STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Paul	445 Galtier Avenue Saint Paul, MN 55103

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and record review, the facility failed to provide bathing preferences for 1 of 3 residents (R74) reviewed for choices. Findings include: R74's admission Minimum Data Set (MDS) dated [DATE], indicated R74 was in room [ROOM NUMBER]-1 and had intact cognition, did not have delirium, disorganized thinking, altered level of consciousness, hallucinations, delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Additionally, the MDS indicated R74 was dependent on staff for showering and bathing. Further, the MDS indicated an interview for preferences including for receiving a tub, shower, or bed bath should be conducted, however was not assessed. R74's Medical Diagnosis form dated 6/27/24 at 9:53 a.m., indicated the following diagnoses: sepsis, rhabdomyolysis (a muscle injury where muscles break down), encephalopathy (a disturbance of brain function), blindness, and personality disorder. R74's care sheet lacked information when R74 would receive a bath or what type. R74's care plan saved on 6/27/24 at 12:06 p.m., indicated R74 had a weekly bath as scheduled. R74's Clinical Physician Orders form, indicated the following order: 5/17/24, weekly skin inspection by licensed nurse. Complete weekly skin inspection in the electronic medical record (EMR) one time a day every Sunday at 8:00 a.m., for bath day. R74's medication administration record (MAR) and treatment administration record (TAR) dated May 2024, indicated R74 was to receive a bath within 24 hours of admission and after admission bath was completed, to follow the bath day every day and evening shift for two days. A check mark was located for the day shift on 5/18/24, and the day and evening shift on 5/19/24, and no additional check marks or initials were located on the form. R74's Clinical Resident Profile form, dated 6/27/24 at 9:52 a.m., indicated R74 was in room [ROOM NUMBER]-1. (continued on next page)

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A form, Second Floor Bath Schedule, undated, identified resident room numbers under the various days of the week and additionally were separated into an a.m., or p.m. slot. The bath schedule indicated R74 would receive a bath on Sunday a.m. The form further indicated the nurse assessed skin for every bath or shower and completed a skin assessment and refusals were documented in the EMR. Further, the form indicated the nurse must complete a weekly skin inspection evaluation on bath days. R74's Clinical Assessment form dated 6/27/24 at 11:42 a.m., in the EMR indicated one Weekly Skin Inspection form dated 6/9/24. No other Weekly Skin Inspection forms were located. R74's Weekly Skin Inspection form dated 6/9/24 at 9:37 p.m., indicated R74 had a bed bath and it was not necessary to trim R74's fingernails. R74's Follow Up Question Report from 6/1/24, through 6/27/24, indicated the following: 6/2/24, (Sunday) not applicable for how R74 took a full body bath, shower, sponge bath and transfers in and out of the tub shower. 6/9/24, (Sunday) physical help limited to transfer only for how R74 took a full body bath, shower, or sponge bath and transfers in and out of the tub shower. 6/16/24, (Sunday) no documentation was found under the report. R74's progress notes were reviewed from 5/24/24, to 6/25/24, and lacked information a bath was provided or if resident refused. During interview and observation on 6/24/24 between 1:21 p.m., and 1:30 p.m., R74 stated he has not had a shower since he has been at the facility. R74 had an odor and stated he hasn't had a bath in weeks. R74 had black debris under his fingernails that were approximately 1/2 inch long. R74 stated he had a sponge bath twice but stated they don't give him a shower. R74's family member (FM)-A stated she received a voicemail from approximately a week ago Friday and played the voice message that indicated R74 would receive a bath if not that evening, the following morning. During interview on 6/25/24 at 11:19 a.m., nursing assistant (NA)-C stated residents had a bath schedule and went into the 2nd floor nursing station to show the Second Floor Bath Schedule form hanging on the wall. The schedule indicated room [ROOM NUMBER]-1's bath day was on Sunday a.m. shift. During interview on 6/26/24 at 8:38 a.m., NA-C stated she offered to get R74 up, but R74 was just going to hang out in bed. During interview on 6/26/24 at 8:55 a.m., R74 stated NA-C asked if there was anything she could do for him and he told her no and stated he did not like to get up at 7:00 a.m., or 8:00 a.m., but still wanted to have a bath. During interview on 6/26/24 at 9:53 a.m., the director of social services (DSS)-A stated if R74 was sleeping she wouldn't disturb R74 because he gets agitated and at times refused to get out of bed and sit at the table and at times would refuse therapy at times as well. (continued on next page)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/24 at 10:27 a.m., certified occupational therapist assistant (COTA)-A stated R74 refused therapy once because his sister was visiting, otherwise participated in therapy. During interview on 6/26/24 at 1:56 p.m., physical therapist (PT)-B stated R74 didn't sleep well this week and was not motivated so therapy needed to come back a few times to convince R74 to do stuff. During observation on 6/26/24 at 2:00 p.m., R74 was up in the wheelchair and had moved to room [ROOM NUMBER]-2. During interview on 6/27/24 at 9:27 a.m., the director of reimbursement (DR) stated she scheduled the MDS and stated registered nurse (RN)-D completed all the sections of the MDS except C, D, E, F, K, and Q. DR stated activities completed section F (preferences) of the MDS. DR further stated section F was completed to incorporate a resident's preferences in the plan of care and stated it was important to have a personalized person centered plan of care and expected section F to be completed. During interview on 6/27/24 at 10:45 a.m., RN-D stated she had been helping out to complete the MDS sections and make sure the MDS got completed and stated if a section was not completed, she had to go in and finish it and stated if a section was not done, she would go in and dash the answers to get the MDS completed and stated section F hasn't been getting completed consistently, but was not sure why and stated it was important to complete to know what a resident's preferences were and stated residents could refuse interviews, but stated staff would follow the resident assessment instrument (RAI) manual instructions for completing