STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40550 Based on interview and document review, the facility failed to ensure that written notifications required for transfers were given to the resident and/or resident representative for 1 of 5 residents (R1) reviewed for admission, discharge and transfers. Findings include: R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 was cognitively intact and had diagnoses which included seizures, anxiety and depression. Identified R1 was independent for transfers and activities of daily living (ADLs). R1's care plan dated 6/7/24, stated R1 had a history and diagnosis of substance use. Staff were to monitor and check vitals if R1 was under the influence of a substance. Identified R1 would have an appropriate discharge plan. R1 would make a safe and appropriate decision regarding discharge. Review of R1's progress notes from 4/12/24 to 6/7/24, identified the following: -On 6/6/24 at 8:45 a.m., resident returned to facility this AM around 8 am intoxicated. Resident stated he drank 4 beers from 10 PM to 2 am. Resident was stumbling and had difficulty focusing. Resident became upset when asked about his alcohol use. The smell of alcohol was noted in room. Resident became upset when asked if he would be willing to be seen in the ED stating he would just go home to St Cloud. Resident did have his vehicle parked near facility, denies driving while under influence. -On 6/6/24 at 12:02 p.m., 30 day (notice of intent to discharge) NOD issued to resident today to (to be determined) TBD location as resident no longer requires SNF care. Resident refused to sign NOD. Writer explained the appeal process to resident, who verbalized understanding. Writer offered resident a copy of the NOD paperwork and provided to resident. (Medical Director) MD updated and NOD mailed to ombudsman office. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/6/24 at 12:07 p.m., Resident back from (leave of absence) LOA @8 am. Resident appeared intoxicated. Resident has slurred speech, appears flushed, teary eyes and tipsy walking. VS BP 100/53 R22 P 81 O2:92% T 97.5 When asked about his drinking, resident states that he started drinking between 10 PM and 2 am had 4 beers max. Provider notified, requested for resident to be sent in. Provider sent order. Resident notified that he had to go in for detoxify since when he starts having withdrawal symptoms, facility is not equipped to care for him, resident refused and stated that if they call (emergency medical services) EMS he would leave (against medical advice) AMA. Resident upset and angry at writer stating that we need to call his lawyer. MT called, administrator applied for emergency hold since resident was upset and adamantly refusing to go in. MT and police arrived @11:45 am, resident agreed to leave with (emergency medical technician) MT. Resident left building @11:55 am sent to Methodist hospital. Paperwork sent with resident. -On 6/6/24 at 1:16 p.m., resident returned to the facility this morning around 7:30 am. resident visibly intoxicated and belligerent, slurring his words and stumbling when walking and a strong ETOH (scientific abbreviation for ethanol, the chemical compound that is found in alcohol) odor coming from resident. resident declined drinking ETOH, but bottles of alcohol were confiscated from resident this morning and yesterday. EMS called to send resident in for detoxify. Resident refused to go and was stating he was going to get into his car and leave AMA. Police arrived prior to EMS and attempted to get keys from resident, but he refused to allow police to enter his room. resident told writer he would not go to the (emergency room) ER for detoxify and told writer to Call my lawyer.' Police officers recommended facility fill out a transport hold on resident. Transport hold filled out and resident was transferred to the ER by EMS. MD updated. -On 6/6/24 at 4:35 p.m., MD okay with 30 day NOD. Review of R1's doctor's order dated 6/6/24 at 9:14 a.m., please send patient to ED for alcohol intoxication. Review of R1's discharge notification dated 6/6/24, checkbox selected stated The residents health has improved sufficiently so the resident no longer needs services provided by the facility. R1's discharge notification revealed R1 refused to sign the form and the administrator signed as the witness. R1's medical record lacked documentation R1 or R1's representative had received a written notification of discharge. During an interview on 8/6/24 at 3:55 p.m., the administrator indicated emergency medical service (EMS) arrived to transfer R1 to detoxify. The administrator further indicated she issued a 30-day involuntary discharge on 6/6/24, however was unaware of the time. The administrator said R1 was very impaired when the 30-day involuntary discharge was discussed and given to R1. The administrator further said, he might not have