STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	718 Mound Avenue Mankato, MN 56001

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to ensure an allegation of misappropriation of property was reported to the state agency (SA) within 24 hours, in accordance with established policies and procedures, for 1 of 1 resident (R1) reviewed for allegation of money theft. Findings include: R1's facesheet printed on 4/11/24, included diagnoses of macular degeneration (an eye disease that causes vision loss) and cognitive communication deficit. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, had adequate vision and hearing, clear speech, was understood and able to understand. R1 was independent with most activities of daily living. R1's care plan initiated on 8/18/23, indicated R1 had a behavior problem of paranoia related to dementia and would have fewer episodes of paranoia. During an interview on 4/8/24 at 1:20 p.m., R1 stated he had cash stolen from his room a couple weeks ago, approximately $70 in a pouch. R1 stated the facility was aware of the missing cash and a police officer had talked to him about it over the phone. According to R1, as of today (4/8/24), the money had not been found. A progress note dated 3/12/24 at 11:11 a.m., indicated R1 reported to staff money had been stolen from his room. The note indicated R1 informed staff all his dollars and change were taken but was unsure of the exact amount. Writer reported this to nurse manager and social worker. A progress note dated 3/14/24 at 10:23 a.m., indicated SW (social worker) contacted the local police department to report R1's allegation of missing cash. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance report hand-written by LSW-A and dated 3/12/24, indicated the following: R1 was missing money - a purse and money clip. It happened over the course of about a week; three different times. R1 had not suspected a specific person or time when it may have occurred. R1 was interviewed and also FM-A to verify the objects existed and validity of the report. R1's room was searched and did not find a purse or money clip. The first time it occurred, the $20's and $10's went missing and two dollars were folded and put in the money clip. The second time, the five-dollar bills were gone and the last time, the change was gone. Each happened about two days a part. Filed a police report with R1 speaking on the phone. Police filed a MAARC report. R1 had a functioning key and lock in which to put his belongings. During an interview on 4/9/24 at 2:32 p.m., licensed social worker (LSW)-A stated she was aware of R1's allegation of missing cash and when informed of it, searched R1's room and had not found it. LSW-A stated law enforcement had been notified and a police report filed. LSW-A stated a report had not been filed with the SA because law enforcement informed her they would file a MAARC (Minnesota Adult Abuse Reporting Center) report. According to LSW-A, on 4/4/24, at care conference, R1 reported he found the cash in his underwear drawer. LSW-A stated R1's family member (FM)-A brought the pouch of cash to the care conference that day and then took the pouch home. LSW-A stated they had questioned whether the cash was ever really missing since R1 tended to fabricate stories. During an interview on 4/11/24 at 1:45 p.m., regional nurse consultant (RNC)-B stated LSW-A had informed her of the allegation, including not reporting it to the SA. RNC-B stated she would have expected the missing money to be reported to SA within the required time frame indicated in the facility policy. The facility Investigating Incident of Theft and/or Misappropriation of Resident Property with revised date of April 2021, indicated all reports of exploitation, theft or misappropriation of resident property were promptly and thoroughly investigated. Residents had the right to be free from exploitation, theft and/or misappropriation of personal property. If an alleged or suspected case of theft, exploitation or misappropriation of resident property was reported, the administrator or his/her designee notified the following persons or agencies within 24 hours of such incident as appropriate: state licensing and certification agency, ombudsman, resident representative, adult protective services, law enforcement.