section F. During interview and observation on 6/27/24 at 11:20 a.m., licensed practical nurse and nurse manager (LPN)-E stated R74 was in room [ROOM NUMBER]-1 and moved to 205-2 and stated R74 preferred to go to the shower and liked to sleep in and was adamant about that and did not like to get up in the morning. LPN-E viewed section F of the admission MDS dated [DATE], and stated the MDS created a structure for a care plan for them to follow and stated they lost their MDS nurse and stated R74's bath day was on Sunday a.m.'s according to the bath schedule and stated that would change to Wednesday evenings after viewing the Second Floor Bath Schedule. LPN-E further stated they covered things in care conferences so they knew what R74 liked. LPN-E stated baths were documented under the Forms tab in the EMR in a Weekly Skin Inspection form. LPN-E viewed R74's Forms tab and located one Weekly Skin Inspection form dated 6/9/24, that indicated R74 had a bed bath and verified he did not see any additional Weekly Skin Inspection forms and verified again they were documented in the EMR under Forms and stated if R74 refused, a progress note was documented. Further, LPN-E stated R74 could provide information accurately and stated R74's admission assessment on 5/17/24, indicated he wanted a sponge bath, but stated R74 was more lethargic when he first arrived and stated he would have to dig into locating documentation on baths and stated he was aware R74 has told him he hasn't had a shower and stated the showers should be documented and added he saw R74's dirty nails on 6/24/24, and offered to trim them and should have documented that, but did not. Additionally, LPN-E viewed R74's progress notes that lacked any documentation of refusals. During interview on 6/27/24 at 11:44 a.m., the director of nursing (DON) stated after admission, they check if a resident wants a shower and what time of day and whatever preferences they have they update the care plan and would have expected the MDS to be completed and did not know why it was not and stated it was very important to know what a resident's preferences were. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/27/24 at 12:41 p.m., the DON stated they did not have a policy regarding preferences.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42580 Based on observation, interview, and document review, the facility failed to ensure privacy was maintained when personal cares was provided for 2 of 2 residents (R42, R64) reviewed for activity of daily living. Findings Include: R42 R42's quarterly Minimum Data Set (MDS) dated [DATE], indicated R42 was cognitively impaired, dependent on staff for toileting, transfers, dressing and personal hygiene. R42's face sheet printed 6/27/24, indicated diagnosis included cerebrovascular disease affecting right dominant side, with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing). R42's care plan revised on 5/3/23, indicated R42 was to be turned every two to three hours, and staff were to perform peri care after each incontinent episode and as needed. R64 R64's quarterly MDS dated [DATE], indicated R64 was cognitively intact, always incontinent of bowel and bladder and dependent on staff toileting hygiene, shower/bath, dressing and personal hygiene. R64's face sheet printed 6/27/24, indicated chronic obstructive pulmonary disease, generalized anxiety disorder, peripheral vascular disease, and bed confinement status. R64's care plan updated on 5/21/24, indicated R64 required assist of one staff for toileting, peri cares and used incontinent products. During observation on 6/26/24 at 7:27 a.m., NA-A provided care for R42 including washing, drying, and applying lotion to R42's skin. When providing personal cares for R42, his door was shut however the privacy curtain was not pulled and his bed was within view from the door. An unidentified staff knocked on the door and NA-A stated it was okay for them to enter R42's room while R42 was undressed, front facing the wall, uncovered with backside and buttock area exposed when the door was opened. The staff shut R42's door and left then closed the room door. During observation on 6/26/24 at 7:49 a.m., NA-A assisted R64 to change her brief. R64's door was shut however the privacy curtain was not pulled to ensure privacy when the door was opened since R64's bed was within view from the door. During R64's cares several staff knocked on her door and was told by NA-A to enter room however R64's private areas including buttock were exposed and seen when the room door was opened. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/24 at 9:08 a.m., nursing assistant (NA)-A stated they would normally pull resident's privacy curtains when providing cares to residents to prevent exposure of residents while they were undressed however the curtain in R42's and R64's rooms were stuck and not pulling all the way to provide privacy for the residents. NA-A clarified they had completed a work order for the request for repair of the privacy curtains but it had not been completed yet. During interview on 6/27/24 at 9:27 a.m., director of nursing (DON) stated it was her expectation that staff provided privacy for residents while providing personal cares for the residents with curtains pulled to ensure privacy. A facility resident privacy policy was requested but it was not provided.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50762 Based on observation, interview, and document review, the facility failed to provide a clean and sanitary environment for 1 of 1 resident (R29) reviewed who had enteral feeding liquid spilled on the support legs of the tube feeding (TF) pump pole. Findings include: R29's quarterly Minimum Data Set, dated dated dated [DATE], included R29 was dependent on staff for all activities of daily living, had diagnoses of traumatic brain injury, hemiparesis (weakness or the inability to move on one side of the body), and aphasia (the loss of ability to understand or express speech), and also indicated they had a feeding tube through which they received more than 50% of their nutrition. R29's physician order with revision date 6/25/24, indicated to wipe down and sanitize TF pump and pole once a week, every Thursday night shift. During observation on 6/24/24 at 12:19 p.m., R29 was lying in bed in their room with tube feeding running. The tube feeding pump was attached to a pole and there was dried brown substance on 3 of 4 support legs of the pole. Approximately 3 inches by 1.5 inches of the dried brown substance was adhered to two of the support legs. During observation on 6/25/24 at 11:58 a.m., the dried brown substance was still present on the support legs of the pole. During observation on 6/26/24 at 7:32 a.m., at 9:54 a.m., and at 1:15 p.m., the dried brown substance was still present on the support legs of the pole. During interview on 6/26/24 at 10:09 a.m., a registered nurse (RN-A) verified that the pole was dirty and that it should be cleaned. RN-A stated that it was the responsibility of the nursing staff to clean. During interview on 6/27/24 at 8:46 a.m., the nurse manager (RN-B) verified the presence of the dried substance and stated it looked like tube feeding. RN-B expected it would be cleaned once a spill was identified and that it was the responsibility of the nursing staff to clean. During interview on 6/27/24 at 11:29 a.m., the director of nursing expected nursing staff to clean on the spot if equipment was dirty. Cleaning policy regarding TF pump poles requested, none provided.