STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to comprehensively assess, discuss risks and benefits, obtain informed consent and attempt alternatives prior to use of bed rails for 9 of 12 residents (R11, R14, R3, R19, R6, R7, R16, R22, R188) reviewed who were observed to have bed rails raised while in bed. Findings include: R11 R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment with diagnoses which included diabetes mellitus, anxiety and depression. R11's MDS identified R11 required supervision and touching assistance to roll left and right and substantial/maximal assistance for bed to chair transfer. R11's Safety assessment dated [DATE], identified R11 had cognitive impairment, adaptive devices for bed included positioning rail times two on bed, no risk for entrapment identified, and used adaptive devices with prompting. R11's care plan revised 4/23/24, identified R11 had self care deficit and required assistance for transfers and had a half positioning rail to aid in bed mobility. R11's medical record lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:06 a.m., R11 was lying on back in bed, eyes closed, covered with bed linen. R11 had one half bed rail raised on the side of bed facing the doorway. No movement noted. At 8:23 a. m., R11 remained in bed, bed rail continued to be raised, eyes closed and no movement noted. At 8:45 a.m., R11 was lying on back in bed, eyes open, no movement noted and bed rail remained raised. During an interview on 7/17/24 at 9:53 a.m., registered nurse (RN)-A indicated she was not aware R11 used a bed rail as R11 required two staff to transfer her and did not have much strength in her shoulder. RN-A stated she would refer to R11's care plan to determine if R11 used a bed rail. (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14 R14's quarterly MDS dated [DATE], identified R14 had severe cognitive impairment and diagnoses which included: dementia, depression and diabetes mellitus. Indicated R14 required substantial/maximal assistance to roll left and right and for bed to chair transfers. R14's Safety assessment dated [DATE], identified R11 had cognitive impairment, adaptive devices for bed included positioning rail times one on bed, no risk for entrapment identified, and was aware of risk versus benefit of adaptive devices. R14's Safety assessment and medical record lacked documentation of who was informed of risk versus benefits. R14's care plan revised 5/3/24, identified R14 had self-care deficit related to dementia and mobility deficit and required stand by assistance with transfers, assistance for bed mobility and had a left side positioning rail to aide in mobility as needed (PRN). R14's medical record lacked a comprehensive bed rail assessment and attempted alternatives used prior to bed rail use. During an interview on 7/16/24 at 3:20 p.m. licensed practical nurse (LPN)-A indicated bed rails were used mostly so residents did not fall out of bed. In addition, the bed rails were used for residents to hold when they transferred out of bed. LPN-A stated R14 used her bed rail when she transferred out of bed. LPN-A stated bed rails would have been identified on the Resident Care Sheet for that resident. LPN-A reviewed the Prairie Meadow certified nursing assistant (CNA) Resident Care Sheet Side A form, updated 7/12/24, and confirmed the care sheet did not include bed rail use for R14. Review of Prairie Meadow CNA Resident Care Sheet Side A form, updated 7/12/24, lacked identification of bed rails or instructions for their use for R14, R11, R19, R6, R7, R16, R22, and R188. During an observation on 7/17/24 at 7:02 a.m., R14 was lying in bed, eyes closed, while holding a nebulizer to her mouth. R14 had half bed rails raised up on both sides of her bed. At 7:11 a.m. NA-A was in R14's room, standing next to her bed and asked R14 if she wanted to get up. R14 indicated she wanted to sleep in. R14's bed rail on the side towards the door was down when NA-A put it back into the raised position and then exited R14's room. During an interview on 7/17/24 at 7:14 a.m., NA-A indicated R14's rails were up sometimes. NA-A stated she had lowered R14's bed rail while she was in there and then raised it back up. NA-A indicated it was usually not identified on the Resident Care Sheet form to use bed rails however, when residents were in bed, staff usually raised their bed rails and NA-A was unsure of the reason why staff raised the rails. During an observation on 7/17/24 at 8:11 a.m., R14 remained in bed with eyes closed and covered with bedding. R14 had a bed rail up on the side by the wall and the bed rail towards the door lowered. During an interview on 7/17/24 at 7:37 a.m. NA-B stated bed rails were raised while residents were in bed to prevent them from falling out of bed. NA-B reviewed the Prairie Meadow CNA Resident Care Sheet form she carried and stated most residents did not have bed rails listed however, NA-B stated she raised most of the residents' bed rails while in bed to keep them safe. