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	345283	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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E 000	Initial Comments An unannounced recertification survey and complaint investigation survey was conducted on 05/12/25 through 05/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: PGR611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 05/12/25 through 05/15/25. Event ID #PGR611. The following intake was investigated: NC00229859. Two (2) of the 2 allegations did not result in a deficiency.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 644	The facility failed to ensure a	5/17/25

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

Electronically Signed | 06/04/2025

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F 644	Continued From page 1 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. The findings include: 1. Review of Resident #18's medical record revealed the resident was admitted to the facility on 7/09/24. 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. 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. 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. During an interview on 5/15/25 at 12:20 PM with	F 644	Preadmission Screening and Resident Review (PASARR) Level II was completed for Resident #18 and Resident #61. On 5/15/2025, Social Worker #1 and Minimum Data Set (MDS) Nurse audited current residents with newly evident or possible serious mental disorder, intellectual disability or a related condition for Level II resident review. Two additional residents were identified (JC and BG). On 5/14/2025, Social Worker #2 submitted a Level II resident review for B.G. identified on the audit. On 5/15/2025, Social Worker #1 submitted updates for Res #18, Res #61, and J.C. to be reviewed for Level II PASARRs. 3. On 5/14/2025, the Administrator educated Social Worker #1 and #2 on the Preadmission Screening and Resident Review policy. 4. The Director of Nursing/Unit Manager/Minimum Data Set Nurse/Social Worker will review newly admitted and readmitted mental health diagnosis during the clinical interdisciplinary team (IDT) meeting determining qualifications for Level II residents' review. The IDT will also review diagnosis weekly during at risk meetings for residents with a significant change in status. The Administrator will ensure any newly hired Social Worker receives education during orientation. The Administrator/Social Worker will monitor using a Quality Assurance tool for Level II PASARR. The monitoring will	

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F 644	Continued From page 2 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 2. Review of Resident #61's medical record revealed the resident was admitted to the facility on 6/12/23. 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. 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. 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.	F 644	include reviewing residents' mental health diagnosis upon admissions, readmission from the hospital, and psychiatric consultations. The QA monitoring will be weekly x 8 weeks, then biweekly x 4 weeks. The Social Worker will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F 644	Continued From page 3 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.	F 644		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/17/25

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F 690	Continued From page 4 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: 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. The findings included: a. Resident #87 was admitted to the facility on 10/31/23 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). Review of Resident #87's Minimum Data Set assessment dated 3/04/25 revealed the Resident was cognitively intact and had an indwelling urinary catheter. 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. Review of Resident #87's Medication Administration Record for 4/2025 indicated the Resident's urinary catheter was changed last on	F 690	On May 16, 2025, the licensed nurse changed Res #87's catheter. On May 15, 2025, the licensed nurse updated Res # 87's physician orders to include size 16 french with 10cc balloon. On May 15, 2025, the Unit Manager conducted an audit of all residents with catheters to ensure physician orders include catheter size, as well as change frequency. Audit findings revealed eleven residents have catheters in place. All residents' physician orders included catheter size and change frequency. Observations noted catheters were changed as ordered. On May 15, 2025, the Unit Manager educated the Medication Aides on not signing off for catheter changes. On May 15, the Director of Nursing/Unit Manager began educating all licensed nurses on ensuring physician orders include the catheter size, as well as changing the catheter as ordered. The Director of Nursing/Unit Manager will be responsible for ensuring newly hired licensed nurses receive education during facility	

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F 690	Continued From page 5 4/04/25 by Nurse #4. 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. 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. 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. 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. 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	F 690	orientation. Contracted staff will be educated prior to their assignment. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for catheter care. The monitoring will include reviewing physician orders, administration records, and observation of catheter change. The QA monitoring will be conducted weekly x 8 weeks, then biweekly x 1 month. The Director of Nursing/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F 690	Continued From page 6	F 690		

catheter had already been obtained from the physician.

b. Resident #87 was admitted to the facility on 10/31/23 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).

Review of Resident #87's Minimum Data Set assessment dated 3/04/25 revealed the Resident was cognitively intact and had an indwelling urinary catheter.

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.

Review of Resident #87's 4/2025 Medication Administration Record revealed the last urinary catheter change was on 4/04/25.

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 initialed by a Medication Aide #1.

An interview was conducted with Medication Aide (MA) #1 on 5/14/25 at 3:28 PM. The MA explained that if she initialed 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.

On 5/14/25 at 3:40 PM an interview was

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F 690	Continued From page 7	F 690		

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.

