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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olivet Careview Home	5517 Lyndale Avenue South Minneapolis, MN 55419

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 1 resident (R14) reviewed for dignity related to unwanted facial hair. Findings include: R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had severe cognitive impairment and diagnoses of peripheral vascular disease (reduced circulation of blood to a body part, such as arms or legs, due to a narrowed or blocked blood vessel), diabetes mellitus, arthritis, dementia, anxiety disorder, depression, and psychotic disorder. R14 had delusions and no behaviors or rejection of cares. R14 required substantial and/or maximal assistance for personal hygiene, which included combing hair, shaving, washing and/or drying face. R14's care plan intervention dated 11/1/22, indicated R14 preferred to be shaved when hair present as needed. R14's care plan did not indicate refusals of care. During observation on 1/13/25 at 1:34 p.m., R14 laid in bed and hair on chin was observed. During interview on 1/14/25 at 10:38 a.m., family member (FM)-B stated R14 preferred to be shaved and felt better when they didn't have long hairs on their chin. FM-B stated they brought a shaver with when they visited R14 and assisted R14 with shaving. During observation on 1/15/25 at 9:01 a.m., R14 was in their wheelchair in the dining area and had 15 or more grayish colored hairs approximately a half inch or longer on their chin. During interview and observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-K stated residents' preferences to be shaved or not, or if they refused, would be in the care plan. NA-K stated they did not work with R14 often, but R14 let staff know what they did or did not want done. NA-K approached R14 and asked if R14 would allow NA-K to shave them. R14 consented, and NA-K went to find a shaver. NA-K brought R14 to their room and shaved R14. During interview on 1/15/25 at 1:32 p.m., NA-L stated they helped transfer R14 that morning, but the night shift dressed R14. NA-L stated staff shaved residents on their shower day and was not sure when R14's shower day was. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/16/25 at 11:04 a.m., registered nurse (RN)-E stated residents' care plans directed whether they wanted to be shaved or not. RN-E stated R14 was already up most of the time when RN-E started their shift. RN-E stated if the staff on the night shift did not shave R14, the morning shift should shave R14. RN-E stated cares were 24 hours and not being shaved could impact R14's dignity. During interview on 1/16/25 at 1:06 p.m., RN-C stated residents' care plan reflected whether they wanted to be shaved or not. RN-C stated they tell staff to shave all female residents unless they specified they did not want to be shaved. RN-C expected staff on night shift to shave R14 if they got them up in the morning, but any shift could shave R14 as long as it got done. RN-C stated R14 told staff if they did not want something done and thought staff should be able to shave R14. RN-C stated keeping R14 shaved impacted R14's appearance and dignity and was part of keeping R14 clean, happy, and looking nice. During interview on 1/16/25 at 2:46 p.m., the director of nursing (DON) expected staff to offer to shave if care planned and hair visible. If the resident refused, staff should notify the nurse and they resident should be reapproached. DON stated a reasonable person would not want to have facial hair and was a dignity issue. The facility's policy ADL [activities of daily living] Completion / Cares revised 1/11/23, directed staff to be familiar with residents plan of care and follow the care plan. ADL tasks included bathing, dressing, grooming, and oral care. The policy directed staff to treat residents with respect and dignity during cares.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49617

Based on observation, interview and documentation review, the facility failed to comprehensively assess for safety to determine if self-administration of medication was appropriate for 1 of 2 residents (R77) reviewed for self-administration of medication (SAM).

Findings include:

R77's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and diagnoses of heart failure, high blood pressure, multiple sclerosis (a chronic disease that damages the central nervous system, including the brain, spinal cord, and optic nerves), and muscle weakness.

R77's medication administration record (MAR) dated 1/14/25, reflected the following administered medications:

- ascorbic acid oral tablet, Give 1000 mg by mouth one time a day for health care maintenance, dated 8/26/24.

- cholecalciferol oral tablet, Give 4000 unit by mouth one time a day for Vitamin D def [sic], dated 10/10/23.

- docusate sodium oral tablet, Give 100 mg one time a day for constipation, date 9/28/23.

- furosemide oral tablet, Give 20 mg by mouth one time a day for edema (swelling), dated 9/13/23.

- potassium chloride oral tablet Extended Release (ER), Give 100 milliequivalents (mEq) by mouth two times a day, for low potassium levels, dated 9/13/23.

During observation on 1/14/25 at 8:52 a.m., during R77's morning medication pass, trained medication assistant (TMA)-A stated she was alert and takes her medications by herself. TMA-A verified each medication in the morning pass against R77's MAR and placed the potassium chloride tablets into a separate cup per R77's preference. TMA-A walked to her room and introduced self and surveyor, provided the medication cups to R77, and stated, I will be back to check on you, before leaving the room without ensuring she had taken the medications. Back at the medication cart, TMA-A stated SAM orders were usually written in the MAR for residents, and showed an example from an unidentified resident's chart who had an order for ok to crush medications. TMA-A stated if a resident could take their own medications and had a SAM, it would show up on the MAR like the unidentified resident's MAR. TMA- A was unsure where a SAM assessment was located and indicated the nurse manager would be responsible for assessing a resident's safety to take medications. TMA-A located a physician's order, dated 11/8/23, indicating ok to self administer [sic] medications after set up and stated, registered nurse (RN)-A told me it was written in the care plan, and I just take her word for that.