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 7/17/24 at 12:28 p.m., family member (FM)-A stated he was aware R14 had a new bed and had bed rails raised on the bed. FM-A indicated the facility staff had not discussed why R14 used bed rails and confirmed they had not discussed the risks versus benefits of using the bed rails. 45844 R3 R3's quarterly MDS dated [DATE], identified R3 had moderate cognitive impairment and diagnoses which included heart failure, hypertension (elevated blood pressure), and End Stage Renal Disease. Identified R3 required limited assistance for activities of daily living (ADL's) which included toileting, transfer and bed mobility. Prairie Meadow CNA Resident Care Sheet Side B form, updated 6/28/24, lacked instructions for R3's bed rail use. R3's care plan revised 5/2/24, identified R3 required staff assistance to transfer and reposition in bed and used bilateral positioning rails in bed to assist in self repositioning. R3's Safety assessment dated [DATE], identified R11 did not require any adaptive devices for the bed. R3's medical record lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:16 a.m., R3 was lying in bed, had one half bed rail raised on side of bed facing the doorway. NA-B entered R3's room to assist R3 with ADL's. R3 sat up in bed per self without using the bed rail. NA-B placed a walker in front of R3 which R3 used to stand up and walk into the bathroom. During an interview on 7/17/24 at 7:20 a.m., NA-B stated the bed rail on R3's bed was used to keep R3 from rolling out of bed. NA-B indicated she was unsure if R3 ever used the bed rail for positioning. R19 R19's quarterly MDS dated [DATE], identified R19 had severe cognitive impairment and diagnoses which included non traumatic brain dysfunction, dementia, and hypertension. R3 required extensive assistance for ADL's which included toileting, transfer, and bed mobility. Prairie Meadow CNA Resident Care Sheet Side A form, updated 7/12/24, lacked instructions for R3's bed rail use. R19's care plan revised 5/3/24, identified R19 required staff assistance to transfer and reposition in bed and was to use positioning rails in bed as needed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's Safety assessment dated [DATE], identified R19 had cognitive impairment, adaptive devices for bed included positioning rail times two (X 2) on bed, no risk for entrapment identified. Assessment lacked any indication R19 was able to use the bed rails independently. R19's medical record lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 8:43 a.m., R19 was lying in bed had one half bed rail was raised on side of bed facing the doorway. NA-B and NA-F entered R19's room to assist her out of bed. NA-F assisted R19 to a sitting position by placing one hand behind R19's back and the other under R19's legs and turned and lifted her to a sitting position on the edge of the bed. NA-F placed a transfer belt around R19's waist and NA-F and NA- B pivot transferred R19 into her wheelchair. During an interview on 7/17/24 at 8:48 a.m., NA-B stated the bed rail on R19's bed was supposed to be for R19 to assist with repositioning however, R19 was only able to use the rail on her good days and most days R19 was not able to use the rail at all. NA-B stated the usual practice was to leave R19's bed rail up whether she was able to use it or not. During a phone interview on 7/17/24 at 11:35 a.m., FM-B stated the facility had not informed her R19 had received a new bed with bed rails. In addition, FM-B stated the facility had not discussed benefits versus risk with her prior to R19 using the bed with bed rails. During a phone interview on 7/17/24 at 12:23 p.m., FM-C stated the facility had not informed her R3 had received a new bed with bed rails. In addition, FM-B stated the facility had not discussed benefits versus risk with her prior to R3 using the bed with bed rails. 