STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center White Bear Lake	1900 Webber Street White Bear Lake, MN 55110

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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 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** 42584 Based on observation, interview, and document review, the facility failed to ensure proper self-administration of insulin for 1 or 1 resident (R87) reviewed for self-administration of medications (SAM). Findings include: R87's quarterly minimum data set (MDS) dated [DATE], indicated R87 was cognitively intact, rejection of care behavior not exhibited, required staff supervision, and set up for bathing and eating, and was independent with all other activities of daily living (ADLs) and mobility. The MDS indicated R87 had impaired vision, and received insulin and opioids. R87's diagnoses included type 2 diabetes, age-related cataract, need for assistance with personal care, depression and anxiety. R87's care plan last revised 11/20/24, indicated R87 was non-compliant with medications, treatments, lab work and typically rejected care on a daily basis. The care plan further indicated, Resident has been assessed by interdisciplinary care plan team to be capable of self-administration. The care plan indicated R87 received high risk medications identified as insulin and opioids and instructed administration of medications per doctor's order. R87's November 2024 medication administration record (MAR) indicated R87's medication orders included the following: -Calcium acetate 667 mg, two tabs three times a day with meals. -Insulin glargine-yfgn insulin pen; 100 unit/ml (3ml)-administer 9 units at Bedtime; subcutaneous (SQ), ok to keep in room and self-administer. -insulin lispro solution; 100 unit/ml; administer per sliding scale (SS) based on blood sugar (BS), SQ, three times a day with meals (ok to keep in room and self-administer): If BS is 70-149, give 0 units If BS is 150-199, give 2 units (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	If BS is 200-249, give 4 units If BS is 250-299, give 6 units If BS is 300-349, give 8 units If BS is 350-399, give 10 units If BS is 400-450, give 12 units If BS greater than 450, call doctor. -Dexcom G7 Sensor (blood-glucose sensor) device, change every 10 days. -Okay to keep in room and self-administer insulins. Has Dexcom for blood sugar checks. R87's Self-Administration of Medication observation assessment dated [DATE], indicated R87 wanted to self-administer insulin glargine 9 units at bedtime and insulin lispro SS three times a day. The SAM assessment further indicated R87 had a history of non-compliance with medications or other treatments and wore a Dexcom monitor. The SAM indicated R87 was provided teaching and was determined safe for insulin administration and in-room storage. During observation and interview on 11/18/24 at 6:10 p.m., R87 had insulin pens, alcohol wipes and a sharps container in her room. R87 stated she stored and administered her own insulin. R87 also had a medicine cup which contained 2 big blue and white pills sitting on her table in front of her and stated she did not know what they were, but she was supposed to take them, but they were hard to swallow. R87 further stated she had visual impairment, could not read small print, and required cataract surgery. R87 stated she monitored her own blood sugar using an app on her phone connected to the Dexcom monitor she wore on her arm. During interview on 11/20/24 at 8:19 a.m., registered nurse (RN)-B stated R87 was supposed to monitor her own BS and administer her own insulin. RN-B stated all other medications were supplied by the nurse but R87 often refused medications when offered by nurses. During observation and interview on 11/20/24 at 8:47 a.m., R87 checked her phone app and showed it indicated her BS was 206. R87 stated per the SS, she needed to administer 4 units of the short acting insulin. R87 picked up the lispro pen, attached a needle, turned the dosage four clicks, used the flashlight on her phone to look at the dial to confirm it was set to 4 units, used an alcohol wipe to prepare her abdomen and administered the insulin. R87 did not prime the insulin pen. R87 stated she was provided education on and then observed self-administration of insulin and that she never primed her pens. R87 stated not thinking priming was necessary with this pen since the nurses don't do it. During interview on 11/21/24 at 8:20 a.m., RN-C stated R87 often declined medications, but she was assessed for safe insulin self-administration. RN-C stated R87 would have been educated and performed