

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/19/2025
NAME OF PROVIDER OR SUPPLIER  North Pointe Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Windmill Drive Meridian, MS 39305	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a soft belt as a restraint for one (1) of seventeen (17) sampled residents, Resident #36.</p> <p>Findings included:</p> <p>A review of the facility's policy titled Physical Restraint, dated 2/20/2012, revealed, .Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Policy Interpretation and Implementation 1. Restraints will only be used after other alternatives have been tried unsuccessfully, and only with the informed consent from the resident, physician and/or responsible party .Order of Restraints Least Restrictive to Most Restrictive .Soft belts are RESTRAINTS under any circumstance .</p> <p>On 6/16/25 at 1:30 PM, during an observation, Resident #36 was observed sitting in a wheelchair with a Velcro soft belt secured across her lap. The resident was unable to remove the belt upon request.</p> <p>On 6/16/25 at 1:40 PM, during an interview with Certified Nursing Assistant (CNA) #1, she explained that the soft belt was applied to prevent the resident from sliding and falling out of the wheelchair. CNA #1 confirmed that Resident #36 could not remove the belt on her own.</p> <p>On 6/16/25 at 1:55 PM, during an interview with Registered Nurse (RN) #1, she stated that the soft belt was used to keep Resident #36 from sliding out of her high-back wheelchair and was applied each morning, removed at lunch when the resident went to bed for a nap, and then reapplied in the afternoon until bedtime. RN #1 confirmed the soft belt was released every two (2) hours to assist with toileting and peri care.</p> <p>On 6/17/25 at 11:05 AM, during an interview with the Director of Nursing (DON), she acknowledged that Resident #36 was unable to remove the soft belt upon request and confirmed the device had not been previously identified or documented as a restraint. She stated the facility would begin pre-restraint evaluations, obtain physician's orders and representative consent, ensure documentation, and provide staff in-service training on identifying and documenting restraints.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 10:50 AM, during an interview with the Administrator, she stated the soft belt was used to prevent the resident from sliding out of her wheelchair. The Administrator confirmed the resident could not remove the soft belt on request but stated the facility did not consider it a restraint because the resident lacked the mental capacity to understand or remove it.</p> <p>A record review of the admission Record revealed the facility admitted Resident #36 on 10/22/23 with current diagnoses including Alzheimer's Disease.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/12/25 revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated her cognition was severely impaired.</p> <p>A record review of Resident #36's medical record revealed there was no documentation identifying the soft belt as a restraint or supporting evaluations, orders, consent, or monitoring.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) regarding an anticoagulant medication for one (1) of 17 sampled residents reviewed for MDS accuracy, Resident #2.</p> <p>Findings included:</p> <p>A review of the facility's policy titled MDS Assessment, dated 5/2006, revealed, .It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol .The facility will follow directions per federal and state guidelines for resident assessment protocol and will refer to the MDS RAI manual .</p> <p>A review of the Resident Assessment Instrument (RAI) Manual 3.0, Version 1.19.1, dated October 2024, revealed, .N0415: High-Risk Drug Classes .Do not code antiplatelet medications such as aspirin .as N0415E, Anticoagulant .</p> <p>A record review of Resident #2's admission Record revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease and Hypertension.</p> <p>A record review of the Order Summary Report with active orders as of 5/1/25 revealed Resident #2 had a Physician's Order, dated 1/10/2024, for Aspirin EC (Enteric Coated) Tablet Delayed Release 81 milligrams (mg), one tablet by mouth daily for Essential (Primary) Hypertension. There were no active orders for an anticoagulant medication.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section N0415 was coded to indicate that the resident received an anticoagulant medication.</p> <p>On 6/18/25 at 9:12 AM, during an interview and record review with Registered Nurse (RN) #3, she reviewed the physician's orders and the MDS dated [DATE] for Resident #2 and confirmed the resident was not on an anticoagulant medication during the MDS lookback period. RN #3 acknowledged the MDS had been coded in error and explained that the resident was receiving aspirin, which should have been coded as an antiplatelet.</p> <p>On 6/19/25 at 12:15 PM, during an interview with the Administrator and the Director of Nursing (DON), they both confirmed that their expectation was for all MDS assessments to be coded accurately to reflect each resident's condition and treatment.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, staff interview, record review, and the facility policy review, the facility failed to implement a care plan for enhanced barrier precautions (EBP) by failing to wear the proper Personal Protective Equipment (PPE) while providing care for one (1) of 17 resident care plans reviewed. Resident #2</p> <p>Findings include:</p> <p>A record review of the facility's policy Care Plans- Comprehensive dated 10/2016 revealed . An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychological needs is developed for each resident . Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level functioning the resident may be expected to attain .