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 2 resident (R52, R21) reviewed for hospice and pressure ulcers. Findings include: R52's Face Sheet indicated admitted was 2/7/24, and diagnoses of malignant neoplasm (uncontrolled growth and division of abnormal cells) of upper lobe of lung, malignant neoplasm of bone and heart failure. R52's admission significant change, Minimum Data Set (MDS) dated [DATE], section O, K1 under special treatments and programs, did not include hospice care services. Section J 1400 Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months was marked as yes. R52's provider order dated 2/29/24, indicated hospice was to evaluate. During interview on 4/8/24 at 12:42 p.m., R52 indicated she is receiving hospice services but was not sure who the hospice agency was. During interview on 4/9/24 at 8:56 a.m., registered nurse (RN)-A, also identified as MDS coordinator, indicated R52 is currently receiving hospice services. Upon review of the significant change MDS, RN- A confirmed section 0 was not coded correctly as R52 is receiving hospice services. R21's Face Sheet included diagnoses of hemiplegia and hemiparesis (mild or partial weakness to severe or complete loss of strength or paralysis on one side of body) following cerebral infarction (area of dead tissue in the brain resulting from brain bleed or blood clot) affecting left dominant side, and diabetes mellitus type 2. R21's quarterly MDS dated [DATE], listed as ready for export and locked, indicated R21 was at risk for pressure ulcer (PU) injury but has none. Deep tissue injury was also answered no. PU or injury care included application of ointments/medications other than to feet. R21's Skin assessment dated [DATE], indicated small open shallow area on left buttock, and pressure ulcer on left heel measuring 2 cm x 3 cm, closed with peeling edges. During interview on 4/11/24 at 12:13 p.m., RN-B, also identified as MDS coordinator, confirmed the quarterly MDS was incorrect as R21 does have pressure ulcer present and injury cares and treatment. RN-B confirmed she would not have looked at the MDS again and would have submitted it incorrectly. During interview on 4/10/24 at 2:37 p.m., the director of nursing stated the MDS should have been completed accurately. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility MDS Assessment Coordinator policy and procedure dated 11/2019, included an RN shall be responsible for conducting and coordinating the development and completion of the resident assessment. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident representative for 3 of 3 residents (R29, R57, R112) reviewed who were newly admitted . Findings include: R112's Admission Record identified an admitted [DATE], with diagnoses of displaced fracture of head of right radius (bone of forearm) and fracture (break) around internal prosthetic right hip joint (hip replacement). R112's admission Minimum Data Set (MDS) dated [DATE], identified R112 as having a brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact. R112's activities of daily living MDS section was not completed. R112's baseline care plan indicated R112 required staff will assist with dressing grooming with extensive to limited assistance as R112 is non weight bearing on right leg. Comments included use pivot disc and assist of two from wheelchair to bed or recliner. When interviewed on 4/8/24 at 4:15 p.m., R112 stated she never received a copy of her plan of care and would like to have one. During interview on 4/9/24 at 2:55 p.m., R112 indicated she did have a care conference and some things about her care were discussed but was never was offered or received a copy of her plan of care. When interviewed on 4/10/24, at 12:41 p.m., social worker (SW)-A indicated they bring a copy of the care plan with to the care conference and pass it around, but do not give a copy to the resident or family member. SW-A stated We only give copies if one is requested. When interviewed 4/10/24 at 2:39 p.m., the director of nursing (DON) confirmed a copy of the baseline care plan was not being offered to the resident or a family member. 44630 R29's admission MDS dated [DATE], indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment . R29's baseline care plan indicated effective date of 3/5/24. On 4/11/24 at 12:30 p.m., during a interview family member (FM)-H stated she did not recall the facility providing a copy of the baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57's admission MDS dated [DATE], indicated R57 was admitted the facility 3/14/24, had severe cognitive impairment, required supervision with personal hygiene, sit to stand, chair transfer, and walking and diagnoses included aphasia (ability to understand or express speech), hemiplegia following cerebral infract (paralysis of partial or total body function on one side of the body after a stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes. R57's baseline care plan indicated effective date of 3/14/24. On 4/11/24 at 9:49 a.m., registered nurse (RN)-C, known as the regional nurse coordinator, stated it was not current facility practice to provide the resident or resident representative a copy of the baseline care plan. The facility Care Plans-Baseline policy and procedure dated 3/2022, included: - A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. - The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes but is not limited to the following: - The stated goals and objectives of the resident; -A summary of the resident's medications and dietary instructions; -Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; -Any updated information based on the details of the comprehensive care plan, as necessary. -Provision of the summary to the resident and or resident representative is documented in the medical record.