49620 R6 R6's admission MDS dated [DATE], identified R6 had moderately impaired cognition and required extensive assistance with bed mobility and transfers. R6's diagnoses included dementia with psychotic disturbance, heart failure, compression fractures of vertebrae (bones in the spinal column). The MDS did not identify use of bed rails. R6's care plan revised 6/19/24, indicated R6 had confusion at times. R6's care plan revised 7/11/24, indicated R6 was at risk for falls related to mobility deficit, pain, incontinence and history of falls. R6's care plan revised 7/16/24, did not include bed rails. R6's safety assessment dated [DATE], indicated bilateral positioning rails. R6's electronic health record (EHR) lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:06 a.m., R6 was laying in bed, one half bed rail raised on side of bed towards doorway. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/24 at 11:45 a.m., NA-D stated the bed rail was always up on R6's bed to prevent R6 from falling out of bed. NA-D stated the bed rails were up on many residents' beds in the facility, just in case to prevent them from falling out of bed. R7 R7's quarterly MDS dated [DATE], identified R7 had severe impaired cognition and required extensive assistance with bed mobility and transfers. R7's diagnoses included multiple sclerosis, psychotic disorder with delusions and hallucinations, depression, anxiety. The MDS did not identify use of bed rails. R7's care plan revised 2/21/19, indicated R7 was a risk for falls related to poor balance, impulsive and poor decision making. R7's care plan revised 4/15/24, indicated staff assist as needed with bed mobility. Bilateral positioning rails as needed. Stand up lift and assist of one staff for transfers. R7's safety assessment dated [DATE], indicated bilateral positioning rails as needed. R7's EHR lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/16/24 at 8:51 a.m., R7 was laying in bed, one half bed rail were raised on both sides of the bed. R16 R16's quarterly MDS dated [DATE], identified R16 had moderately impaired cognition and required extensive assistance of two staff with bed mobility and total dependence of two staff and a hoyer lift for transfers. R16's diagnoses included multiple sclerosis, depression, paraplegia, obesity. The MDS did not identify use of side rails. R16's care plan problem revised 7/24/19, indicated R16 could appear to remember at times but may not and had two appointed guardians. R16's care plan problem revised 6/22/20, indicated R16 was at risk for falls related to diagnoses and medication regimen. R16's care plan problem revised 3/7/19, indicated two staff assist with bed mobility, bariatric bed due to height and stature. Bilateral positioning rails as needed. Hoyer lift and two staff assist for transfers. R16's safety assessment dated [DATE], indicated bilateral positioning rails. R16's EHR lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:06 a.m., R16 was laying in bed, the bed rails were raised on both sides of the bed. R22 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's quarterly MDS dated [DATE], identified R22 had severe impaired cognition and required extensive assistance with bed mobility and transfers. R22's diagnoses included Alzheimer's dementia, anxiety, chronic obstructive pulmonary disease, heart failure, muscle weakness. The MDS did not identify use of side rails. R22's care plan problem revised 8/24/23, indicated R22 had impaired cognition function, impaired thought processes and impaired decision making. R22's care plan problem revised 11/14/23, indicated R22 was high risk for falls related to confusion, gait and balance problems and was unaware of safety needs and a history of self transfers. R22's care plan problem revised 11/7/23, indicated staff assist as needed with bed mobility, R22 turns self at times. Positioning rails as needed. Stand up lift and assist of one staff for transfers. R22's safety assessment dated [DATE], indicated no positioning rails. R22's EHR lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:05 a.m., R22 was laying in bed, one half bed rail was raised on the bed facing the doorway. R188 R188's face sheet identified admission on 7/11/24. R188's admission MDS dated [DATE] was in progress. R188's diagnoses included orthopedic aftercare following removal of internal fixation device, depression, fibromyalgia (disorder causing widespread pain, fatigue, sleep problems and cognitive difficulties). R188's baseline care plan dated 7/11/24, indicated R188 had a history of falls and required no setup or physical help from staff for bed mobility, one person assist for transfers, no bed rails indicated. R188's safety assessment dated [DATE], was not completed. R188's EHR lacked a comprehensive bed rail assessment, including discussion of risks versus benefits, informed consent and attempted alternatives prior to bed rail use. During an observation on 7/17/24 at 7:04 a.m., R188 was laying in bed, one half bed rail was raised on the bed facing the doorway. During