A self-administration of medications assessment dated [DATE] indicated R77 did not wish to self-administer any of her medications.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Self-administration of medications assessments dated 5/18/24, and 8/9/24, both identified she wished to self-administer oral medications and had a current order to self-administer medications. The assessment lacked documentation on if R77 could state the name and use of each medication; the correct dosage, route, and time of administration; state if she was experiencing any side effects; and if the interdisciplinary team (IDT) deemed her safe to SAM. R77's care plan dated 7/11/24, identified her preference to SAM with a goal to have her preferences respected and followed. The care plan indicated a test was passed and order to self administer [sic] was placed in chart. During interview on 1/16/25 at 9:12 a.m., RN-A, also the long-term care (LTC) nurse manager, stated the process for residents who wish to SAM was to first assess the resident for safety and if they were deemed successful, an order would be obtained and placed into the chart and the resident's care plan would be updated. RN-A stated staff should not leave oral medications in a resident's room if a resident does not have a SAM and order in place. RN-A stated there had been an error on R77's SAM assessment dated [DATE] and the nurse meant to enter yes instead of no. RN-A explained there had been conversations with R77 about her medications and she knows her medications and she understands the meds she gets. RN-A reviewed R77's previous SAM assessments dated 8/9/24 and 5/18/24 and confirmed they lacked documentation if she was safe to SAM. RN-A stated the importance of assessing a resident's safety to SAM was to make sure they understood the implications of their medications, and to ensure we aren't leaving medications with residents who could potentially hide or stockpile them. Per interview on 1/16/25 at 3:23 p.m., the director of nursing (DON) expected the SAM assessment to be completed by checking the box if it was safe or not for the resident to SAM because that was what drove the order from the physician, and if it was not checked, we wouldn't have the order. Per facility policy titled Self Administration of Medication revised 7/3/19, it was the responsibility of the IDT to determine if a resident was safe to self-administer drugs, and the determination would be made would be made before the resident exercised that right. The policy guided nursing staff to complete Self Administration of Medication Data Collection (SAM) for Self-Administration of Medication if/when a resident indicated a desire to do so or when staff identified the need for the resident to be assessed. The policy indicated the assessment must include the resident was competent and safe to proceed with the self-administration of medications before proceeding.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure food preferences were honored for 1 of 2 residents (R76) reviewed for food choices. Findings include: R76's annual Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and did not have weight loss or gain of during the lookback period. The MDS identified his diagnoses of high blood pressure, diabetes, high cholesterol, and Parkinson's disease (a chronic brain condition that causes movement problems, such as stiffness and tremors). R76's Care Area Assessment (CAA) dated 12/5/24, triggered for nutritional status and identified his potential nutritional problem. The CAA indicated the objective was to avoid complications and minimize risks and guided staff to the care plan. The CAA lacked resident-specific documentation regarding efforts to avoid complications and minimize his risks. R76's care plan revised on 12/5/24, identified his potential nutritional problem and guided staff to provide his diabetic diet as ordered and it was OK to request regular foods if desired. Additionally, the care plan identified he should be served the same breakfast items every day, which included Greek yogurt, oatmeal with brown sugar, toast, orange juice and coffee, unless otherwise preferred. The care plan included his preference for an evening snack of vegetables, however, lacked documentation on his preferences for larger or double portions at meals. A quarterly nutrition assessment for the lookback period of 9/6/24 through 9/12/24, encouraged staff to continue to provide, offer and encourage meals and snacks as scheduled and throughout the day if indicated or requested. An annual nutrition assessment for the lookback period of 11/29/24 through 12/5/24, indicated R76 should have assorted raw vegetables with ranch for an evening snack every day. The assessment reported he believed he was not eating enough vegetables, which is why the snack was added and staff were encouraged to continue to provide, offer and encourage meals and snacks as scheduled and throughout the day if indicated or requested. A care conference summary note dated 9/26/24, indicated R76 expressed he was not getting the food he ordered at meals and the dietitian will follow up with kitchen director. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During dining observation on 1/13/25 at 6:41 p.m., R76's meal ticket indicated he should be served double portions of the broccoli, tilapia, and mashed potatoes. He was served a bowl of broccoli and tilapia but no mashed potatoes. R76 stated he did not believe the fish was a double portion and was unsure about the broccoli. Culinary aid (CA)-A confirmed R76 was not served mashed potatoes and should have been as indicated on his meal ticket. CA-A stated the broccoli was a double portion and the fish was two smaller pieces and considered it double portion. CA-A stated staff were aware of a resident's menu preferences or special diet by what was identified on the meal ticket as well as during department meetings. CA-A stated residents who had double portions on their meal tickets, like R76, would be served the double portions right away and would not have to request the second portion, and said if the unit ran out of food, staff only needed to call down the main kitchen for more food. During dining observation on 1/14/25 at 9:35 a.m., R76 did not receive the apple fritter he ordered for breakfast along with the usual items he requested. An unidentified nursing assistant (NA) answered his call, verified the missing pastry, and called the kitchen for the missing item. During dining observation on 1/16/25 at 1:09 p.m., R76 was served his meal and was missing mandarin oranges, which was marked on his meal ticket. Licensed practical nurse (LPN)-A verified the missing item and that it was marked on his meal ticket. LPN-A stated, he should have gotten the oranges. I spoke with the nursing assistant, and he said it was a mistake, it was missed. I educated him that we should be checking the trays. During interview on 1/16/25 at 9:43 a.m., R76 stated he was not served a double portion of chicken at the previous supper meal and was not served mashed potatoes, rather tater tots. He stated the portions were not enough for him and he still felt hungry after supper. During interview on 1/16/25 at 3:20 p.m., the director of nursing (DON) stated the dietitian interviewed residents and their representatives about their food and menu preferences and was able to update the care plan, meal tickets and resident profiles. The DON expected staff to follow a resident's plan of care, including a resident's care planned preferences. Per facility policy titled Person-Centered Care Planning revised 6/26/19, each resident would be assessed for their individual risk factors, strengths, goals, interventions, and outcomes at the time of admission and throughout their stay, and these would be identified on the care plan. The policy guided the interdisciplinary team (IDT) to collect data via various assessments to contribute to the development of the comprehensive care plan. The policy indicated the care plan would be reviewed throughout the resident's stay and as required for the MDS assessment, as well as at a care planning conference with the resident and their representative. Furthermore, the policy indicated interventions should be written to help meet the goal and they should be individualized to the resident and be person-centered.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to develop and implement a comprehensive and resident-specific care plan for 1 of 1 residents (R76) reviewed for urinary tract infections. Findings include: R76's annual Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition, was occasionally incontinent of urine and used an external catheter. The MDS identified his diagnoses of high blood pressure, benign prostatic hyperplasic (BPH, a condition that causes the prostate gland the enlarge), diabetes, Parkinson's disease (a chronic brain condition that causes movement problems, such as stiffness and tremors), and a history of urinary tract infections (UTIs). R76's Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 12/5/24, identified he had a history of chronic UTIs and was followed closely by Urology and indicated his urinary incontinence would be addressed in his care plan. R76's care plan, revised 10/4/23, lacked documentation pertaining to his history of chronic UTIs and interventions identifying resident-specific treatment preferences, including his preference to exclude the antibiotic Macrobid since he stated that antibiotic did not work to treat his UTIs. A provider progress note dated 7/29/24 indicated R76 was seen for a telehealth visit and the Macrobid antibiotic was stopped due to the consideration of a possible chronic prostatis component. The recommendation under the assessment and plan was to treat with Cipro (another type of antibiotic) and consider taking a probiotic. During interview on 1/14/25 at 9:24 a.m., R76 stated he had chronic UTIs and was working with Urology for ongoing management. He stated he had multiple UTIs while staying in the facility and believed his medical record reflected his preference to avoid Macrobid, but a recent UTI with three doses of Macrobid made him question if staff were aware. R76's medication administration