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 1 resident (R29) reviewed for activities. Findings include: R29's admission Minimum Data Set (MDS) dated [DATE], indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, identified it was very important to do his favorite activities, keep up with the news, participate in religious services, and go outside to get fresh air, and somewhat important to have reading material, listen to music, and do things with groups of people and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment, . R29's care plan dated 3/5/24, did not include R29's activities, interests or interventions related to activities. R29's baseline care plan dated 3/5/24, activities coordinator (AC)-A indicated R29 will independently choose activity of choice with both in-room and scheduled events, enjoys watching sporting events, reads the daily newspapers, playing cards, listening to music, may decline activities to attend therapy sessions and rest. Activities/Initial review document dated 3/11/24, indicated R29 wished to participate in activities, wished to participate in group activities, does not wish to participate in 1:1 with staff, and liked independent activities, expressed interest in attending activities as tolerated once acclimated to facility, enjoyed playing cards in the past (sheep's head and buck euchre), independently watched TV in room, especially sporting events, wife visits daily, assistance should be provided to get resident to to the activity. On 4/8/24 at 7:15 p.m., R29 was observed in his room seated in a wheelchair, television on, and family member (FM)-H present. R29 was interviewed about what, if any, activities he attended or was offered . R29 stated he could not recall being offered to attend activities and stated he could not recall any activities attended while at the facility, but expressed he would like participate in activities, if offered. R29 stated he enjoyed playing card games and listening to music. FM-H stated she was at the facility most days and stayed all day, and stated she had not observed staff offer R29 any activities. FM-H stated staff have offered him to take naps. On 4/9/24 at 9:52 a.m., R29 was seated in a wheelchair in his room and FM-H was present. R29 stated his activities of choice would include anything with games, cards, music, and stated he would attend activities if the facility had something. FM-H stated R29 had gone to church one time that she was aware of. A activity calendar was posted in R29's room and R29 stated he had not been offered to attend the activities listed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 7:49 a.m., the AC-A stated she completed R29's admission activities interests and activities preferences to find out what activities R29 enjoyed. AC-C stated the assessment is used for the activity coordinators to offer those activities to residents. AC-A stated the activity assessment indicated R29 loved playing card games, interested in sports and stated the assessment indicated once he was acclimated to the facility he would participate in more activities. AC-C stated activity staff were expected to offer R29 activities based of the assessment which would include cards and music. AC-C stated she wondered if staff assumed since he had company he would not want to participate in activities and stated staff were not expected to ask a resident if they wanted to participate in an activity when company was present in the room. AC-C stated if the wife was always present would expect activities staff to ask resident to participate and would expect staff to ask resident to play cards based of his interest. AC-C stated in the medical record she was not able to find documentation R29 had participated in activities at the facility. On 4/9/24 at 9:00 a.m., AC-B confirmed she had not offered R29 to participate in any activities and was not sure if other staff had offered R29 activities. AC-B stated R29 was on short term care and AC-A completed the intakes and activities for short term care residents. On 4/9/24 at 9:30 a.m., AC-A stated she was responsible to ensure that residents participated in activities and she was expected R29 was offered activities based off his interest and admission intake information. On 4/9/24 at 12:24 p.m., nursing assistant (NA)-F stated nursing assistants were responsible for offering residents the activities posted on the calendar in the room and the activity coordinators were expected to offer the resident specific activities based on their interests. NA-F stated she has offered R29 activities on the calendar and R29 did not want to participate. On 4/9/24 at 12:30 p.m., the director of nursing (DON) stated residents were expected to be offered activities based of interests and specific to each resident and the DON confirmed activities staff were expected to offer R29 activities based of his preferences and activity assessment. The facility Activity Programs policy dated 6/18, indicated: 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 4. Activities are considered any endeavor, other than routine ADL's in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared toward the individual resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning preparation, conducting, clean up and critique of the programs. 