STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	1115 4th Avenue North Sauk Rapids, MN 56379

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 3 resident s (R5) who were observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R5's annual Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact and had diagnosis which included arthritis, hypertension (elevated blood pressure) and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). Further, R5 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. R5's care plan dated 3/4/24, identified R5 had an activity of daily living (ADL) self-care performance deficit related to activity intolerance. R5's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Directed staff to administer medications as ordered. Review of R5's electronic health record (EHR) revealed a self-administration of medication (SAM) assessment dated [DATE], and identified R5 did not wish to self- administer medications. R5's Order Summary Report dated 2/18/25, directed staff to administer Albuterol Sulfate inhalation nebulizer 2.5 MG/3 ML via nebulizer twice daily for chronic cough. Further, it directed staff to administer Budesonide inhalation suspension 0/5 MG/2 ML via nebulizer twice daily for chronic cough. R5's Order Summary Report lacked an order to self administer medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 4/15/25 at 9:33 a.m., R5 was seated in her wheelchair in her room and trained medication aide (TMA)-A entered R5's room with a vial containing albuterol nebulizer solution. (TMA)-A poured the solution into a nebulizer mask, placed the mask on R5's face, and told R5 she would return in 10 minutes to place the second nebulizer. TMA-tuned on the nebulizer machine, left R5's room, and returned to medication cart in the hallway which was not within visual sight of R5's room. At 9:43 a.m., TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask and rinsed it out with water in R5's bathroom. TMA-A placed the budesonide nebulizer solution in the nebulizer mask. TMA-A placed the nebulizer mask on R5's face and told R5 she would return in 10 minutes to remove the nebulizer mask. TMA-returned to her medication cart in the hallway not within visual sight of R5's room. At 9:50 TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table with solution still coming from the mask. TMA-A picked up the nebulizer mask, turned the nebulizer machine off and placed the nebulizer mask on the nebulizer machine. During an interview on 4/15/25 at 10:05 a.m., TMA-A verified she had placed the nebulizer treatment on R5 and exited the room. TMA-A stated she was unsure if a SAM assessment had been completed for R5. TMA-A stated she was unsure what the process was for a resident that did not have an order to self-administer medications. During an interview on 4/15/25 at 10:10 a.m., registered nurse (RN)-A confirmed R5's SAM dated 3/4/24, identified R5 had not wished to self-administer medications. RN-A stated her expectation was nursing staff would have stayed in the room with R5 while she received the nebulizer treatments to ensure R5 received the nebulizer treatments appropriately. During an interview on 4/16/25 at 1:05 p.m., director of nursing (DON) verified R5 was not safe to self-administer medications. DON stated if a resident had not been assessed to safely self-administer medication or have a physician order to self administer medications staff were expected to remain with the resident the entire nebulizer treatment. Review of a facility policy titled Medication Administration revised 6/2024, identified medications ordered by the physician would be set up and administered within the established guidelines. Identified the resident must take the medications when the nurse/TMA is present unless the resident has completed Medication Self-Administration Assessment and noted to be safe.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration of an inhalation medication for 1 of 3 residents (R5) observed for medication administration. Findings include: R5's annual Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact and had diagnosis which included arthritis, hypertension (elevated blood pressure) and and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). Indicated R5 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. R5's care plan dated 3/4/24, identified R5 had an activity of daily living (ADL) self-care performance deficit related to activity intolerance. R5's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Directed staff to administer medications as ordered. R5's Order Summary Report dated 2/18/25, directed staff to administer Budesonide inhalation suspension 0/5 MG/2 ML via nebulizer twice daily for chronic cough. Identified to rinse mouth with water and spit after use, if unable to rinse and spit mouth should be swabbed. During an observation on 4/15/25 at 9:43 a.m., trained medication aide (TMA)-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask and rinsed it out with water in R5's bathroom. TMA-A placed the budesonide nebulizer