a return demonstration when assessed for SAM. RN-C stated expectation that R87 was assessed appropriately and that she would be priming the insulin pen prior to administration. RN-C stated R87 would not be receiving the correct amount of insulin if the pen was not primed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 9:40 a.m., director of nursing (DON) stated residents were educated and assessed with return demonstration for determination of safe SAM. DON stated expectation R87 would be priming the insulin pen prior to admission to ensure she received the proper dosage. Facility policy Self-Administration of Medications dated 8/31/23, indicated residents had the right to SAM if determined to be clinically appropriate and safe to do so. The policy further indicated the resident should have the ability to correctly identify their medications and the indications for their use. Residents would be assessed for ability to swallow without difficulty and any changes in ability to SAM safely would prompt further review. Facility policy on priming insulin pens was requested but not received. Per standard nursing practice and manufactures instructions, insulin pens/needles should be primed with 2 units prior to each injection.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and record review the facility failed to ensure proper nail care for 1 of 1 resident (R95) reviewed for activities of daily living. Findings include: R95's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, diagnoses of dementia, need for assistance with personal care, and there were no rejection of care behaviors noted. It further indicated R95 required assistance with personal hygiene. R95's care plan dated 1/25/2024, indicated R95 needed assistance with dressing, personal hygiene, and bathing due to lumbar stenosis. It further indicated an intervention to assist in handing him a soapy wash cloth and cue to wash face, hands, arms, and torso as able during weekly bath. Staff should also wash resident's hair, back, peri area, and legs during weekly bath and trim his nails as needed. R95's progress notes (11/1/24-11/19/24), lacked documentation R95's fingernails had been cut or that he had refused to have them cut. During observation on 11/18/24 at 5:51 p.m., R95 was sitting in his room in his wheelchair watching television (TV). The fingernails on his left hand were approximately 1 inch long and the thumb, middle finger and pinky on his right hand were also approximately 1 inch long. R95 stated he doesn't like his nails long and wanted them cut. During observation on 11/19 24 at 1:00 p.m., R95 was sitting in his room in his wheelchair, watching TV. The fingernails on his left hand were approximately 1 inch long and the thumb, middle finger and pinky on his right hand were also approximately 1 inch long. During interview on 11/19/24 at 2:19 p.m. nursing assistant (NA)-B stated NA's were responsible for cutting the residents nails unless the resident was diabetic. If the resident was diabetic or their nails were too thick, then the nurses were responsible for cutting them. It was completed once a week, usually on bath day. During interview on 11/19/24 at 3:06 p.m. NA-C stated nurses were responsible for cutting residents nails, they do skin assessments on the residents bath day and it's their responsibility to look at their skin and nails. During interview on 11/19/24 at 3:15 p.m. registered nurse (RN)-A stated the nurses were responsible for cutting the residents nails if they are diabetic. NA's can cut the residents nails who are not diabetic but there's more responsibility on the nurse to make sure it get's done. The residents nails are clipped once a week typically on their shower day and it should be documented in a progress note. There was no specific spot to document it unless someone added it on the weekly skin assessment. Refusals should be documented. RN-A also verified R95's nails were long and more then a few weeks growth and stated his nails should've been cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 10:22 a.m., the director of nursing (DON) stated the NA's were responsible for cutting the residents nails who were not diabetic and the nurse were responsible for cutting the residents nails who were diabetic. She further stated it should be done weekly along with skin checks and usually done on the residents bath day. She would expect it to be documented in the progress notes, including refusals which would prompt it to be care planned. The facility's policy on activities of daily living (ADL) dated June of 2021, indicated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility.

