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	01/09/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 48299 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed to assure individualized interventions and resident-specific targeted behavior monitoring was completed for 1 of 2 residents (R32) reviewed for mood and behavior. Findings include: R32's admission Minimum Data Set (MDS) dated [DATE], indicated R32 was cognitively intact, had no behaviors or rejection of cares, was independent with eating and rolling left and right, and required substantial and/or maximum assistant with lower body dressing and personal hygiene. R32's MDS did not identify R32 took antipsychotic medications. R32's care plan reviewed 1/6/25, indicated they had an alteration in mood and behavior focus area, and directed staff to document mood state and/or behaviors upon occurrence, redirect prn [as needed], provide emotional support, validation, and comfort measures prn, and MDS section D and/or PHQ 9 [patient health questionnaire which screens for depression] would be conducted per regulation and PRN. The care plan lacked individualized interventions and resident-specific target behaviors to be monitored to determine effectiveness. R32's physician orders identified: -Resident specific targeted behaviors of dry mouth, agitation, headaches, abnormal involuntary movements with directions to chart non-pharmacological interventions, such as redirect and provide one to one time and/or validation, and outcome if interventions were effective or not, with start date of 12/16/24. R32's medication administration record identified medications which included: - Haloperidol (an antipsychotic) oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation, with start date of 1/3/25 and discontinued 1/7/25. - Haloperidol oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation for 14 days, with start date of 1/7/25. (continued on next page)

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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's encounter note with the provider on 12/16/24, indicated R32 was a new patient and took olanzapine (an antipsychotic) oral tablet 2.5 mg at bedtime for dementia with behaviors, with active date of 12/14/24. R32's encounter note with the provider on 12/27/24, indicated R32's olanzapine order had an end date of 12/28/24. During interview on 1/8/25 at 9:13 a.m., nursing assistant (NA)-E stated R32 had mood swings, scratched staff and refused cares. NA-E stated R32 spoke about preaching and religious topics and then would switch to another topic. NA-E was not aware of anything specific to help R32 and tried to talk to R32 and reapproached when R32 had behaviors. During interview on 1/8/25 at 9:00 a.m., licensed practical nurse (LPN)-C stated R32 refused to eat and drink and threw medications and food trays. R32 had paranoia and dementia and thought staff were the devil. LPN-C stated they tried to talk to R32 calmly and ask another staff to reapproach or updated the provider when R32 had behaviors. LPN-C stated they wrote notes about resident behaviors for providers and other staff to be aware of resident status. During interview on 1/9/25 at 8:33 a.m., NA-A stated behaviors were charted in the computer or in the care plan, or the nurse would tell them about agitated residents and what to do to help them. NA-A stated R32 hallucinated and refused meals and thought the medication and food were poisoned. NA-A stated they talked to R32, gave R32 water, and assisted R32 to watch television to calm them down. When interviewed on 1/9/25 at 9:19 a.m., social worker (SW) stated they were involved in resident's behaviors if reported to them, and their behaviors were discussed during morning meets, but SW mostly connected residents with ACP (associated clinic of psychology) services and updated care plans after ACP visits. SW stated R32 had an order for ACP but refused to sign the consent. SW stated R32 was impulsive and not aware of their surroundings and switched subjects often during conversations. SW was not aware of R32's recent refusals and behaviors. When interviewed on 1/9/25 at 10:48 a.m., clinical managers (CM)-B and CM-C stated they entered resident specific target behaviors into the medication or treatment administration record to monitor. CM-B and CM-C stated they assessed residents' target behaviors by looking at the consent form and reviewing if the resident got dry mouth, agitation, headaches, or other listed items with psychotropic medication use. When interviewed on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to interview residents or representative about target behaviors for psychotropic medications and place monitoring into the treatment administration record and update the care plan. DON agreed the target behaviors listed in R32's orders were medication side effects and stated examples of target specific behaviors included delusions or hallucinations. DON stated documentation of target behaviors were used to monitor if a psychotropic medication was effective. The facility Psychotropic Medication Use policy dated 11/2024, Indicated the care plan would reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy. The care plan will also include monitoring for drug specific side effects such as gait disorders, movement disorders, cognitive or behavioral changes, signs of hypotension or dry mouth.