solution in the nebulizer mask. TMA-A placed the nebulizer mask on R5's face and told R5 she would return in 10 minutes to remove the nebulizer mask. TMA-returned to her medication cart in the hallway not within visual sight of R5's room. At 9:50 TMA-A entered R5's room and the nebulizer mask was lying on R5's bedside table. TMA-A picked up the nebulizer mask, turned the nebulizer machine off and placed the nebulizer mask on the nebulizer. R5 was not observed to rinse her mouth out and TMA-A had not instructed R5 to rinse mouth out as ordered after taking the Budenoside nebulizer. During an interview on 4/15/25 at 10:05 a.m., TMA-A confirmed she had not instructed R5 to rinse her mouth after receiving the Budesonide nebulizer. TMA-A stated she had not seen the order instructions to rinse mouth after use. TMA-A stated it was not her usual process to instruct R5 to rinse her mouth after the Budesonide nebulizer. During an interview on 4/15/25 at 10:10 a.m. registered nurse (RN)-A verified R5 had an order to rinse and spit after the Budesonide nebulizer. RN-A indicated it was important to rinse the mouth after a steroid nebulizer was received to prevent any infections. During an interview on 4/15/25 at 10:39 a.m., pharmacy consultant (PC)-A stated it was important to rinse the mouth after receiving Budesonide nebulizer because it was a steroid. PC-A indicated it could cause thrush, a fungal infection inside the mouth. PC-A stated it was her expectation nursing staff would instruct the resident to rinse their mouth after each use. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 1:05 p.m. director of nursing (DON(confirmed R5's Budesonide nebulizer physician orders included instructions to rinse mouth after use. DON stated it was important for residents to rinse their mouth after use to prevent infections in the mouth. DON stated her expectation was nursing staff to instruct R5 to rinse mouth after receiving the Budesonide nebulizer. R5's Budesonide nebulizer box instructions indicated Budesonide was indicated for chronic respiratory conditions. Indicated Patients should rinse the mouth after inhalation of budesonide inhalation suspension to prevent fungal infections. Review of a facility policy titled Medication Administration revised 6/2024, identified medications ordered by the physician will be set up and administered within the established guidelines and given according to physician orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 4 residents (R12) with a current pressure ulcer and at risk for further development of pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition and diagnosis which included arthritis, anxiety disorder and paraplegia (paralysis of the legs and lower body). Identified R12 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting R12's annual Care Area Assessment (CAA) dated 8/2/24, identified R12 was a at risk for skin breakdown and had a pressure ulcer to her left gluteal fold. Identified R12 required extensive assistance to reposition in bed and wheelchair. she required a regular turning schedule. R12's care plan revised 10/4/24, identified R12 had a chronic wound to her right gluteal fold. Care plan directed staff to reposition R12 every two hours when in bed. R12's weekly wound assessment dated [DATE], identified R13 had a chronic pressure ulcer to her right gluteal fold which measured 3 centimeters (CM) in length and 2.2 cm in width. Identified pressure ulcer was a stage 3 (a deep, open wound that penetrates through the dermis and into the subcutaneous tissue, exposing fat but not bone, muscle, or tendon) and required a foam dressing. R12's current physician orders dated 4/14/25, identified wound to right sacrum -cleanse wound with wound cleanser and pat dry. Apply skin prep around the wound and allow to dry then place Santyl to the wound base and cover with adhesive foam dressing daily and as needed. During an interview on 4/14/25 at 1:26 p.m., R 12 stated she had a sore on her bottom and required staff assistance to turn and reposition off of her bottom. During a continuous observation on 4/15/25 at 1:41 p.m., nursing assistant (NA)-A and NA-B exited R12's room with a hoyer lift. NA-A sanitized the hoyer lift and placed the lift at the end of the hallway. -1:42 p.m., R12 was lying in bed on her back. -2:00 p.m., R12 remained lying in bed on her back. -2:20 p.m., R12 remained lying in bed on her back. -2:48 p.m., R12 remained lying in bed on her back. -3:17 p.m., R12 remained lying in bed on her back. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3:47 p.m. R12 remained lying in bed on her back. -4:10 p.m., R12 remained lying in bed on her back. -4:35 p.m., R12 remained lying on her back and surveyor requested NA-C to reposition R12 after R12 remained lying in bed on her back and not repositioned for almost 3 hours. During an observation on 4/15/25 at 4:38 p.m., NA-C, NA-D, and registered nurse (RN)-A sanitized hands, put a gown and gloves on and entered R12's room, changed R12's incontinent product, wound bandage, and repositioned R12. During an interview on 4/15/25 at 4:48 p.m., NA-C stated R12 required staff assistance to reposition and was to be repositioned every two hours because she has a pressure ulcer. NA-C stated according to the day shift's documentation the the last time R12 had been repositioned was around 1:45 p.m. NA-C stated R12 should have been repositioned around 3:45 p.m. During an interview on 4/15/25 at 4:53 p.m., RN-A verified R12 had a pressure ulcer and required staff assistance to reposition. RN-A stated R12 was at continued risk of developing further skin breakdown and should have been repositioned every two hours while in bed. RNA stated her expectation was that R12's care plan would have been followed to help prevent any further skin breakdown. During an interview on 4/16//25 at 1:08 p.m., director of nursing (DON) verified R2 required staff assistance to reposition. DON stated R2 had a pressure ulcer on her right gluteal fold and was at risk for further skin breakdown. DON stated her expectation was that R12's care plan for repositioning would have been followed. A repositioning policy was requested and was not received. .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 44645 Based on record review and interviews, the facility failed to ensure all required data were included on the nurse staffing information posted daily. This had the potential to affect all 114 residents residing in the facility and their visitors who may wish to view the information. Findings include: On 4/14/25 at 1:21 p.m., the posted nurse staffing information dated 4/14/25, was observed in a clear, plastic cover on the visitor sign-in table. However, the nurse staffing information lacked the total number and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Additionally, the nurse staffing information lacked the resident census. On 4/15/25 at 2:12 p.m., the posted nurse staffing information dated 4/15/25, lacked the total number, and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Additionally, the posting lacked resident census. On 4/16/25 at 7:18 a.m., the posted nurse staffing information dated 4/16/25, lacked the total number and the actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Additionally, the posting lacked resident census. On 4/17/25 at 7:58 a.m., the posted nurse staffing information lacked the total number, and the actual hours worked, by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift, and resident census. Additionally, the posted nurse staffing information was dated 4/16/25. On 4/17/25 at 10:10 a.m., the director of nursing (DON) stated she was unaware the information on the nurse staffing information postings lacked required information. The DON stated the nurse staffing post was expected to be updated and posted with correct information and was important so that residents and visitors knew who was in the facility providing care. On 4/16/25 at 8:56 a.m., DON verified the facility did not have a nurse staffing information policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49035 Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 7 medication carts. Findings include: On 4/15/25 at 9:12 a.m., medication cart on locked memory care unit was observed to be unlocked. Medication cart was in a common area. Medication cart remained unlocked while staff walked past unlocked medication cart. On 4/15/25 at 2:44 p.m., medication cart on 100 wing of the facility was observed being unlocked. At 2:46 p.m., staff walked past medication cart to pass water. Cart remained unlocked. At 2:48 p.m., staff walked past cart with housekeeping cart. Cart remained unlocked. At 2:49 p.m., registered nurse (RN)-B was observed coming out of spa room and walking down hall away from medication cart. Medication cart remained unlocked. At 2:50 p.m., RN-B re-entered locked spa room. Cart remained unlocked. AT 2:53 p.m., RN-B walked from spa to nurse's office out of direct eyesite of medication cart. Cart remained unlocked. At 2:54 p.m., staff passed medication cart while pushing a resient in a wheelchair. Cart remained unlocked. At 2:55 p.m., licensed practical nurse (LPN)-A walked past medication cart. Cart remained unlocked. At 2:57 p.m., RN-B locked the cart. During interview on 4/15/25 at 2:57 p.m., RN-B confirmed the medication cart was unlocked for an unknown amount of time. RN-B confirmed she did not have the medication cart direct eyesight during that time. During interview on 4/16/25 at 2:39 p.m., director of nursing (DON) stated she expected medication carts to be locked any time the nurse is away and out of eye site of them for any amount of time. DON stated this was important to make sure no one had access to items in the cart they should not have access to. The DON confirmed this was especially important in on the dementia until where residents had memory impairments. The DON confirmed the do complete regular audits to ensure medication carts were locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy was requested, but none provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 