understood the discharge and if he would have come back to the facility I would have had to discuss it with him again. I would have probably had to create a new 30-day discharge notice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/7/24 at 9:26 a.m., R1 indicated the administrator came to his room and informed him he was going to detoxify and that she placed a hold on him. R1 further indicated three police and EMS were at the facility to take him into the emergency room (ER). R1 stated the administrator never gave him a 30-day written notice before sending him to the ER. R1 indicated the social worker at the hospital was the one who told him he only had 30 days left at the facility. R1 stated he was discharged from the hospital and was going to stay with a friend because he felt the administrator was kicking him out. Review of facility policy titled Discharge Planning Policy dated 11/16, Discharge planning was completed to assure continuity of care to meet the needs of a resident returning to independent living in the community or discharged to another facility or institution when and if possible. Involuntary discharge policies were covered in a separate policy. They were written to include interpretive guidelines under Federal Statute 483.12(a)(1). Review of facility policy titled Transfer or Discharge Notice for Facility-Initiated Discharges updated 7/24, residents and/or representatives were notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge for all facility-initiated discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 5 residents (R1) reviewed for hospitalization . Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1's diagnoses included seizures, anxiety, depression and was cognitively intact. Identified R1 was independent with transfers and activities of daily living (ADLs). R1's care plan dated 6/7/24, identified R1 had a history of and diagnosis of substance use. Staff were to monitor and check vitals if R1 was under the influence of a substance. Identified R1 would have an appropriate discharge plan. R1 would make safe and appropriate decision regarding discharge. Review of R1's progress notes from 4/12/24 to 6/7/24, identified the following: -On 6/6/24 at 12:07 p.m., Resident back from (leave of absence) LOA @8 am. Resident appeared intoxicated. Resident has slurred speech, appears flushed, teary eyes and tipsy walking. VS BP100/53 R22 P81 O2:92% T97.5 When asked about his drinking, resident states that he started drinking between 10 pm and 2 am had 4 beers max. Provider notified, requested for resident to be sent in. Provider sent order. Resident notified that he had to go in for detox since when he starts having withdrawal symptoms, facility is not equipped to care for him, resident refused and started that if they call (emergency medical services) EMS he would leave (against medical advice) AMA. Resident upset and angry at writer stating that we need to call his lawyer. EMT called, administrator applied for emergency hold since resident was upset and adamantly refusing to go in. EMT and police arrived @11:45 am, resident agreed to leave with (emergency medical technician) EMT. Resident left building @11:55 am sent to Methodist hospital. Paperwork sent with resident. R1's medical record lacked documentation R1 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer. During an interview on 8/6/24 at 11:38 a.m., administrator stated she did not have a bed hold for R1 as he was not coherent or of sound mind to sign a bed hold. During an interview on 8/6/24 at 3:40 p.m., director of nursing (DON) stated if a resident was going to be transferred to another facility in a medical emergency a bed hold should have been completed. If the resident was unable to be provided a bed hold, the facility should have reached out to the family/legal representative. During an interview on 8/6/24 at 3:55 p.m., the administrator indicated EMS arrived to transfer R1 to detox. The administrator stated R1 was very impaired when he was getting ready to leave the facility. The administrator said we did not feel he could understand his bed hold agreement at that time therefore, one was not provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/7/24 at 9:26 a.m., R1 indicated the administrator came to his room and informed him he was going to detox and that she placed a hold on him. R1 stated three police officers and EMS staff were at the facility to take him into the emergency room (ER). R1 stated he was not aware of a bed hold and he never received a form to sign. Review of facility policy Bed-Holds and Returns updated 5/24, When a resident was temporarily transferred on an emergency basis to an acute care facility, this type of transfer was considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and/or resident representative as soon as practicable before the transfer, according to 42 CFR S483.15(c)(4)(ii)(D). Prior