2, LVN 2 stated she had been the nurse for Resident 1 for over a year and half. LVN 2 stated Resident 1 could feed herself and was a one-person assistance with showers. LVN 2 stated CNA 4 was familiar with Resident 1 and reported to her Resident 1 did not look like her normal self in the afternoon on 5/14/24. LVN 2 stated, Resident 1 was responding slowly and staring out the window on 5/14/24. LVN 2 stated she believed Resident 1 ' s slow response was from a side effect (unwanted undesirable effects) of an antibiotic. LVN 2 stated she did not notify Resident 1 ' s doctor on 5/14/24. LVN 2 stated Resident 1 ' s condition worsened on 5/15/24 when she responded slower to questions. LVN 2 stated she called the physician, RP, ADON 1, ADON 2 and Director of Nursing (DON) on 5/15/24 (one day after Resident 1 ' s change in condition was noticed).</p> <p>During an interview on 6/6/24 at 12:08 p.m. with the ADON 1, ADON 1 stated she went to assess Resident 1 on 5/15/24 at around 2:30 p.m. ADON 1 stated Resident 1 consumed 50-70% for breakfast and zero percent for dinner on 5/14/24. ADON 1 stated Resident 1 ate zero percent of her breakfast and lunch on 5/15/24. ADON 1 stated on 5/15/24 Resident 1 was not able to drink from a straw which Resident 1 had done before. ADON 1 stated a change of condition for a resident would include an elevated temperature, increased respirations, a change in mental status, a change in eating habits and a change in their ability to perform self-care and an increased demand for oxygen.</p> <p>During an interview on 6/6/24 at 2:05 p.m. with ADON 2, ADON 2 stated nurses were expected to complete a full head to toe assessment and compare the findings to the resident ' s baseline (initial measurement of a residents condition). ADON 2 stated a change of condition for a resident would include an increased pulse, headache, nausea, vomiting, lethargy, change in vital signs, increased oxygen demand, not eating or drinking and difficult to arouse. The ADON 2 stated, all certified nursing assistants were responsible to notify a charge nurse when there was a change in meal consumption. ADON 2 stated charge nurses were responsible to start the process for a change in condition assessment. The ADON 2 stated Resident 1 was lethargic and speaking slowly on 5/14/24 and Resident 1 ' s change in condition should have been assessed.</p> <p>During an interview on 6/6/24 at 2:34 p.m. with the Director of Nursing (DON), the DON stated, a change in condition was when a resident had abnormal vital signs and/or a clinical change from the baseline. The DON stated nurses were to assess residents from head to toe during a change in condition and to complete a situation, background, assessment, and recommendation (SBAR a structured communication framework that help teams share information about the condition of a resident.) The DON stated staff completed change in condition training in March 2024.</p> <p>During an interview on 7/15/24 at 3:41 p.m. with the Medical Doctor (MD), the MD stated, when a resident was difficult to arouse or lethargic it was considered a change in condition. The MD stated staff were to notify him or the nurse practitioner. The MD stated each resident was treated differently depending on the family or RP ' s wishes. The MD stated each resident ' s medical care was dependent on the Physician Orders for Life-Sustaining Treatment (a POLST is a physician order that helps give seriously ill patients more control over their end-of-life care) form and medical history.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s document titled SBAR Communication Form and Progress Note for RNs/LPN/LVNs (SBAR) for Resident 1, dated 5/15/24, the SBAR indicated .Situation .The change in condition, symptoms, or signs observed and evaluated is/are: Altered Mental Status .This started on 05/15/2024 .Since this started it has gotten: .[box checked] Better .Things that make this condition or symptom better are: IV Hydration (replenishes lost fluids through a tube in a vein) .This condition, symptom, or sign has occurred before: [box checked] Yes .Treatment for last episode .: Changing the [Residents] [Medication] and IV Hydration .Resident/Patient Evaluation .1. Mental Status Evaluation (compared to baseline check all that changes that you observe) .[box checked] Altered level of consciousness .Describe symptoms or signs [blank] .2. Functional Status (capacity an individual can perform activities and tasks) Evaluation (compared to baseline; check all that you observe) . No changes observed .10. Neurological Evaluation .[box checked] Altered level of consciousness .Describe symptoms or signs: [Resident] noted Not responding as Normal .Appearance .Summarize your observations and evaluations: [Resident] was noted with [Altered Mental Status] and is slow to respond. [Resident] was not eating and had to be fed .Review and Notify . Primary Care Physician Notified: Yes .Date 05/15/2024 .Time: 9:20 AM .Interventions .IV (soft flexible tube placed inside the vein) .</p> <p>During review of SNF/NF to Hospital Transfer Form dated 5/15/24, the SNF/NF to Hospital Transfer Form indicated Resident 1 was transferred from the skilled nursing facility to the acute care hospital on 5/15/24 at 4:13 p.m.</p> <p>During a review of Resident 1 ' s General Acute Care Hospital (GACH) H&amp;P Addendum (H&amp;P), dated 5/15/24, the H&amp;P indicated, .CT (computerized tomography x-ray imaging) head shows acute [experienced to a severe or intense degree]or early subacute [ a recent onset or rapid change] infract [stroke] in the right PCA (posterior cerebral artery -one of a pair of arteries that supply oxygenated blood to the back of the brain) .Neurology was consulted. Not a candidate for TPA (tissue plasminogen activator- medication used to dissolve blood clots in stoke patients and must be given with 3 hours of onset of symptoms) since her symptoms started 3 days ago .</p> <p>During a review of Resident 1 ' s General Acute Care Hospital (GACH) Discharge Summary (DS) dated 5/24/24, the DS indicated, .admitted : 5/15/2024 discharge date : 5/24/2024 .Indication for Admission: Chief Complaint Patient presents with Altered Mental Status . [chief complaint of Altered Mental Status for] 3 days . baseline glasgow coma scale 15 (a system to measure how conscious a person is, a score of 15 means you ' re fully awake, responsive and have no problems with thinking ability or memory) .Admission Diagnoses: Acute CVA (cerebrovascular accident) .Active Hospital Problems Diagnosis .