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview, observation, and document review, the facility failed to ensure the comprehensive assessment was developed, completed, and implemented for one of one resident (R74) reviewed for assessments. Findings include: See also F561. The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.18.11, dated October 2023, indicated the purpose of the manual was to offer clear guidance about how to use the resident assessment instrument (RAI) correctly and effectively to provide appropriate care. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. Under the heading, Section F: Preferences for Customary Routine and Activities, indicated the intent was to obtain information regarding the resident's preferences for their daily routine and activities. Further, this is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. R74's admission Minimum Data Set (MDS) dated [DATE], indicated R74 was in room [ROOM NUMBER]-1 and had intact cognition, did not have delirium, disorganized thinking, altered level of consciousness, hallucinations, delusions, physical, verbal, or other behavioral symptoms, and did not reject care. Additionally, the MDS indicated R74 was dependent on staff for showering and bathing. Further, the MDS indicated an interview for preferences including for receiving a tub, shower, or bed bath should be conducted, however was not assessed. Under section F, number F0300 indicated an interview for daily and activity preferences should be conducted and should continue to F0400 and further, the instructions indicated to attempt to interview all residents able to communicate, if resident is unable to complete, attempt to complete interview with family member or significant other. Additionally, if neither a family member nor a significant other is available skip to item F0800, Staff Assessment of Daily and Activity Preferences. A dash, indicating the question was not assessed, was identified on all of the questions for F0400, Interview for Daily Preferences, that included: how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. R74's Medical Diagnosis form dated 6/27/24 at 9:53 a.m., indicated the following diagnoses: sepsis, rhabdomyolysis (a muscle injury where muscles break down), encephalopathy (a disturbance of brain function), blindness, and personality disorder. R74's care sheet lacked information when R74 would receive a bath or what type. R74's care plan saved on 6/27/24 at 12:06 p.m., indicated R74 had a weekly bath as scheduled, but did not indicate the type or time. R74's Clinical Physician Orders form, indicated the following order: (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/17/24, weekly skin inspection by licensed nurse. Complete weekly skin inspection in the electronic medical record (EMR) one time a day every Sunday at 8:00 a.m., for bath day. A form, Second Floor Bath Schedule, undated, identified resident room numbers under the various days of the week and additionally were separated into an a.m., or p.m., slot. The bath schedule indicated R74 would receive a bath on Sunday a.m. The form further indicated the nurse assessed skin for every bath or shower and completed a skin assessment and refusals were documented in the EMR. Further, the form indicated the nurse must complete a weekly skin inspection evaluation on bath days. R74's Clinical Assessment form dated 6/27/24 at 11:42 a.m., in the EMR indicated one Weekly Skin Inspection form dated 6/9/24. No other Weekly Skin Inspection forms were located. R74's Weekly Skin Inspection form dated 6/9/24 at 9:37 p.m., indicated R74 had a bed bath and it was not necessary to trim R74's fingernails. R74's Follow Up Question Report from 6/1/24, through 6/27/24, indicated the following: 6/2/24, (Sunday) not applicable for how R74 took a full body bath, shower, sponge bath and transfers in and out of the tub shower. 6/9/24, (Sunday) physical help limited to transfer only for how R74 took a full body bath, shower, or sponge bath and transfers in and out of the tub shower. 6/16/24, (Sunday) no documentation was found under the report. R74's progress notes were reviewed from 5/24/24, to 6/25/24, and lacked information a bath was provided or if resident refused. During interview and observation on 6/24/24 between 1:21 p.m., and 1:30 p.m., R74 stated he has not had a shower since he has been at the facility. R74 had an odor and stated he hasn't had a bath in weeks. R74 had black debris under his fingernails that were approximately 1/2 inch long. R74 stated he had a sponge bath twice but stated they don't give him a shower. R74's family member (FM)-A stated she received a voicemail from approximately a week ago Friday and played the voice message that indicated R74 would receive a bath if not that evening, the following morning. During interview on 6/25/24 at 11:19 a.m., nursing assistant (NA)-C stated residents had a bath schedule and went into the 2nd floor nursing station to show the Second Floor Bath Schedule form hanging on the wall. The schedule indicated room [ROOM NUMBER]-1's bath day was on Sunday a.m. shift. During interview on 6/26/24 at 8:38 a.m., NA-C stated she offered to get R74 up, but R74 was just going to hang out in bed. During interview on 6/26/24 at 8:55 a.m., R74 stated NA-C asked if there was anything she could do for him and he told her no and stated he did not like to get up at 7:00 a.m., or 8:00 a.m., but still wanted to have a bath. (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/24 at 9:53 a.m., the director of social services (DSS)-A stated if R74 was sleeping she wouldn't disturb R74 because he gets agitated and at times refused to get out of bed and sit at the table and at times would refuse therapy at