to a transfer, written information would be provided to the resident and the resident representatives that explains in detail: -The rights and limitations of the resident regarding bed-holds; -The reserve bed payment policy as indicated by the state plan (Medicaid residents); -The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and -The details of the transfer (per the Notice of Transfer). Review of facility policy titled Transfer or Discharge Notice for Facility-Initiated Discharges updated 7/24, the resident and representative were notified in writing of the following information: the facility bed-hold policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure appropriate donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 2 of 2 residents (R3, R26) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. In addition, the facility failed to ensure appropriate donning/doffing of PPE was performed and that the door remained closed for 1 of 1 resident (R31) observed for enhanced respiratory precautions ([NAME]) (used to protect others from illnesses spread through the air). Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. According to Minnesota Department of Health, Enhanced Respiratory Precautions ([NAME]) require staff to gown, apply a N95 respirator or higher level respirator, eye protection (goggles or a faceshield), and a pair of gloves. Only essential personnel should enter the room and the door should be kept closed if possible. The resident should be placed in an Airborne Infection Isolation Room (AIIR) if available. According to the CDC guidelines dated 4/3/24, in a setting where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed would reduce the likelihood of airborne transmission. EBP R3 R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and diagnoses which included hypertension (elevated blood pressure), neurogenic bladder (name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem.), and diabetes mellitus (DM). Identified R3 required extensive assistance for activities of daily living (ADL's) which included toileting, transfer and dressing. Indicated R3 had a foley catheter. R3's annual Comprehensive Care area Assessment (CAA) dated 1/21/24, identified R3 had a foley catheter and indicated staff provided catheter care and emptied catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's care plan revised 5/2/24, indicated R3 had a foley catheter. Care plan instructed staff to position the catheter below the level of the bladder, provide catheter care per policy and monitor for signs of a urinary tract infection (UTI). During an observation on 8/6/24 at 7:27 a.m., there was no PPE located near R3's room for staff to wear while providing care for R3 (who was on EBP). During an observation on 8/6/24 at 7:35 a.m., nursing assistant (NA)-A was standing next to R3's bed wearing gloves and a surgical mask and was putting R3's pants on. NA-A had no gown on. NA-B entered R3's room wearing gloves and a surgical mask and had no gown on. NA-A and NA-B assisted R3 to roll over as NA-A pulled up R3's pants and placed a hoyer lift sheet under R3. NA-A and NA-B proceeded to use a hoyer lift to transfer R3 into her wheelchair. NA-A and NA-B removed gloves and sanitized hands. During an observation on 8/6/24 at 8:44 a.m., NA-A and NA-B while wearing a surgical mask and gloves and had no gown on, entered R3's room, hooked R3 up to a hoyer lift and transferred R3 into bed. NA-A and NA-B rolled R3 over and removed the hoyer sheet. NA-A and NA-B removed gloves and sanitized hands. During a joint interview on 8/6/24 at 8:50 a.m., NA-A and NA-B verified they had not worn a gown while dressing or transferring R3. NA-A and NA-B stated R3 had a foley catheter and the only PPE that was required while providing care to R3 was a surgical mask and gloves. NA-A and NA-B indicated they were unaware that a gown was required while providing cares to R3. 49620 R26 R26's admission MDS dated [DATE], identified R26 was cognitively intact and required moderate assistance with activities of daily living ADL's for dressing and transfer, supervision with toileting, and required use of a wheelchair. Indicated R26 had diagnoses of acute osteomyelitis (infection of bone caused by bacteria, injury or surgery), type two diabetes with foot ulcer, stage three (moderate) chronic kidney disease and generalized muscle weakness. Identified R26 had a peripherally inserted central catheter (PICC) and received intravenous (IV) medication through the PICC line. Indicated R26 had a wound vacuum-assisted closure (VAC) device that used negative pressure to pull the edges of a wound together and promote healing on R26's left foot on the heel of the foot. R26's admission CAA dated 7/28/24, identified R26 had a left heel ulcer and was on IV antibiotics. R26's care plan dated 7/17/24, identified R26 had a PICC line that was to be flushed before and after IV medication administration and to monitor for signs or symptoms of infection and infiltration. The care plan dated 7/24/24, identified R26 had an alteration in skin integrity related to a wound on R26's left heel. Staff were to provide treatment to open area per order. The care plan lacked documentation on use of EBP for R26. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/6/24 at 12:15 p.m., registered nurse (RN)-A removed gloves from the PPE supply bin hanging over the outside of R26's door and entered R26's room. RN-A placed the IV supplies and IV medication onto R26's bedside table and applied gloves. RN-A proceeded to connect the IV medication to R26's PICC line. RN-A removed the gloves, disposed of the gloves into the garbage can and exited R26's room. During an interview on 8/6/24 at 12:19 p.m., R26 stated staff wore gloves when completing IV cares and a gown and gloves when providing wound cares to the left foot. R26 stated some staff wore a gown and gloves when providing IV PICC line care and or assisting with personal cares however not all staff did so. During an interview on 8/6/24 at 12:22 p.m., RN-A verified she only wore gloves and had no gown on when completing the IV PICC line cares and administering IV medication for R26. RN-A stated staff only needed to wear a gown when providing wound cares and not for any other cares. 48583 [NAME] R31 R31's quarterly Minimum Data Set (MDS) dated [DATE] identified R31 had severe cognitive impairment and diagnoses which included heart failure, aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), and anxiety. Identified R31 was independent with activities of daily living (ADL's) which included toileting, transfer and dressing. R31's care plan revised 3/6/24, lacked documentation R31 was to be in [NAME]. R31's Order Review History Report dated 8/7/24, indicated the following: -staff to follow: [NAME] every shift active 8/1/24. -Amoxicillin-Pot Clavulanate (antibiotic used to treat bacterial infections) oral tablet 875-125 milligrams (mg) give one tablet by mouth two times a day for Pneumonia for five days starting 8/01/2024 to 8/06/2024. During an observation on 8/6/24 at 11:32 a.m., R31 had a sign on the door that stated R31 was in [NAME]. R31's door was open and R31 was laying on her bed with her eyes closed and television playing. During an observation on 8/6/24 at 12:08 p.m., R31's door was open and she was sitting on the edge of her bed finishing eating her lunch. R31's tray had been removed and R31's door remained open. During an interview on 8/6/24 at 9:59 a.m., infection preventionist (IP) verified R3 had a foley catheter and was on EBP. IP stated the facility had just started implementing EBP therefore, there were not enough over the door PPE bins for all resident on EBP. IP stated her expectation was all staff would have worn the appropriate PPE while performing high-contact cares for R3 to prevent the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/24 at 10:20 a.m., director of nursing (DON) verified the facility had just started to implement EBP. DON stated they were hoping to have all PPE and supplies by last week however were not able to obtain all the supplies that were ordered. DON indicated her expectation was all staff would have worn the appropriate PPE during high- contact activities for residents on EBP. During a follow-up interview on 8/6/24 at 4:54 p.m., IP confirmed R31 was on [NAME] due to pneumonia. IP indicated R31's door was to remain closed at all times. IP further indicated she was not aware R31's door was open and stated the facility had a plan for [NAME] however it had not been fully implemented yet. During a follow-up interview on 8/6/24 at 4:55 p.m., IP verified R26 had a PICC line and was on EBP. IP stated the expectation of staff was to wear a gown and gloves when providing PICC line cares for R26 to prevent the spread of infection. IP stated the facility was still in the process of providing education to staff about EBP and had not fully implemented EBP in the facility at the time as there were not enough over the door PPE bins for all residents on EBP. During an interview on 8/6/24 at 5:07 p.m., the administrator verified the facility was still in the process of implementing EBP and were not able to obtain all the supplies that were ordered. Administrator stated the expectation was that staff would follow the current CDC guidelines for use of EBP to prevent the spread of infection. Review of a facility policy titled Enhanced Barrier Precautions dated 4/1/24, identified it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy stated the use of gown and gloves was expected during high-contact resident activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters,feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a MDRO. Requested a facility policy on [NAME], however one was not received.