record (MAR) dated 1/25 reflected the following order administrations: - Macrobid oral capsule 100 milligrams (mg) Give 100 mg by mouth two times a day for UTI for 5 days, dated 1/9/25, discontinued 1/10/25. - Keflex oral capsule 500 mg, Give 500 mg by mouth two times a day for UTI for 5 days, dated 1/10/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/16/25 at 1:00 p.m., family member (FM)-A verified ongoing conversations with the facility about R76's chronic UTIs and treatment preferences to avoid Macrobid. Per FM-A, the facility started R76 on Macrobid in July and it just didn't work, he gets weaker and weaker. I told them back in the summer it just doesn't work but the Keflex does. FM-A stated when the facility wanted to start him on Macrobid in the beginning of January, I told him, 'you go tell the charge nurse or manager that Macrobid just doesn't work.' During interview on 1/16/25 at 3:13 p.m., the director of nursing (DON) reviewed R76's electronic health record (EHR) and verified his admission diagnosis of chronic UTIs. The DON expected his care plan to include documentation pertaining to his history of UTIs and confirmed the care plan lacked this documentation. Per facility policy titled Person-Centered Care Planning revised 6/26/19, each resident would be assessed for their individual risk factors, strengths, goals, interventions, and outcomes at the time of admission and throughout their stay, and these would be identified on the care plan. The policy guided the interdisciplinary team (IDT) to collect data via various assessments to contribute to the development of the comprehensive care plan. The policy indicated the care plan would be reviewed throughout the resident's stay and as required for the MDS assessment, as well as at a care planning conference with the resident and their representative.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview, and document review, the facility failed to identify pressure injury, and/or provide preventive care consistent with care planned interventions for residents at risk for pressure injuries for 2 of 5 residents (R28, R45) reviewed for pressure ulcers. Findings include: Pressure ulcer or pressure injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury looks like intact skin and may be painful. A pressure ulcer will look like an open area, the appearance of which will vary depending on the stage and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue. R28's annual Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment with verbal behaviors direct towards others reported 1 - 3 days during the lookback period. These were not identified as putting the resident at risk for physical injury and did not interfere with the resident's care. No other behavioral symptoms or rejection of care was reported on the MDS. The MDS indicated R28 required substantial to maximal assistance with bed mobility and was totally dependent on staff for personal and toileting hygiene. The MDS identified diagnoses of heart failure, high blood pressure, coronary artery disease (when arteries that carry blood to the heart narrow), peripheral vascular disease (when blood vessels outside the heart narrow or become blocked, causing circulation problems), diabetes, dementia (a condition that causes a decline in thinking, memory, and reasoning), anxiety, and depression. Furthermore, the MDS identified R28's risk of developing pressure ulcers and listed preventive treatments in place, including a pressure reducing device for the chair and bed, a turning and repositioning program, application of ointments and medications, and nutrition and hydration inventions. R28's Care Area Assessment (CAA) for pressure ulcer/injury dated 11/28/24, identified high risk for skin breakdown and indicated he had a history of pressure injuries. The CAA directed staff to his care plan to minimize risks. A Braden Scale for predicting pressure sore risk assessment dated [DATE], evaluated R28 and placed him at moderate risk. A weekly skin check assessment dated [DATE] indicated R28's skin was assessed and had no new skin issues noted. A weekly skin check assessment dated [DATE] indicated R28 had an open coccyx area and irritation to the scrotum. R28's undated order summary printed 1/16/25, included the following orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor wound daily coccyx signs/symptoms of infection, need for PRN dressing change, and pain. Update provider as needed, every day and evening shift, dated 1/3/25. - Reposition every 2 hours for wound healing, dated 11/01/24. - Resident to lay down after break fast [sic] and after lunch to get checked and changed and to off load [sic]. Staff to lay resident side to side to reposition. Document refusals and update nurse manager, two times a day, dated 11/4/24. - Wound: R ischial tuberosity: Cleanse with vashe, pat dry, secure with allevyn dressing. Apply thin layer of calmoseptine to surrounding area of moistures associated skin breakdown, one time a day. Update nursing manager and provider if worsening, dated 1/3/25. Per R28's care plan revised 12/9/24, he had a potential for alteration in skin integrity due to his mobility dependence, diabetes, bowel and bladder incontinence, medication usage, obesity, and peripheral vascular disease (PVD). The care plan identified an open area to his right inner buttock/coccyx on 11/1/24 that resolved on 11/12/24 and an open area to his left rear thigh that was resolved with an unknown date. The care plan identified a goal to keep his skin intact by directing staff to lay the resident down after breakfast and lunch to get checked and changed and to offload side to side. The care plan guided staff to document and report any refusals to the charge nurse. Additionally, the care plan directed staff to turn and reposition R28 every 2 hours for wound healing and re-approach and re-educate of risks and benefits if he refused. R28's kardex printed 1/16/25, indicated he was to lay down after breakfast and lunch to get checked and changed and to offload. A task record dated 1/2025, reflected the order to lay R28 down after breakfast and lunch for wound healing and lacked documentation for the dates 1/2/25, 1/4/25, 1/10/25, 1/12/25, and 1/14/25. A PointofCare (POC) task sign-off with a lookback period from 12/18/24 - 1/15/25, for the task to lay the resident down after breakfast and after lunch to get checked and changed and to offload lacked documentation for the dates of 1/2/25, 1/4/25, 1/10/25, 1/12/25, and 1/14/25. R28's progress notes were reviewed on 1/16/25, and lacked documentation of refusals to be offloaded, repositioned, or checked/changed. A progress note dated 11/4/24, indicated staff discussed the risks and benefits of repositioning, offloading and incontinence cares for wound healing due to history of noncompliance. The progress note indicated R28 responded and stated, I will do as you said because I want the wound to heal. During observation on 1/15/25 at 9:01 a.m., R28 was sitting in his wheelchair in the dining room for breakfast and had a clothing protector on. During observation on 1/15/25 at 11:26 a.m., R28 was sitting in his wheelchair in the lounge area participating in activities. During observation on 1/15/25 at 11:58 a.m., R28 was sitting in his wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/15/25 at 2:12 p.m., NA-H confirmed working with R28 that shift and stated R28 laid down about 9 and was seen by the wound nurse during rounds before they assisted him to get back up for lunch. NA-H stated it was important to help him reposition every 2-3 hours to protect the safety of his skin, and if he refused to lay down, we would document that. NA-H stated they also re-approach if a resident refused repositioning, because we want to keep trying to help them. During continuous observation on 1/16/25 between 8:42 a.m. and 1:41 p.m., R28 remained upright in his wheelchair and was not offered to offload or reposition. The following observations were made: - 8:42 a.m.: R28 was sitting in his wheelchair at the dining room table for breakfast. - 9:58 a.m.: R28 was sitting in his wheelchair in the lounge area participating in group activities. - 11:11 a.m.: R28 remained in the lounge area for group activities, his condition unchanged. - 11:44 a.m.: Activities (A)-A pushed R28 in his wheelchair out of the lounge area and offered him a choice of going back to his room or the dining room. R28 requested to sit in the dining room. Per interview with (A)-A, R28 did not leave the group throughout the morning. He was sitting here with us through both morning activities. - 12:01 p.m.: Nursing assistant (NA)-A and NA-B brought other residents into the dining room and NA-B set up the dinging room tables for the noon meal. There was no offer to reposition or offload R28. - 12:15 p.m.: NA-B stood beside R28 and discussed the newspaper he was reading. NA-B did not offer to reposition, check and change or offload R28. - 12:28 p.m.: NA-E walked over to R28's table and asked him what he wanted to eat for lunch. NA-E took his lunch order and walked away without offer to reposition or offload him. - 12:45 p.m.: Various staff served meals to residents in the dining room, brought trays to residents in their rooms, and answered call lights. R28's condition remained unchanged. - 12:53 p.m.: NA-B assisted another resident with ambulation in the hallway adjacent to the dining room. R28's condition remained unchanged. - 1:33 p.m.: R28's condition remained unchanged. - 1:36 p.m.: Per interview with R28, he had been up all morning and had not laid down since he woke up. He stated he was feeling a little tired now. - 1:41 p.m.: NA-A, trained medication assistant (TMA)-B, and NA-C brought R28 to his room and told him they were going to lay him down in bed and he replied, very, very soon. NA-A, NA-C, and TMA-B assisted R28 with incontinence cares and R28 stated he had very little soreness to his backside. The dressing on his coccyx was not intact, and the nursing assistants left the bedside to notify the charge nurse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mount Olivet Careview Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5517 Lyndale Avenue South Minneapolis, MN 55419	