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.

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.

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.

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

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F 690	Continued From page 8 to be changed per that order. 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.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 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). Findings included: 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	F 695	On May 14, 2025, Res #46 air intake on the back of their concentrator was vacuumed using a shop vacuum by the Maintenance Director. On May 14, 2025, the Unit Manager placed a precautionary oxygen sign outside of the storage room. On May 15, 2025, the Maintenance Director conducted an audit of current resident's concentrator air intake. Sixteen concentrators were identified, and the Maintenance Director vacuumed the air intakes. The Maintenance Director will vacuum the air intake on the back of concentrators every two weeks as part of routine maintenance.	5/17/25

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F 695	Continued From page 9 #1. 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. #2. Resident #46 was admitted to the facility on 03/12/20 with diagnoses that included dementia without behaviors, sleep apnea, and chronic respiratory failure. 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. Review of Resident #46's physician orders revealed the following physician order dated 12/22/25: - "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." 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. 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.	F 695	On May 15, 2025, the Administrator educated the Maintenance Director and Maintenance Assistant on ensuring oxygen storage rooms have precautionary signs in place. On May 15, 2025, the Director of Nursing/Unit Manager began educating licensed nurses on ensuring air filters are cleaned according to orders and any dust observed of air intake should be communicated to maintenance using TELS, the work order app. The Director of Nursing/Unit Manager will be responsible for ensuring newly hired licensed nurses receive education during facility orientation. Contracted staff will be educated prior to their assignment. The Director of Nursing/Unit Manager/Maintenance Director will monitor using a Quality Assurance tool for respiratory care. The monitoring will include reviewing physician orders for oxygen therapy, observation of resident rooms and oxygen storage rooms for precautionary signs, and air intakes on the back of concentrators. The QA monitoring will be conducted twice a week x 4 weeks, weekly x 4 weeks, then biweekly x 4 weeks. The Director of Nursing/Unit Manager/Maintenance Director will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F 695	Continued From page 10 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. 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. 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. 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.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/17/25

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F 812	Continued From page 11 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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. The findings included: 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	F 812	On May 12, 2025, the Dietary Aide disposed of open undated and expired food items noted in the walk-in and reach in refrigerator. On May 12, 2025, the Dietary Manager audited the walk-in and reach-in refrigerator, freezer, and nourishment room refrigerators for open undated and expired items. Opened undated and expired items noted were discarded. On May 12, 2025, the Regional Vice President/Dietary Manager began educating all dietary staff on labeling and dating opened or prepared food items to reflect the open/made on date, the use by	

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F 812	Continued From page 12 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. 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. 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.	F 812	date, and employee initials. The Dietary Manager will ensure all newly hired dietary staff will receive education in orientation. The Dietary Manager will inspect walk-in and reach in refrigerator, freezer and nourishment room refrigerators for open undated and expired items twice a week x 4 weeks, weekly x 4 weeks, then biweekly x 4 weeks. The Dietary Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		5/17/25

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 14 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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). Findings included: Review of the facility's undated infection control policy for Hand Hygiene revealed the staff will perform proper hand hygiene procedures to	F 880	The facility failed to implement our infection control policy when Wound Nurse did not don a gown for enhanced barrier precaution (EBP) when performing wound care for Resident #83 and #61. The Wound Nurse did not perform hand hygiene before applying clean gloves during wound care on Resident #61. On 5/14/2025, the Director of Nursing re-educated the Wound Nurse on the Enhanced Barrier Precaution and hand hygiene policy. The education included proper donning of PPE during wound care as well as proper hand hygiene after doffing gloves.	

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F 880	Continued From page 15 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. 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. 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	F 880	On 5/12/2025, the Director of Nursing conducted an audit of all residents with wounds on EBP. Twelve residents were identified. On 5/14/25, the Director of Nursing/Unit Manager began educating all licensed nurses on EBP and hand hygiene policy during wound care to include donning PPE and proper hand hygiene when doffing gloves. All newly hired licensed nurses, including agency staff, will be educated by the DON or designee during orientation. The Director of Nursing/Unit Manager/RN Supervisor will conduct observations of residents receiving wound care using a QA tool to ensure EBP and proper hand hygiene are performed. Observations will occur twice a week x 4 weeks, weekly x 4 weeks, then biweekly x 4 weeks. The Director of Nursing/Unit Manager/RN Supervisor will report the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revisions.	

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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.

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.

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.

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

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F 880	Continued From page 17 her understanding of Enhanced Barrier Precautions. 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.	F 880		