an interview on 7/17/24 at 11:38 a.m., R188 verified the facility had not discussed the use of the bed rail or the benefits versus risk with her prior to using the bed rail. During an interview on 7/17/24 at 11:39 a.m., family member (FM)-D stated the facility staff had not discussed why R188 used bed rails, and confirmed they had not discussed the risks versus benefits of using the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/24 at 10:20 a.m. unit manager RN-B indicated the facility received new resident beds within the last year and she had conversations with the sales representative regarding the safety of the beds. The representatives assured them residents would not be at risk for entrapment and the bed rails were regulatory sized for long term care use. RN-B stated the bed rails were not used to prevent falls, only for positioning purposes. RN-B indicated it was difficult to monitor if and when the bed rails had been raised by staff since all of the beds had the rails attached. RN-B confirmed they had not had discussions on the use of the bed rails with all residents or resident representatives, or received consents for the use of the bed rails as they had not considered them side rails; they were only used for positioning. In addition, RN-B confirmed they had not documented on any alternatives attempted prior to the use of bed rails. RN-B reviewed the Prairie Meadow CNA Resident Care Sheets for both side A and B, each of the residents' medical records including the Safety Assessments and care plans, for the residents identified and confirmed the above findings. RN-B clarified that if a safety assessment identified the resident used adaptive devices with prompting, that it should have only been when staff were present. RN-B clarified if the bed rails were care planned as needed (PRN) , it could have been interpreted differently, as each resident's needs were very individualized. During an interview on 7/17/24 at 12:52 p.m., director of nursing (DON) stated the facility had not completed any assessments of bed rail use since the facility had considered them positioning bars and not bed rails. In addition, DON confirmed the facility had not discussed risk versus benefits or obtained informed consent from residents or resident representatives prior to using the bed rails. DON indicated her expectation was that a comprehensive assessment, benefits verses risks and informed consent would have been completed as well as attempting alternatives prior to implementing the bed rails. DON stated she would have expected staff to update the resident care sheets and ensure that care plans were being followed. The facility policy titled Bed Rails reviewed 2/24, identified its purpose was to determine if resident use of bed rail use was safe and appropriate. The policy included upon admission, readmission, or change of condition, residents would be screened to determine the need for special equipment or accessories (bed rails, for example.) Staff would assess the resident to identify appropriate alternatives and assess for risk of entrapment, review the risks and benefits with resident and representative, obtain informed consent, and obtain a physician order, prior to installing bed rails. Staff would update the resident's care plan to reflect the use of the bed rails.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37905 Based on observation, interview and document review, food and drinks were not served in a sanitary and clean manner for residents observed during dining observations in both dining rooms. This deficient practice had the potential to affect all residents who ate their meals in the dining rooms. Findings include: During an observation on 7/15/24 at 11:47 a.m., cook (C)-A began to set up the steam table in the A wing dining room. At 11:53 a.m., C-A began serving the lunch meal which included sloppy joes on a bun with gloves on. Each resident had a dietary card in a plastic sleeve in a binder. C-A would flip the pages with her right hand, then remove a bun with her left hand, open the buns with both gloved hands, then place them on the plates. C-A continued to touch the dietary cards, then the buns with her right hand, until all residents were served in the dining room. C-A did not sanitize hands or apply new gloves after touching each resident's dietary card in the binder. During an observation on 7/15/24 at 12:00 p.m., C-A was serving the B wing dining room. C-A again wore gloves, opened the binder, and touched each dietary card with her right hand, flipping each page open, then would open the buns with both hands and place on each resident's plate. C-A did not