times as well. During interview on 6/26/24 at 10:27 a.m., certified occupational therapist assistant (COTA)-A stated R74 refused therapy once because his sister was visiting, otherwise participated in therapy. During interview on 6/26/24 at 1:56 p.m., physical therapist (PT)-B stated R74 didn't sleep well this week and was not motivated so therapy needed to come back a few times to convince R74 to do stuff. During observation on 6/26/24 at 2:00 p.m., R74 was up in the wheelchair and had moved to room [ROOM NUMBER]-2. During interview on 6/27/24 at 9:27 a.m., the director of reimbursement (DR) stated she scheduled the MDS and stated registered nurse (RN)-D completed all the sections of the MDS except C, D, E, F, K, and Q. DR stated activities completed section F (preferences) of the MDS. DR further stated section F was completed to incorporate a resident's preferences in the plan of care and stated it was important to have a personalized person centered plan of care and expected section F to be completed. During interview on 6/27/24 at 10:45 a.m., RN-D stated she worked remotely and had been helping out to complete the MDS sections and make sure the MDS got completed and stated if a section was not completed, she had to go in and finish it and stated if a section was not done, she would go in and dash the answers to get the MDS completed and stated section F hasn't been getting completed consistently, but was not sure why and stated it was important to complete to know what a resident's preferences were and stated residents could refuse interviews, but stated staff would follow the resident assessment instrument (RAI) manual instructions for completing section F. During interview and observation on 6/27/24 at 11:20 a.m., licensed practical nurse and nurse manager (LPN)-E stated R74 was in room [ROOM NUMBER]-1 and moved to 205-2 and stated R74 preferred to go to the shower and liked to sleep in and was adamant about that and did not like to get up in the morning. LPN-E viewed section F of the admission MDS dated [DATE], and stated the MDS created a structure for a care plan for them to follow and stated they lost their MDS nurse and stated R74's bath day was on Sunday a.m.'s according to the bath schedule and stated that would change to Wednesday evenings after viewing the Second Floor Bath Schedule that indicated R74's new room number was located in the p.m., slot for a bath. LPN-E further stated they covered things in care conferences so they knew what R74 liked. LPN-E stated baths were documented under the Forms tab in the EMR in a Weekly Skin Inspection form. LPN-E viewed R74's Forms tab and located one Weekly Skin Inspection form dated 6/9/24, that indicated R74 had a bed bath and verified he did not see any additional Weekly Skin Inspection forms and verified again they were documented in the EMR under Forms and stated if R74 refused, a progress note was documented. Further, LPN-E stated R74 could provide information accurately and stated R74's admission assessment on 5/17/24, indicated he wanted a sponge bath, but stated R74 was more lethargic when he first arrived and stated he would have to dig into locating documentation on baths and stated he was aware R74 has told him he hasn't had a shower and stated the showers should be documented and added he saw R74's dirty nails on 6/24/24, and offered to trim them and should have documented that, but did not. Additionally, LPN-E viewed R74's progress notes that lacked any documentation of refusals. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/27/24 at 11:44 a.m., the director of nursing (DON) stated after admission, they check if a resident wants a shower and what time of day and whatever preferences they have they update the care plan and would have expected the MDS to be completed and did not know why it was not and stated it was very important to know what a resident's preferences were and stated they did not have a policy regarding the MDS, but followed the RAI manual.

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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 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** 42579 Based on observation, interview, and document review, the facility failed to ensure the wound care provider's treatment orders were transcribed into the medical record to ensure continuity of care for 1 of 2 (R48) residents reviewed for pressure ulcers. Findings include: R48's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and no rejection of care or behaviors. Diagnoses included stroke, renal insufficiency, diabetes, aphasia (inability to speak), and malnutrition. Total assistance of two staff was required for bed mobility and transfers; and two stage three pressure ulcers, one unstageable pressure ulcer and diabetic foot ulcer were present. R48's significant change Care Area Assessment (CAA) dated 3/22/24, triggered and identified R48 was at risk for developing a pressure injury and other non-pressure related skin concerns. Nursing was directed to continue to monitor for changes in condition, update provider on concerns, complete a weekly skin check and proceed to care plan. R48's pressure ulcer care plan dated 6/26/24, identified a sacral pressure ulcer, two toe pressure ulcers, one diabetic foot ulcer and a left gluteus (muscles in the buttock/hip area) pressure ulcer. The wound care providers followed due to alterations in skin integrity, and the goal was to remain infection free. Staff were directed to monitor for skin breakdown, for signs/symptoms of infection and to report signs/symptoms to the providers. The care plan lacked direction for wound care dressing change orders. R48's wound care provider orders dated 5/29/24, and 6/5/24, lacked orders or assessment of the left gluteus pressure ulcer. Orders dated 6/12/24, identified a stable stage two left hip [gluteus] wound. Apply foam daily and follow wound care team weekly. R48's electronic medical record (EMR) orders dated 6/12/24 through 6/26/24, lacked documentation of dressing change orders for the left gluteus pressure ulcer. R48's medication administration record (MAR) and treatment administration record (TAR) dated 6/12/24 through 6/26/24 lacked documentation of the above ordered dressing changes to the left gluteus pressure ulcer. During an observation on 6/25/24 at 12:44 p.m., licensed practical nurse (LPN)-A assessed the placement of R48's left gluteus pressure ulcer dressing which was had a written date on it of 6/25/24. LPN-A stated wound care orders would be found in the EMR, she reviewed PCC and stated there was not an order in the EMR to change the dressing and she