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- 2:03 p.m.: licensed practical nurse (LPN)-A and registered nurse (RN)-B, who was also the long-term care nurse manager, entered the room and approached R28's bedside. RN-B confirmed R28 should be offloaded after breakfast and lunch to promote skin integrity as indicated on his care plan. RN-B confirmed being involved in wound rounds on 1/15/25 and denied seeing R28. RN-B stated he was not on the wound rounds list. RN-B assessed R28's coccyx and stated the area was reddened but blanchable and explained he had a previous pressure ulcer to the area that healed and has some tenderness. RN-B assessed and found no open areas to R28's coccyx and stated they would still protect the area with barrier cream.

Per subsequent interview on 1/16/25 at 2:03 p.m., LPN-A stated assessed R28's coccyx during morning cares and stated the area was not open as previously documented in the skin assessment dated [DATE]. LPN-A stated there had not been time to discontinue the previous wound orders or enter a progress note or new skin assessment from the morning.

During interview on 1/16/25 at 3:09 p.m., the director of nursing (DON) stated residents are assessed for their risk for skin breakdown and if identified to be at risk, interventions to reduce their risks are care planned and put on the kardex. The DON expected staff to read the kardex before caring for residents and expected intervention to be implemented. The DON stated the implications for not following interventions to reduce the risk of skin breakdown included putting a resident at risk for skin breakdown or a worsening of skin breakdown.

48299

R45's admission Minimum Data Set (MDS) dated [DATE], indicated R45 was cognitively intact, had delusions, daily behavioral symptoms not directed toward others (such as scratching self, rummaging, throwing or smearing food or bodily wastes, or screaming), and did not reject cares. R45 required partial and/or moderate assistance with toileting hygiene, substantial and/or maximal assistance with upper body dressing, and was dependent for lower body dressing and footwear. R45 needed partial and/or moderate assistance with rolling left and right and other mobility. R45 had diagnoses which included hypertension (high blood pressure), coronary artery disease (narrowing or blocking of coronary arteries, which supplies oxygen-rich blood to the heart), peripheral vascular or arterial disease (blood vessels narrow or become blocked and reduces blood flow to the body), arthritis, anxiety, depression, psychotic disorder, and schizophrenia. R45 was at risk for pressure ulcers and did not have any pressure ulcers. R45 was to have a pressure reducing device for chair, pressure reducing device for bed, and turning and/or repositioning program.