sanitize hands or apply new gloves after touching each resident's dietary card in the binder. During an observation on 7/16/24 at 12:01 p.m., nursing assistant (NA)-C served drinks to residents in the A wing dining room. NA-C held the glasses touching the rims with her bare hands. In addition, NA-B served drinks with bare hands and touched the rims of the glasses while filling them from the drink cart. NA-C filled a coffee cup in the kitchenette, held the cup with her fingers touching the rim of the cup, rubbed the rim of the cup with her finger, then proceeded to fill another coffee cup while touching the rim of that coffee cup. NA-B served a glass of chocolate milk after she touched the rim of the glass, filled a glass of juice, held the glass with her hand over the top of it touching the rim and then set it on the table for the resident. During an interview on 7/16/24 at 2:19 p.m., NA-B indicated she was not aware she had been touching the rims of the glasses prior to serving drinks to the residents. NA-B indicated it was important not to touch the rims of the glasses to prevent cross contamination. During an interview on 7/16/24 at 2:22 p.m., NA-C stated glasses should have been held at the bottom while serving drinks. NA-C indicated she was not aware she had been touching the rims of the glasses and cups while pouring drinks and serving them. NA-C stated it was important to not touch the rim of the glasses or cups to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 7/16/24 at 2:10 p.m., C-A confirmed she had touched the buns after touching the dietary cards and verified she should not have since she did not know what could have been on the dietary cards. C-A stated the binders with the resident's dietary cards were kept in the kitchenettes and were available to all staff for review of each resident's diet. C-A indicated gloves should have been worn when handling foods, like buns, and stated they had a process, that one gloved hand would touch the food and the other hand would touch the dietary cards. C-A indicated she could have also used a butter knife to flip the dietary card pages. C-A indicated it was important not to touch the cards, then the foods, since bacteria and left over foods could have been left on the dietary cards. During an interview on 7/16/24 at 2:30 p.m., dietary manager (DM)-A indicated her expectation was staff were to use a utensil or gloved hand when touching foods. DM-A stated she had instructed staff not to touch the dietary cards and food products with the same hand. DM-A stated this practice was important to prevent cross contamination. In addition, DM-A stated nursing staff should not have been touching the rims of the glasses when serving dinks for the same reason. During an interview on 7/16/24 at 2:40 p.m., director of nursing (DON) confirmed staff should not touch the rims of the resident's glasses or cups, since their hands could have been soiled and could lead to cross-contamination. The facility policy titled Food & Nutrition Services revised 4/22, identified its purpose was to ensure the service of safe food to all patients, residents, staff and visitors. The policy identified food would be served onto clean dishes with clean utensils and sanitary techniques. Hands would not touch the food unless properly covered with clean disposable glove. Gloves would be worn anytime employee would handle food that would not be later cooked, including bread. Gloves would be removed/changed anytime they became contaminated.

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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 implement donning/doffing of personal protective equipment (PPE) practices for 2 of 2 residents (R9 and R32) and to ensure PPE was readily available for use to prevent the spread of infection for 1 of 2 residents (R9) 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). Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of 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. R9 R9's annual Minimum Data Set (MDS) dated [DATE], identified R9 had moderate cognitive impairment and diagnoses which included heart failure, dementia, and arthritis. Identified R9 required extensive assistance for activities of daily living (ADL's) which included toileting, transfer, and dressing. Indicated for activities of daily living (ADL's) which included toileting, transfer, and dressing. Indicated. Indicated R9 had a pressure ulcer. R9's care plan revised 6/17/24, indicated R9 had a stage two pressure injury on her right buttock. (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising). Care plan instructed staff to reposition resident