replaced the dressing she saw was previously in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/26/24 at 1:01 p.m., nurse practitioner (NP)-A, an unidentified wound care provider, and LPN-D entered R48's room for weekly wound care provider rounds. NP-A removed a wet, foam dressing from R48's left gluteus pressure ulcer. NP-A stated the wound was wet with drainage this week, so she was going to change the wound care orders to include calcium alginate (fiber used to treat moderate to heavily draining wounds) and a foam dressing. LPN-D and surveyor reviewed the EMR to find no current orders for left gluteus dressing changes. NP-A stated the dressing changes should be in the EMR for the facility nurses to follow. During an interview on 6/26/24 at 2:49 p.m., the director of nursing (DON) stated she could not find orders for the left gluteus pressure ulcer dressing changes in the EMR, and it was expected the nurse attending wound rounds would enter the orders into the EMR. During a follow up interview on 6/26/24 at 3:38 p.m., with NP-A, the DON, facility administrator, regional nurse consultant (RNC), and an unidentified regional consultant, NP-A reviewed her wound care notes and verified the foam dressing orders should have been entered into the EMR following her 6/12/24, wound care rounds; and the left hip phraseology meant left gluteus. NP-A stated she expected her orders to be entered into the facility EMR to ensure continuity of care and to help prevent infections. NP-A stated she included the same orders as 6/12/24, for foam dressing change daily; in her 6/19/24, wound care orders (notes were requested and not provided) and on 6/26/24 wound care orders, she changed the orders to a foam dressing with calcium alginate (notes were requested and not provided). NP-A stated she did not believe the lack of dressing change orders, or the ability to review documentation if the dressing changes were completed as ordered contributed to R48's wound becoming a wet pressure ulcer. The facility policy titled Skin Assessment and Wound Management dated 3/2024, identified when a pressure ulcer was identified the provider would be notified and treatment ordered, including updating the care plan with interventions.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50762 Based on observation, interview, and document review, the facility failed to ensure restorative nursing program (RNP) was completed for 1 of 1 resident (R47) reviewed for mobility. Findings include: R47's face sheet printed 6/27/23 listed the pertinent diagnoses of peripheral vascular disease, muscle weakness, difficulty in walking, acquired absence of right leg above knee, and chronic pain syndrome. R47's quarterly Minimum Data Set, dated dated dated [DATE], indicated R47 was cognitively intact, no rejection of care noted, lower extremity impairment on one side, wheelchair use, and no restorative nursing program. R47's Physical Therapy Discharge Summary dated 12/21/23, indicated R47 to have a RNP regarding ambulation after discharge from physical therapy to maintain and increase ease with ambulation. R47's care plan dated 5/23/24 indicated the resident has, an ADL Self Care Performance Deficit r/t Amputation, Impaired balance, Limited Mobility, Pain. Resident has a right leg prosthesis. The plan directed staff to ambulate the resident with an assist of x1 for 40-120 feet on the unit using a four-wheel walker, gait belt, and wheelchair to follow once daily and to also ensure the prosthetic is on properly. When interviewed on 6/24/24 at 12:09 p.m., R47 stated they have not used their prosthetic leg lately, as it was causing pain. When interviewed on 6/25/24 at 12:00 p.m., R47 stated they did not use the prosthetic leg yesterday and has not walked for the past four weeks. R47 stated wanted to walk. When interviewed on 6/25/24 at 1:08 p.m., nursing assistant (NA)-D stated R47 sometimes does not like to wear the prosthesis. When interviewed on 6/25/24 at 1:50 p.m., physical therapist (PT)-B stated that R47 had completed gait training and was discontinued from the physical therapy program at the end of December of 2023. At that time, the resident was able to walk 90 feet with the prosthesis while using a front wheeled walker, wheelchair follow, and stand by assist. The physical therapy team conducted and completed training with several nursing staff members regarding R47's therapy plan and it was ended with a RNP plan in place. PT-B stated that there was no end date to this RNP and expected it to be continued unless otherwise notified. PT-B was unaware of any concerns regarding R47's prosthesis. When interviewed on 6/25/24 at 2:49 p.m., registered nurse (RN)-B who was also the nurse manager verified the documentation on the treatment administration record (TAR), stated that it would mean the order was completed, and that most of the time it was the nurse to monitor the identified task. RN-B stated not seeing R47 walking with the prosthesis. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R47's physician order dated 12/25/23, instructed staff to ambulate R47 with staff assist for 40-120 feet on unit using four-wheel walker, gait belt, and wheelchair to follow once daily. Staff to also ensure that the resident has the prosthesis on properly with ambulation. This order was discontinued on 6/25/24. R47's TAR indicated by staff signatures showed the RNP order was being completed; however, an interdisciplinary team (IDT) note dated 6/25/24 at 4:24 p.m. identified IDT met and discussed resident's need for nursing restorative program and determined that resident is not appropriate for program due to refusal to participate. Resident complains of pain with prosthetics fitting. Referral for therapeutic (PT + OT) evaluation to treat active. Resident has a scheduled appointment with pain clinic to eval. When interviewed on 6/26/24 at 9:24 a.m., PT-B stated R47 walked yesterday with prosthetic after the IDT meeting. R47 was able to walk 50 feet with stand by assist, wheelchair follow, while using front wheeled walker with prosthesis fitting well. PT-B stated R47 was motivated to participate with RNP for ambulation. When interviewed on 6/26/24 at 09:42 a.m., RN-B stated if there was an order for staff to complete that they should follow the order. If the resident either refuses or was independent with the order that staff would chart that appropriately. When interviewed on 6/26/24 at 10:07 a.m., registered nurse (RN)-A stated although they had signed off on R47's TAR, they did not recall seeing R47 walking on 6/24/24. When interviewed on 6/26/24 at 10:18 a.m., activities director stated not seeing