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review, the facility failed to ensure interventions of Prevalon boots to both feet were in place for 1 of 1 residents (R44) reviewed for non-pressure skin conditions. Findings include: A diabetic ulcer is an ulcer, often on the foot, caused by a combination of poor circulation and nerve damage in patients with diabetes. R44's quarterly Minimum Data Set (MDS) dated [DATE], identified R44 was cognitively impaired, had diagnosis of diabetes mellitus (DM) and dementia, had one stage 2 pressure ulcer, and was dependent on staff for activities of daily living (ADL) and mobility. R44's care plan dated 6/10/24, indicated R44 had an alteration on skin integrity related to a diabetic ulcer due to a diabetic ulcer on the left heel. An intervention revised 12/10/24 indicated R44 was to have Prevalon boot on both heels while in bed. R44's Braden scale assessment dated [DATE], identified R44 had slightly limited mobility and was at risk of developing pressure ulcers. R44's Kardex report undated, indicated R44 was to have Prevalon boots to left and right feet while in bed. R44's clinical physician orders indicated the following orders and start dates: - 12/10/24, Prevalon boot to right and left foot when in bed - 1/7/25, left heel pressure, cleanse with wound cleaner, apply iodine to wound bed, apply gauze and wrap with kerlix daily. R44's wound note dated 12/31/24, identified diabetic ulcer to left heel was stable and measured 0.1 cubic centimeters (cm) x 0.6 cm and had a depth of 0.1 c.m. During an observation on 1/6/25 at 2:51 p.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and two blue boots were lying in the recliner across the room. During an observation on 1/6/25 at 7:17 p.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and the two blue boots continued to be lying in a recliner across the room. During an observation on 1/7/25 at 7:55 a.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and the two blue boots continued to be lying in a recliner across the room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 1/7/25 ay 7:57 a.m., nursing assistant (NA)-A and nurse manager (NM)-A verified R44 was lying in bed with both feet directly on the mattress and did not have any boots on her heels. NM stated the expectation was that R44 was to have boots on while she was in bed to heal the current wound on her left heel and prevent any further wounds to her heels. During an interview on 1/7/25 at 11:44 nurse practitioner stated it was very important for R44 to have the heel boots on while in bed to protect and heal her current wound on the left heel and to prevent further skin breakdown to her heels. During an interview on 1/8/25 at 9:33 a.m., director of nursing (DON) verified R44 had a diabetic ulcer to her left heel. DON stated her expectation was that R44 would have had the Prevalon boots to both heels while she was in bed to prevent further skin breakdown. A facility policy titled Skin Assessment and Wound Management revised 7/18, identified when a significant alteration in skin is noted such as a pressure or diabetic ulcer staff would update care plan and implement interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to transcribe and follow an oxygen order consistent with current professional standards of practice for 1 of 1 (R17) resident reviewed for oxygen use. Findings include: R17's quarterly MDS dated [DATE], indicated R17 had intact cognition, was dependent on staff for toileting hygiene, required substantial and/or maximal assistance to roll left and right, and had diagnoses of heart failure, urinary tract infection in the last 30 days, asthma, and respiratory failure. The MDS did not note R17's oxygen use. R17's care plan printed 1/7/25, indicated R17 had a focus area of alteration in oxygen and/or gas exchange, respiratory status related to COPD [chronic obstructive pulmonary disease; long disease which causes restricted airflow and breath problems], chronic respiratory failure with hypoxia, restrictive lung disease, and oxygen use. Interventions included monitor oxygen saturation as ordered and prn, administer oxygen as ordered, keep MD [medical doctor] informed of changes, monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum, head of bed elevated while in bed, encourage frequent rest periods, assist with ADL's [activities of daily living] and mobility as needed, inhaler per MD order, provide diuretic per MD order. An intervention under the focus area of oxygen therapy related to chronic respiratory failure with hypoxia, included continuous oxygen via nasal cannula at 3 liters per minute. Further, a focus area indicated R17 had a self-care deficit related to chronic hypoxia with respiratory failure on 4L NC [4 liters via nasal cannula]. R17's physician orders were reviewed on 1/7/25 at 1:46 p.m., lacked an order for oxygen use. R17's discharge orders from North Memorial Health signed 11/29/24, indicated R17 should