every two hours and to provide treatments ordered per the medical doctor (MD). R9's weekly wound assessment dated [DATE], identified R9 had an open wound on her left buttock that measured one centimeter (cm) in length and 1.3 cm in width. Assessment identified that a Duoderm dressing was applied to R9's left buttock. During an observation on 7/15/24 at 11:27 a.m., there was an organizer on the front of R9's door to her room that contained gowns, masks, and gloves. There was no sign on the door or in the immediate area that identified R9 was on EBP. During an observation on 7/16/24 at 9:10 a.m., nursing assistant (NA)- E entered R9's room wearing no PPE and assisted R9 to transfer into her recliner by placing her right hand on R9's back as R9 stood up and guided R9 into the recliner. R9 stated she wanted to get back in her wheelchair so NA-E proceeded to place her right hand on R9's back as R9 stood up and guided R9 back into the recliner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 2:44 p.m., NA-E verified she had not worn any PPE when she transferred R9 into her recliner. NA-E stated she only wore a gown and gloves when completing ADL's or toileting R9. NA-E stated she was unaware she should have worn a gown and gloves while transferring R9 into the recliner. R32's significant change MDS dated [DATE], identified R32 had moderate cognitive impairment and diagnoses which included history of neoplasm of the skin (skin cancer), anxiety, and depression. Identified R9 required extensive assistance for ADL's which included toileting, transfer, and dressing. R32's care plan revised 4/11/24, indicated R32 had a lesion to left ear removed. Care plan directed staff to monitor skin daily with care. Care plan lacked any indication of a dressing being used. R32's weekly wound assessment dated [DATE], identified R32 had an open area on his left ear that measured two cm in length and 0.8 cm in width and 0.8 cm in depth from an excision of a squamous cell carcinoma lesion (a type of cancer that starts as a growth of cells on the skin) that dehisced (a partial or total separation of previously approximated wound edges, due to a failure of proper wound healing.). Assessment identified that an Allevyn dressing was used to protect wound and prevent R32 from picking at the wound. During an observation on 7/15/24 at 12:09 a.m., there was no PPE located near R32's room for staff to wear while providing care for R32. During an observation on 7/16/24 at 9:30 a.m., registered nurse (RN)-B entered R32's room, applied gloves on her hands and proceeded to sit down next to R32 on the bed. RN-B peeled back the dressing to R32's left ear to assess R32's wound which contained a small amount of serosanguinous (thin and watery fluid that is pink in color due to the presence of small amounts of red blood cells) drainage and RN-B replaced the dressing. RN-B did not wear a gown in the above observation. During an interview on 7/16/24 at 2:49 p.m., RN-B verified she had not worn a gown while assessing R32's wound to his left ear earlier that day. RN-B verified R32's wound was from an area of skin cancer which was surgically removed and then dehisced. RN-B stated the wound had been open since 7/11/24, however, EBP were only implemented a few hours ago. RN-B stated her expectation was EBP should have been implemented on 7/11/24, for R32. RN-B indicated the expectation was that all staff follow EBP while caring for R9 and R32 to prevent the spread of infection. During an observation on 7/17/24 at 7:29 a.m., NA-A entered R32's bathroom and applied only gloves, assisted R32 off the toilet, pulled up R32's pants and walked along side of R32 to his bed. NA-A removed her gloves and washed her hands. NA-A did not wear a gown. During an interview on 7/17/24 at 7:31 a.m., NA-A stated her usual process was to only wear gloves while caring for R32. NA-A stated the sign and PPE were new on the door and she was not aware she needed to wear a gown and gloves while toileting R32. During an interview on 7/17/24 at 12:44 p.m., director of nursing (DON) verified R9 and R32 had open wounds with dressings and required EBP. DON stated her expectation was that staff would have followed EBP per CDC guidelines to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy dated 2/10/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. identified EBP employs targeted gown and glove use during high contact resident care activities. Indicated the facility would make gowns and gloves available immediately near or outside of the resident's room; PPE for enhanced barrier precautions was necessary when performing high-contact care activities.