</p> <p>A record review of Resident #2's Comprehensive Care Plan revealed an individual care plan initiated 4/1/24, Focus .has abscess to right buttock and is receiving wound care .Interventions .Use EBP When: Dressing/Bathing, Transferring, Changing Linens, Assisting With Toileting/Incontinence Care, Accessing Indwelling Medical Devices, Providing Wound Care, Any Other High-Contact Resident Care Activities .</p> <p>A record review of Resident #2's admission Record revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease.</p> <p>A record review of the Order Summary Report with active orders as of 6/18/25 revealed a Physician's Order, dated 5/20/25, for Enhanced Barrier Precautions (EBP) related to a history of ESBL (Extended Spectrum Beta-Lactamase) resistance infection.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section H indicated the resident was always incontinent of bowel and bladder.</p> <p>During an observation on 06/18/25 at 09:55 AM, Certified Nurse Aide (CNA) #2 provided incontinence care to Resident #2 without wearing a gown as required by EBP.</p> <p>During an interview on 06/18/25 at 11:50 AM, CNA #2 explained the green sticker by the resident's name on the door indicated she required EBP and she confirmed that she did not wear a gown while providing incontinence care. She stated the PPE that is required for a resident on EBP includes gloves and a gown.</p> <p>During an interview on 06/19/25 at 10:45 AM, Registered Nurse (RN) #2 explained the purpose of the care plan is for the staff to know how to care for the residents per the physician orders. She expects all staff to follow the care plans while providing care for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/19/25 at 11:20 AM, the Director of Nursing (DON) explained she expects all staff to follow EBP as ordered and care planned to protect the resident and the staff members from any spread of infections.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to implement an ongoing resident-centered activities program that incorporated the resident's interests for one (1) of seventeen (17) sampled residents, Resident #22.</p> <p>Findings included:</p> <p>A review of the facility's policy titled Activity Program, dated 1/21/22, revealed: .An ongoing program of activities is designed to meet the needs of each resident . Policy Interpretation and Implementation 1. Our activity program is designed to encourage restoration to self-care and maintenance of normal activity which is geared to the individual resident's needs. 2. Activities are scheduled daily . 3. Our activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident . 7. Residents are encouraged, but not forced, to participate in scheduled activities .</p> <p>A review of the facility's document titled Resident Behavioral Objectives, undated, revealed: .Stimulate resident curiosity and alertness through meaningful activities .</p> <p>On 6/16/25 at 1:32 PM, during an observation on the 200 Hall, Resident #22 was observed sitting in her room with her chair facing the window. She was confused and unable to speak but attempted to smile and express words. There were no organized activities occurring at the time.</p> <p>On 6/16/25 at 1:38 PM, during an observation, a daily activity schedule was posted, listing rest and digest at 1:00 PM and group activity and snacks at 2:00 PM. However, there was another activity calendar, a monthly calendar for June 2025 that indicated ball toss was scheduled at 10:00 AM and bowling at 2:00 PM. These calendars were located at the station on the hall.</p> <p>On 6/17/25 at 2:01 PM, during an observation in the main dining room, several residents were participating in a bowling activity. The monthly calendar for June that was posted indicated movie and popcorn at 10:00 AM and Bingo at 2:00 PM.</p> <p>On 6/17/25 at 2:16 PM, during an observation, Resident #22 was observed sitting in her chair in her room, almost asleep, and smiled when spoken to.</p> <p>On 6/17/25 at 2:30 PM, during an observation on the 200 Hall, three (3) staff were sitting with residents in the common area. A snack tray with lemonade and water and boxed snack cakes was observed at the nurse's station. No activities were occurring.</p> <p>On 6/17/25 at 2:40 PM, during an interview with Certified Nurse Aide (CNA) #3, she stated there was no set activity schedule on the hall. She explained the three (3) CNAs just wing activities and Resident #22 rarely comes out of her room or participates. CNA #3 added that when the resident's family visits, they may take her outside, but this is not often, and no daily routine is followed.</p> <p>On 6/17/25 at 2:50 PM, during an interview with CNA #4, she stated she had done puzzles and coloring activities earlier and had taken some residents to the theater room for popcorn. She confirmed that Resident #22 did not participate in those activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/25 at 2:55 PM, during an interview with CNA #5, she stated that although most staff on the unit were consistent and tried to provide activities daily, there was no consistent activity schedule followed. She stated some residents participate in facility-wide activities, but Resident #22 does not, unless accompanied by family.</p> <p>On 6/18/25 at 7:30 AM, during an observation, Resident #22 was observed dressed and sitting in a bedside chair facing the window.</p> <p>On 6/18/25 at 10:00 AM, during an observation, Resident #22 remained in her room, with no staff interaction observed. Six (6) residents were in the common area. At 10:06 AM, CNA #3 initiated ring toss with residents. Another CNA was giving a shower, and the third CNA was off the unit. Resident #22 remained in her room, uninvolved. The posted schedule listed group activity/devotion at 10:00 AM, while the main activity schedule listed card games.</p> <p>On 6/18/25 at 11:05 AM, during an observation, six (6) residents were watching TV with CNA #3. Licensed Practical Nurse (LPN) #2 entered to perform a blood sugar check. Resident #22 remained in her room with no staff interaction observed. During an interview, LPN #2 stated she did not stay on the unit and rarely saw Resident #22 involved in activities.