R45's Braden scale (a tool used to assess a patient's risk of developing pressure ulcers, or pressure injuries) dated 11/19/24, indicated a score of 16, which indicated R45 was at risk to develop a pressure area.

(continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's care plan printed 1/15/25, indicated R45 had a care focus area of Mobility/Ambulation, which was revised 11/11/24, and indicated R45 required assistance for positioning, locomotion, and transfers. An intervention indicated R45 required assistance to turn and reposition every two to three hours and as needed, and assistance of two staff with bed mobility. The care plan indicated R45 had potential for pressure ulcer development related to morbid obesity, anemia, peripheral vascular disease, osteoporosis, incontinence, and limited mobility, and was revised on 11/18/24. Interventions included daily skin observation with cares and report new or worsening concerns to nurse immediately, house lotion to dry skin with cares as needed, inform resident/family/caregivers of any new area of skin breakdown, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bath or daily care, pressure reducing and/or relieving cushion in wheelchair and/or chair, and pressure reducing and/or relieving mattress. R45's Weekly Skin Check assessment dated [DATE], indicated R45's skin color, turgor, and temperature where within normal limits and noted a bruise on the back of R45's right arm and red area on R45's right knee. During observation on 1/15/25 at 10:36 a.m., R45 was in bed with no pants or incontinence product and nothing on their feet. Nursing assistant (NA)-I entered the room and started to assist R45 with incontinence cares, covered R45 with linen, and left to get another staff member. At 10:44 a.m., NA-I and NA-L assisted R45 to get pants on. When NA-I and NA-L assisted R45 to roll in bed, an area of purplish to reddish discoloration was observed on R45's right heel. NA-I- and NA-L assisted R45 to sit up on the side of the bed and applied R45's shoes without socks. NA-L removed R45's shoes when prompted, and NA-I and NA-L stated they had not seen the discolored area before. NA-L went to get a nurse when prompted. Registered nurse (RN)-C entered R45's room and observed the area. R45 stated their right heel did not hurt when asked. RN-C asked if staff could assist R45 to put socks on and R45 declined socks. NA-I could not find socks in R45's room. RN-C gathered supplies to take a picture, measure, and dress the discolored area. RN-C stated R45's right heel felt boggy, took a picture of the area through a wound app, applied skin prep on both of R45's heels, and placed a 3M Tegaderm dressing on R45's right heel. Staff found and applied shoes without a backing which slipped on instead of the shoes R45 wore previously which had a heel backing. R45's Skin and Wound Evaluation on 1/15/25 at 10:59 a.m., indicated R45 had a deep tissue injury on the right heel. The length was measured as 1.9 cm by 2.3 cm, had no signs on infection, and surrounding tissue was calloused, dry/flaky, fragile, intact, and normal in color and temperature. The wound note indicated R45's shoes were snug to the area and staff requested R45's responsible party bring different shoes. Other interventions included air mattress, repositioning, and foam boots in bed. The nurse practitioner, therapy, and dietician were notified. During interview on 1/15/25 at 1:25 p.m., NA-L stated they normally did not dress R45 and mostly helped R45 to the bathroom and had not noticed the discolored area before. NA-L stated they reported skin concerns to the nurse if they observed an area of concern while helping residents with showers and other cares. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/15/25 at 1:57 p.m., RN-F stated they assessed, treated and covered if needed, documented, and measured new skin concerns. RN-F stated they would notify the charge nurse, family, and doctor. RN-F was not aware of R45's skin discoloration on their right heel. RN-F stated nurses document skin assessment weekly with showers and as needed. RN-F stated R45 was not bedridden, but R45's mobility seemed to decline within the past few days. RN-F stated R45 needed more staff assistance with transfers compared to moving in bed. During interview on 1/16/25 at 10:35 a.m., NA-I stated R45 used to living in the assisted living area of the building and did not wear socks then either. NA-I stated R45 was already in a sitting position when assisting R45 earlier yesterday morning so did not notice the area on R45's heel. NA-I stated they checked residents' skin when helping with cares and reported to the nurse if they noticed something new. During interview on 1/16/25 at 10:57 a.m., RN-E stated R45 was at risk for pressure injuries and did not know R45 refused to wear socks with shoes, and it would have been important to have been aware of. RN-E was not aware of R45's right heel prior to 1/15/25. During follow-up interview on 1/16/25 at 12:37 p.m., NA-L stated they have seen R45 lay in bed a lot, and they required assistance of two staff when in bed and to the bathroom, but R45 was also able to move in bed by themselves. During interview on 1/16/25 at 12:53 p.m., RN-C expected NAs to report skin concerns to nurses immediately, and nurses were to complete risk management and update supervisor, provider, and family. Staff were to monitor residents' skin during baths or showers or anytime they noticed something new to residents' skin. RN-C stated staff knew who was at high risk for pressure ulcers or skin alterations by the care plan and resident diagnoses. Staff were to report if residents refused care planned interventions, so the nurse could chart about it. RN-C did not know R45 did not wear socks and considered R45 at risk for pressure injuries. RN-C stated R45 slept in during the mornings and was up during the day. RN-C stated R45 could move themselves in bed and had self-transferred before but was not sure if R45 moved themselves less now. RN-C stated they were not aware of the suspected deep tissue injury before, and stated the sooner skin changes were identified, the easier they were to heel. During interview on 1/16/25 at 2:42 p.m., the director of nursing (DON) expected staff to bring new skin concerns to the nurse and skin checks to be completed with morning and evening cares. DON stated pressure areas could worsen if not identified timely to implement interventions. DON stated staff should identify new areas of concern on heels when assisting residents with dressing and application of socks and shoes. During interview on 1/17/25 at 10:55 a.m., nurse practitioner (NP)-D stated R45 was at risk for pressure injuries and skin alteration related to their size and immobility. R45 moved slowly and was mostly wheelchair bound. NP-D did not think R45 not wearing socks was a concern and stated R45's heel sitting in one place for an extended period could cause a pressure injury within hours. NP-D stated it was important for nurses to complete diligent skin assessments and look at the pressure points. NP-D stated it was good the area was identified before it got worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Skin Integrity Management Policy dated 8/27/24, indicated the Braden Scale was used to identify residents at risk for impaired skin integrity. The policy directed