9. All activities are documented in the resident's medical record 12. Individualized and group activities are provided that: a. reflect the schedules, choices and rights of the residents b. are offered at hours convenient to the residents, including evenings, holidays and weekends; c. reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of their residents; e. incorporate family, visitor and resident ideas of the desired appropriate activities

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R52) reviewed who received hospice services. Findings include: R52's significant change Minimum Data Set (MDS) dated [DATE], required substantial to maximum staff assistance with all activities of daily living except set up assist for eating and oral hygiene. R52's Brief Interview for Mental Status (BIMS), indicated intact cognition and understands and is understood. R52's facility care plan, dated 3/21/24, included the resident is at the end stage of life and is utilizing hospice services. Intervention included coordinate care with hospice and other end of life services. R52's (local hospice agency) current plan of care, dated 3/28/24, indicated a registered nurse (RN) would provide services 1-2 times times a week (1-2 x/wk) and the home health aide (HHA) 2 times per week. The care plan indicated R52 is her own person, and does not need calls prior to visits. Review of the facility's hospice binder, located at the nurses station, included a March/April 2023 (but dates written were current for 2024) calendar indicating when the RN and HHA would be coming to visit R54. The calendar was completed through 4/8/24 but no further dates were present. The HHA visits included 3/28, 3/29, 4/2 and 4/8. During interview and observation on 4/8/24, at 12:42 p.m. R52 was lying in her bed with call light within reach and a cell phone on bedside table. R52 indicated last Monday (4/1/24), the HHA was supposed to come to give a bath but never showed up and no one told R52 why. R52 stated the HHA then showed up on Wednesday and told R52 it was a scheduled holiday off of work, but would come on Friday (4/5/24) to make up the day missed. R52 stated the HHA didn't show up on 4/5/24 so she called hospice services to find out what happened and was told HHA was sick. R52 stated she asked hospice services why they didn't call the facility or let her know. R52 stated she told them this is very rude and messes things up for the staff at the facility. R52 indicated the hospice agency initially stated they tried but couldn't get a hold of her, then said the scheduler is responsible, but then they claimed they tried to call the facility and no one answered. When interviewed on 4/9/24, at 9:51 a.m., R52 stated concerns with HHA and nurse not letting her know when they are coming. R52 stated I have no calendar, and no one ever calls to let me know when they are coming. They just show up. R52 stated there is a lack of communication from the hospice agency and it isn't fair for staff to have to provide her cares when hospice should be doing them. R52 indicated she has refused baths from the facility staff because they shouldn't have to do hospice's work. R52 indicated she has told the hospice staff before she wants advanced notice and denied every saying she didn't want advanced notice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/10/24 at 9:47 a.m., spoke with local hospice RN-F who indicated R52 had stated previously she did not want to be notified prior to visits. RN-F stated we do not routinely notify the staff in advance but do keep a calendar in her chart. RN-F confirmed it is challenging for the unit staff to know if they should provide personal cares or not if they aren't aware of the HHA's schedule for visits. During interview on 4/10/24 at 10:15 a.m., HHA-G from hospice agency stated she thought R54 would know it was a holiday on the Monday following Easter, but I guess I didn't tell her. HHA indicated she does not let the facility or R54 know in advance of her visits. HHA indicated she was out ill Friday 4/5/24 and notification to R54 is on the office staff members to let the resident know. During interview on 4/10/24 at 2:37 p.m., the director of nursing (DON) confirmed communication is lacking with the hospice agency and the facility and R54 should know in advance when the hospice staff are coming to the facility. A policy on hospice services was requested and none received.