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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** 51577 Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted for 1 of 1 resident (R52) reviewed for the use of psychotropic medications. Findings include: R52 ' s Minimum Data Set (MDS) dated [DATE], indicated they had no cognitive impairment and did not reject cares. R52 reported no signs or symptoms of feeling down, depressed, or hopeless. R52 scored a zero on scale for depression or anxiety. R52 stated did not hallucinate or had delusions. R52 ' s physician orders included the following medications for anxiety: -starting on 7/21/23, Bupropion HCL 100 milligrams (mg) tablet daily by mouth -starting on 7/21/23 Duloxetine Hydrochloride 30 mg coated pellets capsules daily by mouth R52 ' s medical record lacked indication R52 had a GDR attempted for bupropion or Duloxetine since R52 ' s admission to the facility in July 2023. During an interview on 11/21/24 at 12:42 p.m., the consultant pharmacist (CP) stated due to an informational technology (IT) glitch, the monthly reviews were incorrectly sent. The facility had not received the recommendations for the months of July-November of 2024. The CP verified R52 ' s pharmacy reviews for the months August 2024 -October 2024 requested a GDR to be completed for R52 ' s prescribed bupropion and duloxetine. During an interview on 11/21/24 at 2:20 p.m., the director of nursing (DON) stated the CP sent any recommendations to the facility to review and send to the providers. DON stated if residents had no recommendations, they were on a list that was also sent. DON verified R52 was not on the list of residents who had no recommendations for August 2024- October 2024. DON stated the monthly reviews requesting R52 ' s GDR had not been received until they were requested by surveyor on 11/21/24 in the afternoon. DON further stated the facility did not keep track of monthly reviews or resident GDRs were sent to the CP monthly directly from the EMR and then it was up to the CP to send the information back. During a follow up interview on 11/22/24 at 9:24 a.m., the consulting pharmacist (CP) stated R52 ' s GDR had not been attempted. It was CP stated within the first year of admission, the process for the GDR had protocols and parameters, and to be attempted twice within one year of admission, attempt a GDR in two separate quarters, one month apart. To ensure the time frame, the CP entered in the current updated documentation electronically, then went to quality assurance performance improvement (QAPI) and confirmed the orders and recommendations. (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 policy Psychotropic Medication Use dated 8/24/2017, directed the facility to begin a GDR within the first year in which a resident is admitted with or is newly prescribed a scheduled psychotropic medication. GDR is attempted in two separate quarters (with at least one month between the attempts), unless clinically contraindicated and documented by the medical provider. 42584 Based on interview and document review, the facility failed to ensure a discussion of risks, benefits and potential side effects occurred and understood by the resident or resident representative for 1 of 1 residents (105) reviewed for unnecessary medications who received Depakote for indication outside the drug classification. Findings include: R105 admission minimum data set (MDS) dated [DATE], indicated R105 had severe cognitive impairment, exhibited physical and verbal behaviors towards others, and received antipsychotic and antidepressant medications. R105's diagnoses included restlessness and agitation, dementia with behavioral disturbance, and Alzheimer's disease. R105's care plan revised 11/18/24, indicated R105 used high risk medications including antipsychotics, hypnotics, and antidepressants for the diagnosis of dementia with behaviors. The care plan further indicated R105 was at risk for falls. The care plan instructed pharmacist medication review for fall risk and medication adjustments and psychiatry visits and medication reviews. The care plan further instructed to monitor for target behaviors and side effects of psychotropic medications as ordered. R105's November 2024 medication administration record (MAR) indicated provider orders including: -Depakote tablet, delayed release; 125 mg; 1 tab; twice a day for restlessness and agitation -Depakote tablet, delayed release; 250 mg; 1 tab; at bedtime for restlessness and agitation R105's admission assessment dated [DATE], indicated R105 had behavioral symptoms and had a history of falls. R105's associated clinic of psychology (ACP) visit note dated 10/30/24, identified Depakote as one of R105's current psychotropic medications. R105's electronic health record (EHR) lacked evidence of a Consent for Use of Psychotropic Medication for Depakote. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 10:20 a.m., registered nurse (RN)-C stated a consent for psychotropic medication use should be completed upon admission if the resident was admitted on a psychotropic medication, with any changes in dosages or when started on a new psychotropic. RN-C stated the consent was used to inform residents or family members of the risks, benefits and possible side effects of the medication. RN-C confirmed R105 did not have a consent completed for the Depakote. On 11/21/24 at 10:46 a.m., attempted to contact ACP-NP via phone call with no answer. Voicemail left and email sent. Per email response on 11/22/24 at 5:13 a.m., ACP nurse practitioner (ACP-NP) stated R105 was receiving Depakote (an antiepileptic/or antimanic) for agitation and aggression, but was not an antipsychotic. In any event it is considered a psychotropic medication. ACP-NP further stated expectation for facility to follow policies and procedures regarding the use of psychotropic medications. During interview on 11/21/24 at 2:07 p.m., director of nursing (DON) stated was not aware that Depakote was considered a psychotropic, but if being used out of class would expect a consent for use to be completed. R105's family should be informed of the risks, benefits and potential side effects of the medication and allowed to make an informed decision on its use. Facility policy Psychotropic Medication Use dated 9/7/23, indicated target behaviors and side effects must be identified and monitored when psychotropic medications were ordered and informed consent for the use must be obtained.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review the facility failed to ensure insulin was administered in accordance with professional standards of practice for 2 of 3 residents (R100, R51) observed for medication administration. This constituted three (3) errors out of 33 opportunities for a medication error rate of 9.09 % (percent). Findings include: R100's quarterly Minimum Data Set (MDS) dated [DATE], identified she could usually understand others and could be understood. Required partial/moderate assistance with hygiene and diagnoses included diabetes mellitus. R100 received insulin injections seven out of seven days in the lookback period. R100's care plan dated 9/6/24, identified an alteration in nutrition due to type two diabetes mellitus and elevated glucose levels. Interventions included to monitor blood glucose. R100's physician orders included: - 9/19/24, check blood glucose four times a day. - 10/2/24, Lantus (long acting) insulin 24 units subcutaneous (SQ) every morning, hold if blood glucose less than 110. R100's Annual Comprehensive Nursing Home visit dated 10/16/24, identified blood glucose fluctuated between 94 to 371, check blood sugar results four times per day (QID) and continue current insulin orders. During an observation and interview on 11/19/24 at 8:50 a.m., licensed practical nurse (LPN)-B took R100's insulin pen out of the medication cart, attached the needle and dialed up the prescribed dosage of 24 units. LPN-B had not primed the needle and when asked stated she only needed to dial up the prescribed 24 units. LPN-B then administered the insulin without priming the needle, which could potentially have been a subtherapuetic dosage. R51's quarterly MDS dated [DATE], identified intact cognition and was independent with personal hygiene. Diagnoses included type 2 diabetes mellitus with diabetic nephropathy (uncontrolled kidney complications). R51 received insulin injections seven out of seven days in the lookback period. R51's care plan dated 9/10/24, identified an alteration in endocrine function secondary to diagnoses of diabetes mellitus. Interventions included to administer insulin as ordered. R51's physician orders dated 11/15/24, included: - Check blood glucose four times a day via Dexcom (continuous blood sugar monitor). - Lantus insulin 37 units SQ every morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Novolog (rapid acting) insulin 12 units SQ three times daily before meals. R51's Annual Comprehensive Nursing Home visit dated 10/16/24, identified blood glucose was elevated in the late afternoons and Lantus was increased to 37 units. During an observation and interview on 11/20/24, at 8:04 a.m., LPN-A took R51's Lantus insulin pen out of the medication cart, attached the needle and dialed up the pescribed 37 units. LPN-A had not primed the needle and insulin was not observed to come out of the tip of the needle. Next LPN-A took the Novolog insulin pen out of the medication cart, attached the needle and dialed up the prescribed 12 units. When asked if the needles needed to be primed, LPN-A stated only needed to dial up the prescribed units. LPN-A stated he did not think the pen needles needed to be primed before each use. LPN-A then administered the insulins without priming the needle, which could potentially have been subtherapuetic dosages. During an interview on 11/20/24 at 8:19 a.m., LPN-C stated with each administration, insulin pen needles needed to be primed first, then dial up the prescribed dosage. During an interview on 11/20/24 at 2:28 p.m., the director of nursing (DON) stated all insulin pens were expected to be primed with insulin prior to the prescribed dosage to ensure the needles worked and the correct dosage was delivered. During an email communication on 11/21/24 at 2:19 p.m., the DON identified the facility lacked a specific insulin pen policy or procedure and would follow manufacturer's instructions. Lantus insulin pen manufacturer's instructions dated 2022, identified step 3 was to perform a safety test: - Dial a test dose of 2 units. - Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help get the most accurate dose. - Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero as the test is performed. - If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Novolog insulin pen manufacturer's instructions dated 6/2021, identified to always test the insulin flow: - Select 2 units and press the dose button until the dose counter shows 0. The insulin flow test is complete when you see insulin squirt and there is no longer a gap between the piston rod head and the piston.