staff to individually review and implement interventions for each risk factor regardless of the resident's total skin risk score. The policy directed skin to be inspected minimally weekly by a nurse and with daily cares. The areas to be observed during a skin assessment include coccyx, ischial/scrum, trochanter, spine, scapula, heels, elbows, back of head, shoulders, and ears. It was the facility's policy to implement preventative measures and provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care. The policy indicated the care planned interventions would be communicated to the appropriate staff via the nursing assistant assignment sheet or Kardex and/or through report. Further, the policy guided staff to encourage mobility as tolerated and establish and individualized turning and repositioning schedule if the resident is immobile. The policy directed staff to discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment for residents that wish to exercise their right to refuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to implement care planned fall interventions for 1 of 7 residents (R34) who had history of repeated falls and remained at risk for falls. Findings include: R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated R34 had severe cognitive impairment and diagnoses of hypertension (high blood pressure), arthritis, dementia, and depression, and required partial and/or moderate assistance for transfers. The MDS identified no falls since the last assessment. R34's fall risk assessment dated [DATE], indicated R34 had one fall with no injury and one fall with injury (except major injury) since prior assessment. R34 had weakness, cognitive delay/impairment that affects judgement, incontinence. R34 was at risk for falls due to self-transfers. R34's care plan printed 1/15/25, had a focus area Fall/Risk, which was revised 9/14/23, and indicated R34 was at risk for falls related to dementia, impaired memory/cognition, inability to appropriately use call light, poor safety awareness, impulsivity, impaired gait/mobility, generalized weakness, h/o [history of] falls, h/o fall related fractures, attempts to self-transfer/ambulate, refuses to stay out in common area for supervision frequently, difficult to distract/redirect at time, anemia, incontinence, high risk medication use. Interventions included all staff to observe and identify for possible hazards in environment to prevent avoidable accidents/falls, auto lock brakes on wheelchair and ensure functioning properly, commonly used items within reach, purposeful rounding at 11:00 p.m. and offer toileting and ensure all apparent needs were met, encourage resident to call for assist with transfers and ambulation, encourage resident to sit in common areas when awake for closer supervision as much as possible, ensure soft touch call light is in place on right side while in bed, ensure resident has proper and non-slip footwear, ensure w/c [wheelchair] was next to bed while R34 in bed to reduce fall risk if resident tries to self-transfer, keep bed at appropriate transfer height at all times, keep walkways clean and clutter free, assist with evacuation in case of emergency, MD/NP [doctor and nurse practitioner] and consulting pharmacist to review medications with regulatory visits with dose reductions as indicated, need to assist with evacuation in case of emergency, provide adequate lighting at all times, re-orient resident to call light and remind how to use as needed, visual safety checks hourly while in bed and toilet resident when awake at NOC and PRN [night and as needed]. R34's Kardex Report printed 1/17/25, directed for R34's wheelchair to be next to bed while resident in bed to reduce fall risk if resident tried to self-transfer. During observation on 1/15/25 at 9:28 a.m., R34 was in bed with wheelchair facing away from resident and away from the bed, out of R34's reach. During observation on 1/15/25 at 10:04 a.m., the wheelchair was in the same position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 1/15/25 at 10:10 a.m., nursing assistant (NA)-I stated staff had daily meetings to talk about fall interventions and looked on residents' care plans to know their specific interventions. NA-I stated R34 used to be more stable and needed the bed at transferable height. NA-I observed the wheelchair placement and stated they turned the wheelchair away from the R34, so R34 was not tempted to get out of bed. NA-I checked R34's closet to view R34's care plan and the clear, plastic paper protector was empty. During observation and interview on 1/15/25 at 11:13 a.m., NA-K stated they checked the care plan to know how to prevent residents from falling and checked on them. NA-K stated they did not work with R34 often but had seen R34 wandering around before and R34 could fall if no one was around. NA-K was not sure about R34's fall history. NA-K verified placement of the wheelchair facing away from R34 in bed and was not sure what the appropriate wheelchair placement was for R34. During interview on 1/16/25 at 10:50 a.m., registered nurse (RN)-E stated staff completed a risk management after a fall to see what caused the fall, and care planned fall interventions related to the root cause of the fall. RN-E stated staff knew fall interventions based on the care plan and communication. RN-E stated R34's wheelchair and bed should be at transferable height and would not be appropriate or safe for R34's wheelchair to face away from them. During interview on 1/16/25 at 12:45 p.m., RN-C stated they reviewed falls with staff in huddles and updated the care plan. RN-C stated R34's wheelchair should be next to them while R34 was in bed and at risk for self-transferring. R34 had days where they were in bed and would not speak a word and other days where they talked a lot and roamed around in their wheelchair. R34 was at risk for falls when fall interventions were not followed. During interview on 1/16/25 at 2:45 p.m., the director of nursing (DON) expected staff to look at the Kardex for fall interventions, and residents were at risk for further falls and injury when fall interventions were not followed. The facility policy Risk Management Program: Falls and Injuries Program dated 1/24/23, indicated residents who were identified at risk would have care plans which reflected interventions used to minimize falls.