(Principal) Acute Ischemic stroke .AMS (altered mental status) .Hemiparesis (one sided muscle weakness) affecting left side .05/17 . Failed swallow evaluation .05/21 .Daughter agreed to meet with Palliative care to discuss goals of care . Disposition .Hospice .</p> <p>During review of Resident 1 ' s facility Discharge Document (DC) dated 6/11/24, the DC indicated .admitted : 2/3/2021 .discharge date [DATE] .Condition on discharge: Guarded .Significant Findings and Events: Long term patient became weak and altered sent to the hospital .Recommendation and Arrangements for Future Care: Per hospital course Prognosis Fair to poor Physician ' s Signature [signed] Date 06-11-2024 .</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>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949</b></p> <p>Based on observation, interview and record review, the facility failed to ensure an effective infection control and prevention program for one of three sampled residents (Resident 2), when Certified Nursing Assistance (CNA) was observed without proper personal protective equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and not performing hand hygiene (washing hand or using alcohol base hand rub) while providing care on 6/4/24.</p> <p>This failure had the potential to place Resident 2 at increased risk for an infection with multidrug resistant organisms (MRDO- bacteria (germs) that have developed resistance to multiple types of antibiotics) and had the potential transit infection throughout the facility.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record (AR), dated 5/4/24, the AR indicated, Resident 2 was admitted on [DATE] with a diagnosis of Covid -19 (a highly infection respiratory disease) immunodeficiency (the decreased ability of the body to fight infections and other diseases) chronic myeloid leukemia (cancer of the blood and bone).</p> <p>During an observation on 6/4/24 at 10:11 a.m. in station 2, CNA 1 was observed with a mask and gloves but not wearing a gown while providing personal care for Resident 2 in in Resident 2 ' s room. CNA 1 was observed leaving Resident 2 ' s room without performing hand hygiene.</p> <p>During an observation on 6/4/24 at 10:12 a.m. in station 2, CNA 1 was observed returning to Resident 2 ' s room with new clean linen and did not put on a gown prior to entering the room. CNA 1 changed Resident 2 ' s bed linen. CNA 1 left Resident 2 ' s room without performing hand hygiene.</p> <p>During an observation on 6/4/24 at 10:13 a.m in station 2, CNA 1 returned to Resident ' s 2 room without putting on a gown and repositioned Resident 2 in bed. CNA 1 was observed with a bag of dirty linen, no hand hygiene was performed after taking off the gloves.</p> <p>During a concurrent interview and record review on 6/4/24 at 10:15 a.m. at station 2 with the Infection Preventionist (IP), the IP stated, Everyone must clean hands, wear gloves and gowns when providing care. The IP stated residents with open wounds and infections were placed in enhanced barrier precautions (an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms (MDRO). The IP read the sign located next to Resident 2 ' s room which indicated, Everyone must: clean their hands, including before entering and leaving the room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube, tracheostomy wound care and any open skin opening requiring dressing.</p> <p>During an interview on 6/4/24 at 10:20 a.m. in station 2, CNA 1 stated today was her second day on the floor. CNA 1 stated, she changed Resident ' 2 brief and the bedsheet. CNA 1 stated she did not wear a gown while providing care for Resident 2 and stated she did not know the purpose of wearing a gown.</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>During an interview on 6/4/24 at 12:20 p.m. with the IP, the IP stated enhanced barrier precaution training was done the first day of orientation for all new employees. The IP stated enhanced precaution training was provided on 3/20/24 for all current employees. The IP stated Resident 2 came off covid isolation on 6/3/24 and was placed on enhanced barrier precautions. The IP stated, Resident 2 was on enhanced barrier precautions for a week. The IP stated Resident 2 had a deep tissue injury (a form of pressure sore or injury to the skin) to the coccyx (buttock). The IP stated Resident 2 was at high risk of getting Methicillin-resistant staphylococcus aureus (a form of highly contagious bacterial infection.) The IP stated CNAs were required to put on a gown and gloves when providing care to the residents.</p> <p>During an interview on 6/6/24 at 2:34 p.m. with the Director of Nursing (DON), the DON stated staff and visitors are expected to wear PPE when there is a sign next to the resident ' s door. The DON stated staff were trained on infection control when newly hired and annually. The DON stated staff were expected to wear PPE when residents were on enhanced barrier precautions. The DON stated, by putting on PPE staff will prevent the spread of multi-drug resistant organisms (MDRO) and other infections to residents, staff, and visitors.</p> <p>During a review of the facility ' s policy and procedure titled, Personal Protective Equipment, revised dated 10/2018, indicated, Personal protective equipment appropriate to specific task requirements is available at all times .</p> <p>During a review of the facility policy and procedure titled, Policies and Practice-Infection control, revised dated 10/2018, indicated, .the objective of our infection control policies and practices are to: a. prevent, detect, investigate and control infection in the facility, b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public .</p> <p>During a review of the Centers for Disease Control and Prevention (CDC) the article titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated 6/2021, the article indicated, .1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to significant morbidity (disease) and mortality (death) for residents and increased costs for the health care system. 2. Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of Staphylococcus aureus (a type of bacteria on skin or nose) and MDROs . Resident-to-resident pathogen [germs]transmission in skilled nursing facilities occurs, in part, via healthcare personnel, who may transiently carry and spread MDROs on their hands or clothing during resident care activities .</p>		