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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** 40614 Based on observation, interview and document the facility failed to ensure a range of motion program for upper extremities was implemented, wrist brace was applied correctly, and edema glove was on for 1 of 2 residents (R14) who had limited range of motion to prevent contractures. Findings include: R14's face sheet printed 4/10/24, included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness one on side of the body) following cerebral infarction (central nervous system injury) affecting left non-dominate side, osteoarthritis, and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had intact cognition, dependent on staff for transfers, dressing, and personal hygiene, and limited range of motion (ROM) on one side. R14's provider orders dated 5/7/21, included apply resting hand splint on when in wheelchair and at bedtime. Document refusals. Apply edema glove during the day and off at bedtime. Document refusals. R14's plan of care last revised 10/17/23, included limited physical mobility related to stroke with hemiplegia/hemiparesis. A goal included R14 will remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin-breakdown, fall related injury through the next review date. Interventions included R54 to wear edema glove during the day and off at bedtime. Resting hand split when up in wheelchair and at night as resident tolerates. The plan of care also included an activities of daily living self-care deficit. Interventions included passive range of motion (PROM) to left hand, wrist, elbow and shoulder three times per week as resident tolerates. R14's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 10/13/21, indicated R14 was discharged from program with PROM and splint use for left upper extremity; collaborated with nurse manager regarding program to help maintain strength and reduce risk of contractures. A Group Daily Sheet, used by the NA's included R14 should wear his hand/wrist brace at bedtime but did not include PROM or edema glove. R14's medication administration record or task list in the electronic medical record did not identify PROM. (continued on next page)

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	245390	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	718 Mound Avenue Mankato, MN 56001

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 4/8/24 at 3:49 p.m., R14 was lying in his bed with hand splint and edema glove on his left hand from the lower palm of hand to below the elbow. R14's left fingers were curled into the palm of his hand. R14 stated my hand is really curved and I can't move my hand. R14 added no one has done range of motion on hand but would like them to before his hand is permanently stuck this way. R14 added staff are always in such a hurry they don't put on the brace right and it doesn't stay in place. Arm brace was observed to be a flat blue board with 3 Velcro straps and when R14 picked up his arm with his right hand, the splint was loose enough it moved further towards his elbow. During interview and observation 4/8/24 at 5:41 p.m., R14 was in the dining room in a wheelchair. The splint was on his left lower arm and was no longer in the palm of his hand and extended from mid lower arm to past his elbow. R14 had on his edema glove and picked up his left arm with right hand and placed on the arm of the chair. R14 indicated staff forgot to put the platform trough on the arm of the chair to hold his arm in place. R14's left arm fell off the arm of the chair within two minutes and he had to pick up his hand and place back on the armrest. During observation and interview 4/9/24 at 8:23 a.m., R14 was in the dining room having breakfast in his wheelchair. Arm trough was present attached to the left arm of the wheelchair with 3 Velcro straps. R14 did not have his edema glove on. The hand splint was present on his left palm extending to mid arm and attached with 3 Velcro straps. R14's fingers were curled over the end of the splint board towards the under side of the splint. During interview on 4/9/24 at 12:32 p.m., OT-F, indicated she has treated R14's left hand in the past and he should wear an edema glove, resting hand splint, have an arm support trough on his wheelchair and be receiving restorative exercises on his left hand, arm, elbow and shoulder to maintain mobility. OT-F stated the splint that was provided was for his hand and not his wrist or elbow and should be placed on with fingers held outwards and not curved around the end of the splint. OT-F indicated instructions for R14's PROM should be on his closet in his room as they were provided previously to the nurse manager. During observation and interview on 4/9/24 at 12:52 p.m., nursing assistant (NA)-D indicated if ROM is ordered there are instructions on the closet in resident's room with instructions on how to do it. Otherwise OT and activities does the ROM. During interview on 4/9/24 at 1:00 p.m., NA-E indicated she does not perform PROM on R14's left hand. NA-E indicated he has a lot of discomfort when attempting to complete it. During interview and observation on 4/9/24 at 1:08 p.m., NA-B indicated R14 does some range of motion (ROM) exercises himself, which is posted on the closet. On R14's closet, ROM exercises were present for hip abductions and for urinary incontinence exercises but no ROM instructions were present for his left arm, hand, shoulder or elbow. NA-B indicated she has never done PROM to R14's left hand, elbow, wrist or shoulder. During interview on 4/10/24 at 7:39 a.m., R14 was lying in his bed with his arm splint on but fingers were curled under at the end of the splint. R14 stated he would allow staff to perform ROM because he doesn't want to lose the flexibility in his hand and fingers. R14 indicated it is painful and he has shooting pains in his hand when they move his fingers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 