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R112) who had complicated feeding problems received feeding assistance from qualified staff. This had the potential to affect all residents who required feeding assistance. Findings include: During entrance conference on 1/13/25 at 12:44 p.m., the director of nursing (DON) identified there were no paid feeding assistants utilized in the facility. An undated form titled Paid Feeding Assistants in the survey readiness binder presented to the survey team at entrance identified the facility, does not use Paid Feeding Assistants. R112's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and did not identify any signs or symptoms of a possible swallowing disorder or a therapeutic diet. The MDS indicated R112 required supervision or touching assistance in which the helper provides verbal cues or touching/steadying assistance during eating. A Centrex Rehab therapy to nursing communication form dated 9/13/24, recommended R112 have a visual aid of safe swallowing strategies on the table for meals. Per her care plan revised on 6/28/22, R112 required set-up/supervision with some feeding assistance needed, depending on the meal. Additionally, the care plan identified her risk for altered nutrition status related to her self-feeding difficulties and history of taking food from others' plates after meals. The care plan directed staff to provide adaptive equipment for meals, serve food in individual dishes if not on a divided plate, cut up foods, discourage her from taking food from others' plates and encourage healthier snacks, monitor/document/report to the nurse/dietitian/physician signs or symptoms of difficulty swallowing, holding food in her mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, or pocketing food in her mouth. R112's Kardex printed 1/17/25, indicated she required set-up/supervision with some feeding assistance needed, depending on the meal. During a dining observation on 1/15/25 at 12:07 p.m., environmental services (ES)-A was sitting beside R112 in the dining room at the table. ES-A was assisting R112 with her meal. There was a piece of cheesecake sitting on the table in front of R112 and ES-A was feeding her using a fork. At 12:09 p.m., registered nurse (RN)-A walked into the dining room and over to R112's table and stated she would take over and sat down next to R112 and continued assisting with the meal. ES-A got up from the table and walked out of the dining room. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/15/25 at 1:58 p.m., ES-A confirmed assisting R112 with her meal and stated, I like to help the residents. ES-A indicated they had received some prior training, but it was unclear during the interview due to language barriers if the training had been at the current facility or a previous employer. ES-A explained their job duties included cleaning the assigned floor and the resident's rooms on the assigned floor, as well as restocking some supplies. During interview on 1/16/25 at 9:21 a.m., RN-A confirmed ES-A was assisting R112 and stated, I had not seen that happen before, that was a first. I went over there and took over the assistance. RN-A stated they would be discussing disciplinary action or performance management, including counseling and education but not termination, with ES-A and ES-A's supervisor. RN-A stated there had not been conversations with nursing staff on the floor about what to do in situations where they witnessed an unqualified individual assisting a resident during a meal because I've never seen that happen before so now I will be having that conversation. RN-A confirmed the facility did not employ paid feeding assistants. Per interview on 1/16/25 at 3:20 p.m., the DON stated the facility had provided feeding assistance training to some staff previously, including ES-A. The DON confirmed, however, the facility did not currently employ paid feeding assistants and stated, we have enough nursing staff to help with dining on the floor, I don't think we need ES-A to continue helping. An EduCare Skill Competency Paid Feeding Assistant Series form dated 10/14/20, indicated ES-A completed infection prevention and control and dining, nutrition and food safety. Per facility policy titled Feeding Assistant Policy dated 10/30/20, the facility would ensure a feeding assistant (non-nursing staff) feed only those residents who have no complicated eating problems that may include, but are not limited to, difficulty swallowing, recurrent lung aspirations or tube or parenteral/IV feedings. Feeding assistants may not feed any resident who 1.) is at risk of choking while eating or drinking; 2.) presents significant behavior management challenges while eating or drinking; or 3.) presents other risk factors that may require emergency intervention. The facility would base resident selection on the resident's latest assessment and plan of care and the RN assessment of the resident's current condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to use proper infection control practices to prevent and/or mitigate the risk of a potential infection outbreak for 3 of 12 residents (R42, R57, R118) observed for respiratory precautions, and 1 of 4 residents (R138) observed for enhanced barrier precautions. Findings include: PPE FOR COVID-19 R42's quarterly Minimum Data Set (MDS) 10/23/24, indicated R42 had severe cognitive impairment, was dependent on staff for most activities of daily living (ADL's) and required supervision or touching assistance with eating. R42's physician order dated 1/7/25, indicated R42 had an active COVID-19 infection in the contagious stage and required transmission-based precautions for ten days. R57's quarterly MDS dated [DATE], indicated R57 had severe cognitive impairment, required substantial and/or maximal assistance, and was dependent on staff for ADLs. R57's progress note on 1/4/25 at 3:26 p.m., indicated R57 tested positive for COVID and would be on isolation for ten days. R57's treatment administration record (TAR) dated 1/1/25-1/31/25, indicated staff completed a rapid COVID-19 test for R57 and had positive results on 1/6/25. R118's quarterly MDS dated [DATE], indicated R118 had severe cognitive impairment, was independent with most mobility, and required setup/clean-up to partial and/or moderate assistance for other ADLs. R118's progress note on 1/5/25 at 7:51 p.m., indicated R118 had COVID-19 symptoms and tested positive and would be on isolation precautions for ten days. R118's TAR dated 1/1/25 to 1/31/25, indicated staff completed a rapid COVID-19 test for R118 and had positive results on 1/7/25. During observation on 1/13/25 at 6:41 p.m., NA-D entered R57's room with a meal tray and wore gloves, a gown, eye protection, and a regular mask instead of an N95 mask. R57's door had a sign which directed staff to wear a gown, gloves, eye protection, and an N95 mask. During observation on 1/13/25 at 6:43 p.m., NA-F entered R42's room with a meal tray and wore gloves, a gown, eye protection, and a regular mask instead of an N95 mask. NA-F exited the room and removed their PPE other than the regular mask. R42's door had a sign which read Enhanced Respiratory Precautions and directed staff to wear a gown, facemask or N95, eye protection, gloves, and an optional hair cover. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Mount Olivet Careview Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5517 Lyndale Avenue South Minneapolis, MN 55419	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 1/13/25 at 6:43 p.m., NA-G entered R118's room with a meal tray and wore gloves, a gown, and a regular mask. NA-G exited the room and removed their PPE besides the regular mask. R118's door had a sign which read Enhanced Respiratory Precautions and directed staff to wear a gown, gloves, and facemask or N95 mask, and eye protection. NA-G stated the sign meant the resident had an illness which could spread. NA-G stated they did not need to wear an N95 mask to deliver food to R118 and needed an N95 mask if they stayed longer in R118's room, such as if R118 needed help with cares. During an observation on 1/13/25 at 6:55 p.m., surveyor entered R57's room and observed nursing assistant, (NA)-D wearing a blue standard mask, eye shield, gown, and gloves while feeding and repositioning R-57 in their wheelchair. NA-D was not wearing an N95 mask. During interview on 1/13/25 at 6:58 p.m., NA-F stated R42 was on precautions for COVID-19 and they were supposed to use an N95 mask to deliver meal trays but forgot. NA-F stated they didn't change their regular mask when they exited the room. During observation on 1/13/25 at 7:03 p.m., NA-D exited R57's room. During an interview on 1/13/25 at 7:35 P.M., NA-D stated the correct PPE for COVID positive rooms was an N95 mask, eye shield, gown, and gloves as identified on the sign on the door, and was worn to protect the residents from disease and infections. NA-D stated they had on the N-95 mask but removed it. During interview on 1/14/25 at 1:50 p.m., the infection preventionist expected staff to follow the signs on residents' doors and wear an N95 mask in residents' rooms who had COVID. During an interview on 1/16/25 at 11:26 A.M., registered nurse (RN)-C stated the process for proper infection control was hand hygiene and proper PPE. If a resident had signs or symptoms of COVID or tested positive, the resident was placed on respiratory contact precautions, correct signage was posted on door, garbage can was places in the room, and a bin was placed outside of room containing N-95 masks, gowns, gloves, and eye shields. RN-C expected all staff to wear proper PPE when in resident's rooms and to dispose of items per ongoing education and signage to prevent the spread of infections. During further interview on 1/16/25 at 1:15 p.m., registered nurse (RN)-C verified R42, R57, and R118 were on precautions for COVID and expected staff to wear an N95 mask whenever they entered their rooms. During interview on 1/16/25 at 2:48 p.m., the director of nursing (DON) expected staff to wear the appropriate PPE, which included an N95 mask, to enter rooms under COVID and respiratory precautions to prevent the spread of the illness to other residents. Facility policy Mount [NAME] Careview Homes Infection Control dated 5/11/23, indicated residents placed on transmission-based precautions will have signage on their doors to indicate the type of precautions. The policy indicated PPE should be available near the entrance of the resident room, and precautions would be maintained for the length of time necessary to prevent transmission of infection by proximity. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51578 R138's admission Minimum Data Set (MDS) dated [DATE], included R138 was severely cognitively impaired, dependent on staff for toileting, bed mobility, and transfers, and had a diagnoses of cancer and malnutrition. The MDS indicated R138 received 51% or more of their nutrition through a feeding tube. During observation on 1/13/25 at 6:41 p.m., nursing assistant (NA)-J was observed changing R138's wet brief and repositioning R138 in bed wearing gloves without a gown. During an interview on 1/13/25 at 7:10 p.m., NA-J explained that R138 needed to be changed and repositioned. NA-J stated they had several residents in the facility on EBP and the normal practice for the facility was to place a small orange magnet outside of the door, and to keep PPE in a cart inside of each resident's room. NA-J pointed to a cart in the room by the residents door. A sign with correct use of PPE was placed on top of the cart upside down, and the cart did not contain gowns. During an interview on 1/14/25 at 1:50 p.m., the infection preventionist (IP) stated the facility tracked residents who were on EBP, and they were identified by placement of an orange magnet on the doorframe of their rooms. IP indicated staff received education regarding EBP requirements, and all staff were expected to use a gown and gloves while providing certain cares for residents who had an indwelling tubes such as a catheter or G-tube (feeding tube). IP stated PPE carts were placed either inside or outside resident rooms, and staff were expected to re-stock the supplies as needed. During an interview on 01/16/25 at 11:25 a.m., registered nurse manager (RN-D) explained the infection preventionist, administration or nursing supervisors helped with initiating EBP when needed. RN-D stated staff were provided education regarding EBP, and indicated a gown and gloves was required when performing cares with a resident with a chronic wound, indwelling catheter, or a G-tube (feeding tube). During the interview, RN-D identified a resident who was on EBP, and upon observation, RN-D verified an EBP sign was hanging inside their door, but found it to be covered with a large family picture. RN-D explained that they would take down the family picture or relocate the EBP sign. RN-D explained that the facility had some problems with the process, and some new staff found it challenging to understand why specific precautions were needed. RN-D confirmed one resident room had a droplet precautions sign on the door, while another only had a small orange magnet to identify EBP. RN-D confirmed there was inconsistency in signage, and it was difficult to explain to a family member or staff person the difference especially with so many precaution signs. During follow-up interview on 1/16/25 at 12:55 p.m., IP verified the different process for EBP precautions. When interviewed specifically about the EBP inconsistency with the signs, the IP stated the facility used an orange magnet on the door to identify residents who were on EBP for dignity purposes, and they did not want to post EBP signs so as not to expose residents' information. They stated they understood the inconsitent signage could be confusing for family and staff, and indicated EBP was challenging. During an interview on 1/16/25 at 10:30 a.m., DON explained they expected staff to follow the facility policy and continued to work with the IP for ongoing training to keep the residents safe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility wide policy stated Outbreak Management dated 3/12/2020 was reviewed for EBP precautions. The policy provided information that included information from the CDC on what EBP precautions include when working in long term care centers. The policy went on to state that residents with colonization of a CDC targeted infection maybe placed in EBP precautions. Nursing home residents with chronic wounds and indwelling medical devices are at a high risk for possible colonization may be placed in EBP. Staff caring for residents with these conditions will need to wear a gown and gloves during contact high contact activities (see Enhanced Barrier Precaution Sign). See MDRO policy. The facility wide policy named Caring for Residents with Multi Drug Resistant Organisms (MDRO) dated 9/16/24 was reviewed for further indication of EBP information. The policy specified that residents that are on EBP precautions staff will wear proper PPE. Some examples of activities that this would be expected include dressing, bathing/showering/transferring, changing linens, changing briefs or assisting with toileting, wound care, device care- central line, urinary catheter, feeding tube, and tracheostomy. Resident who requires EBP will be communicated with staff. Supplies will be available for easy accessibility. Family and visitors should be educated about MDRO, and precautions taken that include hand antisepsis and ways to limit environmental control. The policy did not further explain the process that was described by the IP and or staff upon interview for consistency on EBP precautions.