3 of 3 residents (R 5, R16, and R13) who resided on the North shore unit, reviewed for food. This deficient practice had the potential to affect all 21 residents residing on this unit. Findings include: R5's annual Minimum Data Set (MDS) dated [DATE], indicated R5 had intact cognition ad was able to feed herself after staff set up her tray. R16's significant change MDS dated [DATE], indicated R16 had intact cognition and could feed herself after staff set up her tray. R13's admission MDS dated [DATE], indicated R13 had intact cognition and could feed himself after staff set up his tray. During an interview on 4/14/25 at 2:00 p.m. R5 stated the food was not always hot by the time they were served on this unit. During an interview on 4/14/25 at 3:56 p.m., R16 stated the food was not always served very hot especially the meat and potatoes. During an interview on 4/14/25 at 4:09 p.m. R13 stated the food was usually only lukewarm. During an observation on 4/14/25 at 6:24 p.m., food was being dished up onto plates and placed on a plate warmer from the steam table in the main kitchen. The plates were placed on trays and put into a cart. As the last plate was being placed into the cart a test tray was requested and placed into the cart. The meal consisted of a hamburger patty, a chicken patty, baby potatoes, and cauliflower. -at 6:24 the cart was wheeled to the north shore unit. -at 6:36 p.m. as the last tray was being passed dietary aide (DA)-A tested the food temperatures and the temps were as follows: -Hamburger was 121 degrees Fahrenheit (F). -chicken was 118 degrees Fahrenheit (F). - baby potatoes were 131 degrees Fahrenheit (F). -cauliflower was 120 degrees Fahrenheit (F). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor tasted the food from the tray: the hamburger and chicken were cold, the baby potatoes, and cauliflower were lukewarm. Dietary aide (DA-A) confirmed the hamburger and chicken were cold and the remaining items were barely warm. During an interview on 4/14/25 at 6:48 p.m. DA-A stated she was unsure of what the food temperatures should be but would find out. During an interview on 4/14/25 at 6:55 p.m., R13 stated his chicken was only lukewarm as always. During an interview on 4/14/25 at 7:00 p.m., R16 stated her chicken was cold tonight but she ate it because she was hungry. During an interview on 4/14/25 at 7:04 p.m., dietary manager stated her expectation was that food holding temps should be at least 140 degrees Fahrenheit (F). Review of a facility policy titled Food Service and Delivery undated, identified, hot food was to be held at 140 degrees Fahrenheit (F). or higher.

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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. 45844 Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators and freezers were labeled, dated and discarded properly. In addition, the facility failed to maintain the ice machines in a sanitary manner to prevent potential food-borne illness. This deficient practice had the potential to affect all 116 residents who received food, beverages, and ice from the refrigerators, kitchen and ice machine. Findings include: On 4/14/25 at 10:44 a.m., during the kitchen tour with the dietary supervisor (DS), the following concerns were identified: Produce cooler: -1/4 container of yogurt without notation of an open date. -3/4 container tartar sauce without notation of an open date. -1/4 container mayonnaise without notation of an open date or an expiration date, and a foul odor when container was opened. Stand up freezer: -1/4 bag of sausage without notation of an open date or expiration date. -3/4 bag of pepperoni without notation of an open date or expiration date. -1/2 container of pork Salisbury steak without notation of an open date or expiration date. Stand up cooler: -1/4 container of yogurt without notation of an open date. -two bowls of yogurt without notation of an open date. -1/4 whip topping no open date or expiration date -1/4 container yogurt -2 bowls of yogurt without notation of an open date. Resident fridge on Ace unit: -bowl of chicken noodle soup without notation of a date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident fridge on Sunny Lake unit: -one bowl of potato soup without notation of a date. -two blueberry muffins dated 3/31/25. - one bowl of chicken rice soup dated 4/3/25. Resident fridge on Milacs Lake unit: -One piece of fish in a Styrofoam container without notation of a date. Ice Machines: During an observation on 4/14/25 at 11:00 a.m., the ice machine located outside of the kitchen had a large white flaky substance approximately one half to one inch thick on the ice machine cover and the drip tray. In addition, the drip tray had a large orange buildup around the edge of the tray. During an observation on 4/14/25 at 11:15 a.m., the ice machine located on the Ace unit had a large white flaky substance approximately one half to one inch thick on the ice machine cover. During an interview on 4/14/25 at 11:30 a.m., (DS) verified the above findings