R47 walking recently and did not remember the last time R47 had walked. When interviewed on 6/27/24 at 11:29 a.m., the director of nursing stated that staff should follow the orders and walk the resident. If the resident refuses, staff should attempt several times. This information should be relayed to the nurse manager and then brought to the interdisciplinary team (IDT) for follow up. If this refusal continues, the IDT will discontinue the order and follow up with therapy and follow their recommendations. A Restorative Nursing Program policy was requested, none provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R19) with repeated falls had implemented interventions to promote safety and reduce the risk of falls. Findings include: R19's Optional State Assessment (OSA) dated 5/30/24, indicated severe cognitive impairment, did not have behaviors, did not reject care, and required extensive assist for bed mobility, transfers, and toileting. R19's admission Minimum Data Set (MDS) dated [DATE], indicated R19 was frequently incontinent of bowel, had an indwelling catheter, and was not on a toileting program, did not fall in the last month prior to admission, did not fall in the last 2 to 6 months prior to admission, and had not fallen since admission. R19's care area assessment (CAA) summary dated 5/30/24, indicated falls was not triggered. R19's Medical Diagnosis form indicated the following diagnoses: peritoneal abscess, traumatic subdural hemorrhage without loss of consciousness, seizures, anemia, chronic kidney disease, acute pyelonephritis, and diabetes mellitus. R19's hospital physician notes dated 5/24/24, indicated R19 had multiple recent hospital admissions including: 2/27/24, for sepsis secondary to acute cholecystitis, 5/1/24, to 5/11/24, subdural (bleeding between the skull and surface of the brain) after a fall, a readmission on 5/11/24 with an abdominal abscess. R19's history of present illness (HPI) dated 6/20/24, indicated R19 was frail, had recurrent falls, seizure disorder, and was at high risk for delirium. R19's care plan saved on 6/24/24 at 2:29 p.m., indicated R19 was at risk for falls related to impaired mobility, safety awareness, and unsteady gait and had the following interventions in place, floor mat next to the bed, and a low bed. R19's care sheet provided on 6/24/24, at 12:48 p.m., by nursing assistant (NA)-E indicated R19 required a floor mat next to the bed. R19's progress notes dated 6/12/24 at 2:00 p.m., indicated R19 fell during the night shift and was alert and oriented as usual with no change in level of consciousness. R19's progress notes dated 6/13/24 at 1:48 p.m., indicated the interdisciplinary team (IDT) met and reviewed R19's fall 6/13/24, and R19 had a bump on his head, the bed was at the lowest position and R19 had a history of seizures; and an intervention for a floor mat was added to prevent further injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's progress notes dated 6/15/24 at 9:30 a.m., indicated R19 was found lying on the floor next to his bed and further was speaking in Spanish and staff could not understand how or why R19 fell . R19's progress notes dated 6/15/24 at 12:0 p.m., indicated R19 was sent to the hospital. R19's progress notes dated 6/17/24 at 2:12 p.m., indicated IDT discussed R19's fall on 6/15/24, and R19 had an elevated white blood cell count and the fall was due to a change in condition. R19's progress notes dated 6/24/24 at 6:23 p.m., indicated IDT met to discuss R19's floor mat and was hospitalized the week prior for a urinary tract infection. The note further indicated R19 had a fall on 6/15/24, and R19 was attempting to go to the toilet that morning before breakfast and the floor mat has been discontinued at this time. Further, the note indicated staff were to complete safety checks between 6:00 a.m., and 6:30 a.m., to assess for toileting, safety, and any other needs. R19's Fall Review Evaluation form dated 5/24/24, and locked on 6/4/24, indicated, R19 had no history of falling, took medications that may contribute to falls, was frequently incontinent, had agitated behavior, was confined to a chair and disoriented, could not independently come to a standing position. The form lacked any summary or interventions. R19's Fall Review Evaluation form dated 6/2024, indicated R19 was on medications that contributed to falls, was incontinent, used a cane, walker, or etc. The documentation lacked any summary or interventions. R19's risk management report dated 6/12/24, indicated R19 was found on the floor next to the bed lying on his right side and R19 was unable to provide a description. Under the section, Immediate Action Taken, indicated R19 was assisted back to bed with a mechanical lift and R19 had a history of seizures and orders were placed for seizure activity; intervention for adding a floor mat to prevent further injury. Under the section, Mobility, indicated R19 was non ambulatory, and there were no predisposing environmental factors. Further, the form identified R19 had an unsteady gait and was confused. Under the heading, Notes, indicated IDT met and reviewed the fall and R19 had a history of seizures and orders placed for seizure activity and intervention for adding floor mat to prevent further injury and the care plan was updated. R19's risk management report dated 6/15/24, indicated R19 was calling for help and staff found R19 lying on the floor next to his bed, was speaking Spanish and could not understand why or how R19 fell . Under the section, Mobility, indicated R19 was not ambulatory, additionally, the report indicated R19 was incontinent and had a history of falls under the section, Predisposing Physiological Factors, and under the heading, Predisposing Situation Factors, indicated R19 rolled out of bed. Additionally, the note indicated IDT discussed R19's fall on 6/15/24, and a lab was completed the evening prior that revealed an elevated white blood cell count and the fall was due to a change in condition and R19 was in the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 6/24/24 between 2:17 p.m., and 2:21 p.m., R19 was in a gown and trying to get out of bed, stating he had to go to the bathroom. R19 was incontinent of stool and was positioned on his left side with a pillow under him. At 2:18 p.m., nursing assistant (NA)-E was alerted R19 was trying to get out of bed and came into R19's room. R19's care sheet indicated R19 was supposed to have a mat on the floor next to the bed. NA-F verified R19's care sheet indicated R19 was to have a mat on the floor. R19's care plan was viewed and indicated R19 was to have a mat on the floor and