</p> <p>On 6/18/25 at 11:55 AM, during an observation, Resident #22 was assisted to the dining room. At the nurse's station, three different activity schedules were observed. CNA #3 stated she was unsure why there were multiple colors and thought they were just for decoration. She said the schedules were for ideas and were not followed or updated.</p> <p>On 6/18/25 at 2:20 PM, during an observation, Resident #22 remained in her room while three (3) CNAs were in the common area with other residents.</p> <p>On 6/18/25 at 3:15 PM, during an interview with CNA #6, she stated she worked the 200 Hall evening shift with three (3) CNAs. She said the nurse checks in periodically. Resident #22 comes out occasionally but mostly stays in her room watching TV. CNA #6 stated there was no set evening activity schedule.</p> <p>On 6/19/25 at 10:23 AM, during an interview with the Director of Nursing (DON), she stated Resident #22 had experienced a decline and was less active. She acknowledged not being aware that Resident #22 had no activity interaction and stated staff were expected to encourage interactions. The DON acknowledged that residents with dementia need consistency and confirmed that several daily schedules were available on the unit and expected to be followed to promote interaction.</p> <p>On 6/19/25 at 12:20 PM, during an interview with the Administrator, she stated her expectation was for all residents to have the opportunity and encouragement to participate in scheduled activities.</p> <p>A record review of the admission Record revealed the facility admitted Resident #22 on 3/4/25 with diagnoses including Unspecified Dementia.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/25 revealed Section B0700 indicated the resident rarely or never had the ability to express ideas or wants and only sometimes understood others. Section C revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident's cognition was severely impaired. Section F noted that very important activities included having books, newspapers, and magazines to read, listening to music, and going outside for fresh air when weather permitted. Other somewhat important preferences included being involved in group activities and doing favorite pastimes.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 observation and staff interview, and facility policy review the facility failed to ensure a dietary staff member wore a hair restraint (beard) while checking food temperatures and preparing meal trays in the food service area, during one (1) of two (2) kitchen observations.</p> <p>Findings included:</p> <p>A review of the facility's document titled Personal Hygiene, dated 2010, revealed, Hair Care. Hair completely restrained including beard restraints .</p> <p>On 6/17/25 at 10:50 AM, during an observation and interview in the kitchen, the Certified Dietary Manager (CDM), who had a beard and mustache, was observed checking food temperatures and preparing resident trays in the food service area without wearing a beard restraint. The CDM acknowledged he was not wearing a hair restraint for his facial hair while handling the food. He confirmed that failing to cover facial hair could result in physical contamination of food. He stated he would begin wearing his beard restraint whenever handling food.</p> <p>On 6/19/25 at 7:50 AM, during an interview with the Administrator, she acknowledged the CDM had not been wearing a beard restraint while in the food service area. The Administrator stated she was aware that the CDM did not wear a hair restraint when checking the food temperature and preparing meal trays and she expected all dietary to wear hair restraints as required.</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>Based on observation, interview, record review, and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) when a Certified Nurse Aide (CNA) did not wear a gown while providing incontinent care for one (1) of two (2) residents reviewed for care, Resident #2.</p> <p>Findings included:</p> <p>A review of the facility's policy titled Enhanced Barrier Precautions, revised 8/7/24, revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Definitions: 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and gloves use during high contact resident care activities .Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC (Centers for Disease Control) .4. High-contact resident care activities include: .d. Providing hygiene .f. Changing briefs or assisting with toileting .</p> <p>On 6/18/25 at 9:55 AM, during an observation, CNA #2 provided incontinent care to Resident #2, who was incontinent of bowel and bladder. CNA #2 did not wear a gown during the care.</p> <p>On 6/18/25 at 11:50 AM, during an interview with CNA #2, she confirmed that the green sticker by the resident's name indicated EBP. She acknowledged that she did not wear a gown or gloves during the care and confirmed that Personal Protective Equipment (PPE) was required to protect the resident from infection.</p> <p>On 6/18/25 at 12:05 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that the facility continued EBP for Resident #2 due to a history of frequent urinary tract infections with ESBL (Extended Spectrum Beta-Lactamase). She reported that staff had been educated and had completed incontinence care check-offs. She stated staff were expected to follow EBP at all times when providing care.</p> <p>On 6/19/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she stated she expected all staff to follow EBP as ordered to protect both the resident and staff from the spread of infection.</p> <p>A record review of Resident #2's admission Record revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease.</p> <p>A record review of the Order Summary Report with active orders as of 6/18/25 revealed a Physician's Order, dated 5/20/25, for Enhanced Barrier Precautions (EBP) related to a history of ESBL resistance infection.</p> <p>A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section H indicated the resident was always incontinent of bowel and bladder.</p>		