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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** 42579 Based on observation, interview and document review the facility failed to follow infection control standards of practice for incontinence cares and/or contact precautions for 2 of 2 residents (R40 and R364) reviewed for activities of daily living (ADLs) Findings include: R40's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, dependent on staff for toileting, and was always incontinent of bowel and bladder. Diagnoses included dementia. R40's care plan dated 9/12/24, lacked a history of bladder inflammation, and identified she had incontinence related to impaired mobility, left (L) hemiparesis (paralysis on one side) due to history of CVA (stroke). Interventions included to check resident every two hours and as needed for incontinence and provide assist of one to change brief and provide perineal hygiene. Additionally, keep the call light within reach. R40's admission to the facility orders dated 1/26/24, identified a prescription for Keflex (antibiotic) 500 milligrams twice daily for four days for bladder inflammation (common cause of bladder inflammation is bacteria, such as E. coli, that enters the urethra and multiplies in the bladder). During an interview on 11/18/24 at 12:13 p.m., R40 stated she thought she needed to be changed. She pushed her call light button to alert staff. During an observation on 11/18/24 at 12:36 p.m., nursing assistant (NA)-A entered the room, R40 said she went potty and needed to be changed. NA-A put gloves on, pulled the bed sheet down and unfastened R40's brief. NA-A wiped the front of R40's groin with a wipe, tucked the wipe between R40's legs and instructed R40 to turn on her side. Once R40 was in a side-lying position, NA-A used wipes to clean up a medium soft incontinent bowel movement. With the soiled gloves still on, NA-A grabbed a tube of skin barrier cream and applied the cream to R40's backside, picked up a new brief, tucked the new brief under R40's hips, assisted her to turn on to a back-lying position, cleaned the front of R40's groin with a wipe and applied skin barrier cream, still with the same soiled gloves on, removed the soiled brief, put it in the garbage, picked up R40's call light cord with the same soiled gloves to move it out of the way and assisted R40 to a side-lying position again to finish adjusting the brief. When asked if NA-A could get more gloves, she removed the soiled gloves and applied new ones without performing hand hygiene between glove usage. During a follow up interview on 11/18/24 at 12:50 p.m., when NA-A was asked about education on hand hygiene use and if gloves should be changed immediately after being soiled, she replied she would do that going forward. NA-A agreed she touched the barrier cream bottle, R40's front groin area and call light cord with gloves soiled with bowel movement. 51577 (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R364's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition, assistance with toileting and dressing, set up for daily hygiene activities. Diagnoses included sepsis (acute system infection) urinary tract infection from extended spectrum beta lactamase (ESBL) resistance (multidrug resistant organism). R364's care plan dated 11/11/24, indicated R364 required contact precautions ESBL and directed staff to implement precautions according to facility protocol. R364's provider and nursing order dated 11/11/24, identified R364 required contact precautions. An observation on 11/18/24, a sign was posted outside R364's room. The sign stated, Contact Precautions and directed anyone who entered the room to perform hand hygiene, don a gown and gloves. A cart was outside of R364's room that contained isolation gowns and gloves. An observation on 11/19/24 at 1:58 p.m., a sign was posted outside R364's room. The sign stated, Contact Precautions and directed anyone who entered the room to perform hand hygiene, don a gown and gloves. A cart was outside of R364's room that contained isolation gowns and gloves. The physical therapist assistant (PTA) knocked on door, introduced self, performed hand hygiene, and foamed hands. PTA did not don a gown or gloves before entering R364's room. The PTA went to the R364 sitting in chair and placed a gait belt (a belt that goes around waist to assist with stability) resident took walker, placed it in front of him and stood. PTA and R364 walked down hallway to rehab area, for therapy. The PTA foamed hands before entering room, did not don gloves or gown before entering R364 room, the PTA assisted R364 to chair. During an interview on 11/19/24 at 2:25 p.m., the PTA verified they did not don a gown or gloves as the indicated. The PTA further stated with contact precautions, gown and gloves should be worn. The rationale for using contact precautions for R364 had EBSL. During interview on 11/21/24 at 12:05 p.m., with infection preventionist (IP) stated the expectation of hand hygiene with personal cares. Staff are expected to clean hands and change gloves between clean and dirty personal cares. The staff are to follow contact precautions per facility policy on wearing gown and gloves when entering resident's room. The facility's Hand Hygiene policy dated 6/2017, identified infection prevention began with basic hand hygiene; proper hand hygiene practices should be followed to reduce the spread of potentially deadly germs and reduce the risk of healthcare provide colonization caused by germs acquired from the residents. Hand hygiene should be performed with soap and water before and after assisting a resident with toileting. The policy lacked instructions for soiled gloves.