have had continuous oxygen via cannula with a flow of 3L. During observation and interview on 1/7/25 at 3:17 p.m., R17 was in bed with oxygen on via nasal cannula at 3 liters. R17 stated their oxygen liter flow should be at 3L. During observation and interview on 1/8/25 at 1:30 p.m., licensed practical nurse (LPN)-A stated they provided residents' oxygen according to physician's orders. LPN-B stated R17's oxygen therapy should be at 4 liters per minute (LPM), since R17's oxygen saturation dropped when not at 4 LPM. R17 was in bed with nasal cannula on and head of bed raised, and LPN-A noted R17's oxygen therapy at 2.5 LPM. R17 stated they were not short of breath when LPN-A asked. During interview on 1/9/25 at 1:05 p.m., clinical manager (CM)-A stated R17 had an order for oxygen which was reviewed quarterly and was not sure how the order disappeared from the chart. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) stated R17 had continuous oxygen and went to the hospital and returned to the facility with oxygen equipment still in their room and verified R17 did not have current oxygen orders in their chart. DON stated oxygen orders were important to make sure staff knew the appropriate oxygen setting for R17. The Oxygen Policy dated 11/19, indicated if the home care agency accepted responsibility for the ordering, refilling, and administration of oxygen, then oxygen shall be managed in the same manner as an ordered medication, including requiring a physician order.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to comprehensively assess and identify target behaviors to determine the effectiveness of psychotropic medication for 1 of 1 (R32) resident reviewed for mood and/or behavior. Findings include: R32's admission Minimum Data Set (MDS) dated [DATE], indicated R32 was cognitively intact, had no behaviors or rejection of cares, was independent with eating and rolling left and right, and required substantial and/or maximum assistant with lower body dressing and personal hygiene. R32's MDS did not identify R32 took antipsychotic medications. During document review of R32's care plan on 1/6/25, a focus area indicated R32 had an alteration in mood and behavior. The care plan directed staff to document mood state and/or behaviors upon occurrence, redirect prn [as needed], provide emotional support, validation, and comfort measures prn, and MDS section D and/or PHQ 9 [patient health questionnaire which screens for depression] would be conducted per regulation and PRN. The care plan did not identify Target Behaviors to be monitored. R32's physician orders identified: -Resident specific targeted behaviors of dry mouth, agitation, headaches, abnormal involuntary movements with directions to chart non-pharmacological interventions, such as redirect and provide one to one time and/or validation, and outcome if interventions were effective or not, with start date of 12/16/24. R32's medication administration record identified medications which included: - Haloperidol (an antipsychotic) oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation, with start date of 1/3/25 and discontinued 1/7/25. - Haloperidol oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation for 14 days, with start date of 1/7/25. R32's progress notes indicated: -On 12/19/24, R32 refused care, treatments, and evening medications. -On 12/27/24, R32 threw drinks on the floor. -On 1/3/25, R32 spat medications and threw food on the floor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/4/25, R32 refused morning medications. -On 1/5/25, R32 refused dinner and medications. -On 1/6/25, R32 refused scheduled medications and cares. R32's encounter note with the provider on 12/16/24, indicated R32 was a new patient and took olanzapine (an antipsychotic) oral tablet 2.5 mg at bedtime for dementia with behaviors, with active date of 12/14/24. R32's encounter note with the provider on 12/27/24, indicated R32's olanzapine order had an end date of 12/28/24. During interview on 1/8/25 at 9:13 a.m., nursing assistant (NA)-E stated R32 had mood swings, scratched staff and refused cares. NA-E stated R32 spoke about preaching and religious topics and then would switch to another topic. NA-E was not aware of anything specific to help R32 and tried to talk to R32 and reapproached when R32 had behaviors. During interview on 1/8/25 at 9:00 a.m., licensed practical nurse (LPN)-C stated R32 refused to eat and drink and threw medications and food trays. R32 had paranoia and dementia and thought staff were the devil. LPN-C stated they tried to talk to R32 calmly and ask another staff to reapproach or updated the provider when R32 had behaviors. LPN-C stated they wrote notes about resident behaviors for providers and other staff to be aware of resident status. During interview on 1/9/25 at 8:33 a.m., NA-A stated behaviors were charted in the computer or care plan, or the nurse would tell them about agitated residents and what to do to help them. NA-A stated R32 hallucinated and refused meals and thought the medication and food were poisoned. NA-A stated they talked to R32, gave R32 water, and assisted R32 to watch television to calm them down. When interviewed