a low bed and NA-F verified there was no mat on the floor. During interview on 6/24/24 at 2:39 p.m., licensed practical nurse manager (LPN)-E stated R19 fell a couple of weeks ago and needed the floor mat to be down and expected staff to follow the care plans. During interview on 6/25/24 at 1:25 p.m., LPN-E later stated they spoke about the mat the day prior and thought the fall was more of a toileting issue that morning and stated if the residents don't need to use the mat, they are discontinued and stated they discussed checking R19 in the morning and stated he was not at the IDT meeting. During interview on 6/25/24, at 1:52 p.m., the director of nursing (DON) stated R19 had the mat on the floor because R19 was trying to self transfer and had fallen due to a change in condition and stated R19 went to the hospital with a urinary tract infection and stated they changed his intervention yesterday a.m. The DON stated when they have IDT, they discussed it in the morning and then staff are updated on changes and stated they communicate with staff and the nurse manager communicates with staff and further stated she would expect staff to follow the care plan. During observation on 6/26/24 at 8:18 a.m., R19 was in bed sleeping and his bed was all the way down to the floor. There was no wheelchair located next to the bed and no mat was on the floor. During interview on 6/26/24 at 12:42 p.m., nurse practitioner (NP)-B stated she was notified of falls via email or phone call and stated she was not not updated on any intervention changes with the mat until the DON updated her today. A policy, Fall Prevention and Management, indicated the purpose of the protocol was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Nursing staff will complete a Fall Risk Evaluation to identify and document resident's risk factors for falls upon admission, annually, with a significant change in condition and as needed. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. A Daily Huddle Notes form was later provided dated 6/24/24, no time identified, that indicated R19's floor mat would be removed and staff would complete safety checks around 6:00 a.m., to 6:30 a.m., to make sure R19 was comfortable and dry, however there was no information in R19's medical record at the time of the observation on 6/24/24, to indicate the floor mat was discontinued.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to ensure respiratory status was monitored and assessed on an ongoing basis, and that respiratory medications were provided as indicated for 1 of 1 resident (R50) reviewed with newly prescribed oxygen use. Findings include: R50's significant change Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition, no rejection of care; diagnoses of psychosis, irregular heart rate, high blood pressure, and chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lung). No supplemental oxygen use was identified. R50 required extensive assist with bed mobility and was independent with eating but required set up. R50's activities of daily living (ADL) care area assessment (CAA) dated 5/8/24, was triggered because the resident required assist with cares and had impaired cognition. Nursing was directed to monitor for changes in condition, update provider as necessary on concerns if observed, and to proceed with care plan. R50's care plan dated 1/19/24, lacked interventions for oxygen use. The care plan identified a potential for respiratory distress related to COPD. Interventions included: elevate head of bed to alleviate shortness of breath, position resident with proper body alignment for optimal breathing pattern, give aerosol or bronchodilators as ordered, and monitor and document any side effects and effectiveness. Lastly, R50 should be monitored for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, and somnolence. R50's physician orders dated 3/17/24, identified: albuterol sulfate inhaler 108 mcg of albuterol sulfate (90 mcg of albuterol base) give two puffs by mouth every six hours as needed (PRN) for wheezing or shortness of breath. R50's Medication Administration Record (MAR) dated 4/1/24 through 6/27/24, lacked administration of the PRN albuterol inhaler. R50's physician orders dated 6/24/24, lacked orders for oxygen use. R50's progress notes identified: - 6/4/24 at 1:03 p.m., the nursing assistant notified nursing of R50's generalized weakness. Oxygen saturations were 87% and the nurse practitioner (NP) was notified. - 6/4/24 at 6:43 p.m., the NP returned the phone call and orders for chest x-ray, covid test, blood work and oxygen at two LPM to keep oxygen saturations greater than 88%. Oxygen saturations were 86 % on room air and after oxygen was placed rose to 94%. - 6/5/24 at 2:47 p.m., chest x-ray showed no acute abnormalities, covid test negative and no respiratory distress was observed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/24/24 at 12:35 p.m., R50 was in bed, an oxygen machine was running and set at two liters per minute (LPM). The nasal cannula or bubbler was not dated. R50's nasal cannula (oxygen delivery tubing) was not in her nares but was on her bed mattress. R50 had labored breathing as evidence by nose flaring and grunting while taking deep breaths. R50 was woken up and asked if she was breathing ok. R50 said she was ok because she had her oxygen, she picked up the cannula and asked for help placing it on and fell back asleep. During a follow up observation and document review on 6/24/24 at 12:44 p.m., R50's nasal cannula was properly placed in her nares, and breathing was regular. R50's medical record from 6/24/24, lacked a respiratory assessment, oxygen saturations, respiratory rate, or response to treatment identifying why oxygen was in use without an order in the electronic medical record. R50's oxygen saturations (blood oxygen level), heart rate or respiratory rate had not been checked since 6/21/24, and at that time she measured 92% on oxygen (normal range is between 92% and 100%.) During an interview on 6/24/24 at 6:48 p.m., nursing assistant (NA)-B stated she worked on R50's hallway routinely, the oxygen had been in her room for a couple of weeks and the nurses were responsible for maintaining the oxygen. NA-B stated R50 had shortness of breath occasionally and they would update the nurse if it occurred. During an observation and interview on 6/25/24 at 1:58 p.m., R50 was in bed with an oxygen concentrator in her room and it was not running. The nasal cannula was on the floor. R50 asked where her oxygen tubing was and asked for it on. R50's call light was activated, and NA-D entered the room. NA-D stated she worked with R50 routinely