during the kitchen tour. DS stated his expectation was that all food should have been dated when opened and placed in fridge or freezer and thrown away after seven days of being opened or prior to the expiration date. During an interview on 4/14//25 at 6:39 p.m., dietary manager (DM) stated her expectation was that all food items would have been dated once opened and thrown away after the shelf life or the expiration date to prevent a food borne illness. DM stated maintenance cleans the ice machine quarterly and her expectation was that there was no build up on the ice machines. During an interview on 4/15/25 at 1:45 p.m. maintenance director (MD) verified the buildup on the ice machines. MD stated his expectation was that the ice machines would not have any build up on them Review of a facility policy titled maintenance: Scale Removal dated 12/2014, identified scale removal was performed on all ice machines at least twice yearly, every three months or as necessary to maintain a sanitary unit. Review of a facility policy titled Food Handling Standards and Procedures dated 2024, identified all food needs to be dated once opened and discarded within seven days or prior to the expiration dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	1115 4th Avenue North Sauk Rapids, MN 56379

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44645 Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement Program (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys regarding drug storage. This had the potential to affect all 114 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 3/17/25, indicated the facility was cited F761 for drug storage on the survey exited 5/2/24. See F761: Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 7 medication carts. The facility's QAPI meeting minutes dated 3/13/25, lacked ongoing data related to the above repeat citation. On 4/17/25 at 10:45 a.m., the quality assurance registered nurse (RN)-B acknowledged the importance of continued monitoring of prior Performance Improvement Projects (PIPS). RN-B stated formal auditing and then more periodic auditing, chart review, and observational audits, were completed to ensure improvements were sustained. The facility's Quality Assurance and Performance Improvement Program policy, revised 4/15/24, indicated the facility monitors the effectiveness of its performance improvement activities to ensure improvements are sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 49035 Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) was used when providing cares for 1 of 1 residents (R80) reviewed for enhanced barrier precautions (EBP). Findings include: R80's admission Minimum Data Set, dated dated dated [DATE], included R80 had moderate cognitive impairment. R80 had diagnosis of COVID-19, depression, and metabolic encephalopathy (a condition causing altered metal status). R80's undated care plan, included R80 was on EBP due to a pressure ulcer on buttocks. Care plan included to wear a gown and gloves when providing high contact cares. On 4/15/25 at 9:21 a.m., licensed practical nurse (LPN)-B was observed in R80's room cutting her toenails. LPN-B was not wearing a gown and was leaning on foot of bed. During interview on 4/15/25 at 9:25 a.m., LPN-B confirmed R80 was on EBP for a pressure ulcer. LPN-B confirmed she had received education on EBP and should be wearing PPE whenever providing close contact cares. LPN-B confirmed she should have been wearing a gown. On 4/15/25 at 9:48 a.m., physical therapy assistant (PTA)-F was observed assisting R80 with walking in her room and transferring to her bed. PTA-F was observed assisting R80 adjust the covers on her bed to cover R80's lower body. During interview on 4/15/25 at 9:51 a.m., PTA-F stated she had received training on EBP and R80 was on EBP. PTA-F stated PPE should have been worn whenever assisting with personal cares, such as dressing or toileting. During interview on 4/16/25 at 8:22 a.m., clinical manager (CM)-A confirmed R80 was on EBP and staff should wear PPE whenever providing close contact cares, such as transferring, toileting and repositioning. CM-A confirmed staff should have been wearing a gown and gloves while clipping toenails, assisting with physical therapy, and adjusting covers on the bed. During interview on 4/16/25 at 12:59 p.m., infection control prevention nurse (IP)-G stated all staff are trained on EBP and the facility follows center for disease (CDC) guideline for precautions. IP-G confirmed gown and gloves should have been worn when clipping toenails and providing therapy assistance. IP-G confirmed all departments including therapy was trained on EBP. During interview on 4/16/25 at 1:16 p.m., director of nursing (DON) stated PPE should be worn any time a staff person is completing hands on care for a resident on EBP. The DON stated this was important to protect all residents and staff. Facility infection control and prevention manual dated October 2024, included EBP involved gown and glove use during high-contact resident care activities.