on 1/9/25 at 9:19 a.m., social worker (SW) stated they were involved in resident's behaviors if reported to them, and their behaviors were discussed during morning meets, but SW mostly connected residents with ACP (associated clinic of psychology) services and updated care plans after ACP visits. SW stated R32 had an order for ACP but refused to sign the consent. SW stated R32 was impulsive and not aware of their surroundings and switched subjects often during conversations. SW was not aware of R32's recent refusals and behaviors. When interviewed on 1/9/25 at 10:48 a.m., clinical managers (CM)-B and C stated they entered resident specific target behaviors into the medication or treatment administration record to monitor. CM-B and C stated they assessed residents' target behaviors by looking at the consent form and reviewing if the resident got dry mouth, agitation, headaches, or other listed items with psychotropic medication use. When interviewed on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to interview residents or representative about target behaviors for psychotropic medications and place monitoring into the treatment administration record and care plan. DON agreed the target behaviors listed in R32's orders were medication side effects and stated examples of target specific behaviors included delusions or hallucinations. DON stated documentation of target behaviors were used to monitor if a psychotropic medication was effective. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Psychotropic Medication Use policy dated 11/2024, Indicated the care plan would reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy. The care plan will also include monitoring for drug specific side effects such as gait disorders, movement disorders, cognitive or behavioral changes, signs of hypotension or dry mouth.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R39, R51) reviewed for food palatability. This deficient practice had the potential to affect all 93 residents residing in the facility who consumed food from the facility main kitchen. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], indicated R39 had intact cognition and required supervision to eat. R51's quarterly MDS dated [DATE], indicated R1 had intact cognition and was able to feed herself after staff set up her tray. During an interview on 1/6/25 at 1:43 p.m., R51 stated the food did not taste very good and the hot items were usually served cold and the cold items were served warm. During an interview on 1/6/25 at 2:08 p.m., R39 stated the hot food is always cold and the cold food usually is not cold. During an observation on 1/6/25 at 5:45 p.m., multiple trays were being placed on a cart from the main kitchen. At 6:08 p.m., as the last plates were being passed from the cart a test tray was requested from dietary aide DA-A. The meal consisted of a cold roast beef sandwich, mashed potatoes, gravy, and pureed corn. The tray was tested for temperatures and results were as follows: -cold roast beef sandwich was 158 degrees Fahrenheit (F). -mashed potatoes were 115 degrees F. -gravy was 129 degrees F. -pureed corn was 113 degrees F. Surveyor tasted the food from the tray: the cold roast beef sandwich was warm, the mashed potatoes, gravy, and pureed corn were cold. During an interview on 1/6/25 at 7:05 p.m., R39 stated the roast beef was not very cold and the mashed potatoes and gravy were cold. During an interview on 1/6/25 at 7:20 p.m., R51 stated the cold roast beef was not very cold and the mashed potatoes and gravy were so cold that they couldn't eat them. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/6/25 at 6:32 p.m., dietary aide (DA)-A stated the process is to plate the food, cover it, place it on a tray, and then the trays are passed to all residents who eat in their room. DA-A stated the holding temps of hot food should be at least 135 degrees F and cold food should be served no warmer than 41 degrees F. During an interview on 1/6/25 at 6:37 p.m., culinary director (CD) stated the normal process was to plate the food either from the steam tables in the dining room or from the main kitchen for residents who eat in their room, cover the food, and place on a cart for staff to pass to residents. CD stated the holding temp of cold food should be 41 degrees F and hot food should be at least 135 degrees F. Review of a facility policy titled Test Tray Evaluation Procedure undated, indicated facility would test last tray delivered, and identified cold food should have been at or below 50 degrees F and hot food at or above 140 degrees F.