and she had oxygen in use intermittently over the past couple of weeks. Registered nurse (RN)-B entered the room, picked the nasal cannula off the floor, and left to get new tubing. RN-B returned, put the tubing on the concentrator, turned it on to two LPM, placed the nasal cannula in R50's nose and left the room. RN-B had not completed a respiratory assessment before or after treatment with oxygen. During an interview on 6/25/24 at 2:35 p.m. licensed practical nurse (LPN)-B stated he worked with R50 today and if a resident required oxygen an order needed to be in place and monitoring should be completed. LPN-B stated he had not seen an order on the MAR for R50 to use oxygen. LPN-B stated he saw oxygen in R50's room over the past couple of weeks but had not checked if an order was in place. During an interview on 6/25/24 at 3:28 p.m., RN-A stated she was familiar with R50, and she had not required oxygen use historically, however, oxygen was in use at this time. RN-B stated a respiratory assessment should be documented with oxygen use and especially for residents with COPD due to the risk of retaining carbon dioxide in the lungs. During a follow up interview on 6/25/24 at 3:32 p.m., RN-B reviewed R50's orders and could not find an order for the oxygen he placed earlier today. RN-B agreed a respiratory assessment should be done before and after oxygen therapy to assess effectiveness. RN-B was not sure if there was a risk in residents with COPD that were given oxygen without an assessment and was not sure if using R50's PRN inhaler was an appropriate intervention to complaints of shortness of breath and would need to check on some things and follow up later. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second follow up interview on 6/25/24 at 3:57 p.m., RN-B found a written provider verbal/telephone order dated 6/4/24, for oxygen which had not gotten transcribed into the electronic medical record. The written order identified oxygen at two LPM via nasal cannula to keep oxygen saturations greater than 88%. RN-B agreed he had not checked oxygen saturations before implementing in accordance with the provider orders. During an observation on 6/26/24 at 10:21 a.m., R50 was in bed with the oxygen concentrator running and the nasal cannula on the floor. R50 asked for her inhaler. LPN-C was notified and entered the room, R50 stated her inhaler was on the floor, LPN-C looked on the floor and stated there was no inhaler. LPN-C asked if R50 meant her oxygen cannula, handed it to her, but stated he needed to get new tubing since it was on the floor. LPN-C was asked by surveyor if giving the albuterol inhaler PRN would be appropriate for R50's complaints of shortness of breath and he stated he would have to talk to the nurse manager. LPN-C left R50's room and had not checked oxygen saturations nor completed a respiratory assessment. During an interview on 6/26/24 at 2:49 p.m., the director of nursing (DON) stated oxygen use and respiratory assessments should be based on provider order and nursing judgement. A policy for respiratory assessments was requested and not provided. Instead, the facility's undated standing house orders (SHO) were provided, which identified one week and one month after admission; a resident's temperature, pulse, respirations, blood pressure and oxygen saturations would be checked monthly unless directed otherwise. The SHO lacked detail for respiratory assessments with oxygen use or shortness of breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 42579 Based on observation, interview, and document review, the facility failed to ensure staff utilized enhanced barrier precautions (EBP) for 1 of 2 residents (R48) observed during tube feeding cares. Findings include: R48's quarterly minimum data set (MDS) dated [DATE], identified she was rarely/never understood, was totally dependent on staff for bed mobility and transfers, and extensive assist was required for eating. Diagnoses included stroke, aphasia (loss of speech) and diabetes. R48 had malnutrition and received tube feeding for nutrition. R48's tube feeding care area assessment (CAA) dated 3/22/24, triggered related to receiving tube feeding for all nutritional needs. Staff were directed to continue to administer tube feeding as ordered, monitor for complications and proceed to care plan. R48's care plan dated 3/29/24, identified EBP was placed related to tube feeding and chronic pressure wounds, and staff were directed to don/doff personal protective equipment (PPE) per EBP when high contact cares were provided. R48's active orders dated 6/14/24, identified to follow EBP while tube feedings were provided, when the feeding tube and associated equipment were handled, when insertion site care was provided, and other high contact care activities. During an observation on 6/24/24 at 1:35 p.m., R48's door had an EBP sign on door directing staff to wear gloves and a gown for high contact care including device care and feeding tube. There was PPE bin hanging on the door containing gloves, goggles, and gowns. During an observation on 6/25/24 at 12:44 p.m., licensed practical nurse (LPN)-A entered R48's room, put on gloves but not a gown, pulled back R48's bedsheet, undid the abdominal binder holding R48's tube feeding line in place, entered the bathroom obtained water in a graduated cylinder, filled up a syringe from the cylinder and flushed the feeding tube with water. LPN-A refastened the abdominal binder, covered R48 back up with the sheet, changed gloves, filled the tube feeding water flush bag in the bathroom sink faucet, re-entered R48's room, spiked the tube feeding formula bottle, and programmed the tube feeding pump which then primed the tubing. LPN-A connected the tubing to R48's feeding tube and exited the room. During a follow up interview on 6/25/24 at 12:56 p.m., LPN-A stated she was told by someone she could not remember who, that she was not required to follow EBP during tube feeding cares, despite the signage on the door and order in the electronic medical record. During an interview on 6/25/24 at 1:19 p.m., the director of nursing (DON) stated staff should wear PPE in accordance with EBP for device cares such as tube feedings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled EBP dated 4/1/24, identified the use of gowns and gloves were required for high contact cares for residents at increased risk of multidrug resistant organism (MDRO) acquisition. Therefore, EBP would be implemented for all residents with indwelling medical devices such as catheters and feeding tubes, even if the resident is not known to be infected or colonized with an MDRO.