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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 record review, the facility failed to ensure a shared glucometer (blood glucose meter) was disinfected after use for one resident (R71), and failed to performed hand hygiene after removing soiled gloves and prior to donning clean gloves and completing clean tasks during perineal care for 2 of 3 residents (R10, R17) observed during change of incontinent product. Additionally, the facility failed to ensure staff performed hand hygiene between assisting multiple residents in the dining area for 3 of 5 residents (R71, R40, R49) observed in a dining area. Findings include: HH DURING PERINEAL CARE R10's admission Minimum Data Set (MDS) dated [DATE], indicated R10 had intact cognition, required substantial and/or maximal assistance for toileting hygiene and partial and/or moderate assistance to roll left and right, and had diagnoses of cancer, heart failure, hypertension (high blood pressure), renal disease, diabetes mellitus, and respiratory failure. R17's quarterly MDS dated [DATE], indicated R17 had intact cognition, was dependent on staff for toileting hygiene, required substantial and/or maximal assistance to roll left and right, and had diagnoses of heart failure, urinary tract infection in the last 30 days, asthma, and respiratory failure. During observation on 1/7/25 at 3:55 p.m., nursing assistant (NA)-B and NA-C had gloves on and assisted R10 with perineal cares. R10 had a saturated incontinent product, and NA-C used wipes to provide perineal care to the front side and back side of R10. NA-C used the same gloves to tuck in clean linen used as a draw sheet and a clean incontinent product under R10. During observation on 1/7/25 at 4:10 p.m., NA-B and NA-C had gloves on and assisted R17 with perineal cares. R17 had incontinent bowel movement, and NA-B assisted R17 with perineal cares. NA-B had feces on gloves, removed gloves, did not perform hand hygiene, applied clean gloves, and moved R17's pillow to the wheelchair. NA-B tucked in the dirty bed linen under R17 and further cleaned bowel movement from R17. NA-B tucked the clean incontinent product under R17 with the same gloves. NA-B removed gloves, did not perform hand hygiene, and rubbed a towel against R17's back per request. NA-B left the room and performed hand hygiene prior to grabbing clean supplies from the supply closet. NA-B re-entered R17's room, applied gloves, and wiped the front perineal area of R17. NA-B did not change gloves or perform hand hygiene and velcroed R17's incontinent product, applied clean bed linen, repositioned R17, and placed a pillow behind R17's head. NA-B removed gloves and did not perform hand hygiene, pushed R17's bedside table towards R17, and brought bagged dirty items to the soiled linen room. During interview on 1/7/25 at 4:32 p.m., NA-C stated their gloves were not visibly soiled, so they did not change their gloves or perform hand hygiene between perineal care and tucking in R10's clean incontinent product. (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	01/09/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/7/25 at 4:44 p.m., NA-B stated they should have removed gloves and performed hand hygiene when gloves removed prior to touching clean items. During interview on 1/8/25 at 2:26 p.m., clinical manager (CM)-B, who worked with the director of nursing (DON) as the infection preventionist, expected staff to remove gloves and perform hand hygiene between dirty and clean tasks to prevent cross-contamination. During interview on 1/9/25 at 12:39 p.m., CM-A agreed staff needed to remove gloves and perform hand hygiene after dirty tasks and before clean tasks. The facility Gloves policy dated 12/19, directed staff to wash hands before applying gloves and wash hands after removing gloves. The Toileting Assistance policy dated 11/19, directed staff to gather incontinent supplies as needed, wash hands and apply gloves, change incontinence product as needed, perform pericares, assist with clothing and incontinence product adjustments as needed, discard soiled incontinence products, and remove gloves and wash hands. GLUCOMETER DISINFECTION R71's quarterly MDS dated [DATE], indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. R71's order with start date of 11/23/23, directed staff to check R71's blood sugar before meals for DM II [diabetes mellitus two]. During observation on 1/7/25 at 5:08 p.m., licensed practical nurse (LPN)-B brought a bin with clean supplies, such as packets of alcohol wipes and bottle of test strips, into R71's room. LPN-B checked R71's blood sugar and placed the glucometer into a plastic cup which sat in the bin of clean supplies. LPN-B removed gloves, performed hand hygiene, and returned to the medication chart at the nursing station with the glucometer and supplies. LPN-B used a glove to remove the used test strip from the glucometer and placed the glucometer on top of the clean alcohol wipes without disinfecting. During interview on 1/7/25 at 5:33 p.m., LPN-B stated the glucometer and bin with supplies were shared between residents in station three. LPN-B stated they usually disinfected the glucometer after use inside the resident's room but rushed so they could write down items they needed to order before they forgot. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to disinfect glucometers after use before leaving the resident room or putting back in clean supply bin. IP stated it was important to prevent the spread of bloodborne pathogens. During interview on 1/9/25 at 12:39 p.m., CM-A stated glucometers were disinfected before placed back in a clean area. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to disinfectant and cover shared glucometers for two minutes after use to prevent spread of bloodborne illness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Prevention and Control Program policy dated 11/24, indicated staff were to be educated and follow proper techniques and procedures for prevention of infection. The policy did not specifically address glucometer disinfection. HAND HYGIENE DURING MEAL ASSISTANCE R40's quarterly MDS dated [DATE], indicated R40 had severe cognitive impairment, required substantial and/or maximal assistance with eating, and had diagnoses of diabetes mellitus, cerebrovascular accident (stroke; when blood flow to the brain is interrupted), dementia, malnutrition, and hemiplegia or hemiparesis (complete loss of movement or weakness in one side of the body). R49's annual MDS dated [DATE], indicated R49 had severe cognitive impairment, required partial/moderate assistance with eating, and had diagnoses of atrial fibrillation (heart condition which causes an irregular and rapid heartbeat), hypertension (high blood pressure), diabetes mellitus, arthritis, dementia, and cerebrovascular accident. R71's quarterly MDS dated [DATE], indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. During observation on 1/8/25 at 8:18 a.m., R71 sat in wheelchair at a dining room table and mixed their oatmeal with their spoon without eating more than a couple bites. LPN-A approached R71 and fed R71 the oatmeal with their spoon without wearing gloves. LPN-A brought juice up to R71's mouth, R71 refused to swallow, and LPN-A wiped R71's mouth with a napkin. LPN-A did not perform hand hygiene and approached R49, who was in a wheelchair at another table, wiped R49's mouth with a napkin and no glove, and assisted R49 to eat pancakes and eggs using R49's silverware. LPN-A did not perform hand hygiene and approached R40 at the same table and assisted R40 with their breakfast using R40's silverware. During interview on 1/8/25 at 8:31 a.m., LPN-A stated they washed their hands before assisting in the dining area and verified they did not perform hand hygiene between assisting residents. LPN-A stated they were touching bowls and utensils and had not touched the food so did not need to wash their hands. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to wash their hands between assisting different residents in the dining area or expected staff to use one hand to help one resident and the other hand to help the second resident. IP stated staff should avoid cross-contamination. During interview on 1/9/25 at 12:39 p.m., CM-A stated staff needed to use a different hand for each resident they assisted with eating in the dining area or perform hand hygiene between assisting residents or ask other staff for help. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to wash their hands prior to meal service and in between residents or designate one hand per resident. Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy dated 10/17, directed staff to wash hands after engaging in activities which contaminate the hands.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 2 residents (R51) who were reviewed for call light accessibility. Findings include: R51's quarterly Minimum Data Set (MDS) dated [DATE], identified R44 was cognitively intact and had diagnosis of anxiety and depression. Identified R51 was dependent on staff for activities of daily living (ADLs) and mobility. R51's care plan dated 8/22/24, identified R51 had an alteration in behaviors and yelled out, with an intervention dated 12/4/24, to ensure call light was within reach and to answer promptly as this helped reassure R51. During an interview on 1/6/25 at 1:30 p.m., R51 was seated in her wheelchair about 3 ft. away from her bed. The call light was on the floor under R51's bed. R51 stated her call light was left out of reach often and asked to get staff to help her because she could not reach the call light. During an observation on 1/6/25 at 1:40 p.m., licensed practical nurse (LPN)-A entered R51's room, talked with R51, picked up the call light from the floor, and handed it to R51. During an observation on 1/7/25 at 8:52 a.m., R51 was seated in her wheelchair about 5 ft. from her bed. R51's call light was attached to the bed rail. R51 stated she could not reach her call light again. During an interview on 1/7/25 at 8:55 a.m., nursing assistant (NA)-A stated R51 was able to use the call light. NA-A further stated R51 was a fall risk so staff should always place R51's call light within reach. During an interview on 1/7/25 at 9:00 a.m., nurse manager (NM)-A entered R51's room and verified R51's call light attached to the bed rail and was not within reach of R51. NM-A stated R51 was able to use the call light and her expectation was that R51's call light was within reach. During an interview on 1/8/25 at 9:38 a.m., director of nursing (DON) verified R51 was able to use the call light. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Facility policy titled Call Light Policy revised 4/25/23, identified when residents were in their rooms, they would have a means of directly contacting caregivers. The policy further identified the facility would have ensured the system was functioning properly.