4/10/24 at 8:28 a.m., R14 was in the dining room. OT-F evaluated the splint and placement. OT-F indicated the splint was not in the correct position and should extend to keep his fingers straight out and not curled under the splint. OT-F stated the splint is for his fingers and not his hand or wrist and the way the splint was placed on R14 was not doing anything to prevent contractures of R14's fingers. OT-F stated the splint had lost its form, as it was a bendable splint, and should not be straight like it is. OT-F added the splint was placed on backwards. R14 was not wearing his edema glove. OT-F went to R14's room and got edema glove and wash cloth. OT-F attempted to move R14's fingers and stated his fingers are tight and was unable to straighten his fingers from the curled position. OT-F placed edema glove on R14's hands with difficulty taking approximately 10 minutes to place on his left hand and fingers. OT-F bent the splint to get into a better position for his hand but was unsuccessful in getting R14's fingers extended for the splint to work. OT-F then placed a rolled washcloth under R14's fingers and stated he will need some continued therapy to get his hand more flexible prior to wearing a hand splint again. During interview on 4/10/24 at 8:49 a.m., RN-B indicated she is aware that R14 has contractures of his hand. RN-B indicated moving his fingers aren't comfortable for him and some staff don't want to hurt him so do the best they can. RN-B confirmed there is an order for PROM and the care plan indicates he should have ROM completed 3 times per week. RN-B confirmed staff should complete the PROM and if not completed they need to let the nurse know it wasn't done and why. RN-B was unable to locate the instructions for PROM in the room or restorative book. During interview on 4/10/24 at 2:25 p.m., the director of nursing stated if PROM is ordered it should be done by the nursing assistants and the hand splint should be applied correctly. The nurses are responsible to ensure the care and treatment is getting done. The facility Resident Mobility and Range of Motion policy and procedure dated 7/2017 included: -Residents will not experience an avoidable reduction in range of motion (ROM). -Resident with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. -Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. - The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. -Documentation of the residents progress toward the goals and objectives identified in the plan of care will include attempts to address any changes or decline in the residents condition or needs.

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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** 44630 Based on observation, interview and document review, the facility failed to properly assess disposing of cigarettes for 1 of 1 resident (R57) reviewed for smoking. Findings include: R57's admission Minimum Data Assessment (MDS) dated [DATE], indicated R57 had severe cognitive impairment, required supervision with personal hygiene, sit to stand, chair transfer, and walking and diagnoses included aphasia (ability to understand or express speech), hemiplegia following cerebral infract (paralysis of partial or total body function on one side of the body after a stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes. R57's care plan revised 4/8/24, indicated R57 would like to smoke while residing at this care community, was offered smoking cessation options and declined, (was on nicotine patch when first admitted , requested for them to be stopped d/t being ineffective for him), will not smoke unless directly supervised by family/responsible party/staff as evidenced by:resident determined unsafe to smoke independently per smoking assessment, facility stores resident's lighter and cigarettes, will be assessed quarterly/PRN (as needed) for smoking safety, will be offered smoking cessation options quarterly, will smoke in designated areas only and will dress appropriately for weather, instruct about smoking risks and hazards and about smoking cessation aids that are available, instruct about facility policy on smoking: locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, observe clothing and skin for signs of cigarette burns, requires supervision by family/friend/staff while smoking. On 4/10/24 at 8:38 a.m., alarm was heard at front entrance door and R57 was observed seated in a wheelchair and interim director of nursing (IDON) stood behind resident's wheelchair and R57 was observed to cross the street and IDON was behind wheelchair and assisted R57 across the street. R57 was observed to smoke a cigarette while near the curb of the street and IDON stood next to R57. R57 was on the side of the street near the curb and observed R57 ash and flick his cigarette ash on the street. When R57 was finished smoking, R57 bent over in his wheelchair and put out the cigarette on the curb of the street. IDON stood behind R57's wheelchair, and R57 wheeled himself across the street with the supervision of IDON. R57 and IDON entered the facility through the front doors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 8:41 a.m., R57 was seated in a wheelchair and observed pushed in the hallway by IDON, and when asked where the cigarette was disposed of, IDON and R57 both put their hands up and said I don't know. R57 further stated, I know nothing. IDON stated he did not know R57 brought the cigarette butt back into the facility. R57 was assisted back to his room by IDON and exited R57's room. IDON was asked where the cigarette butt was disposed, and said he was not sure, when asked if R57 showed him the cigarette butt when they entered the facility, he said he could not remember. IDON was asked to retrace the steps coming into the facility. IDON was observed and walked from the entrance to the right and into the dining room, a garbage located in the dining room was observed and no cigarette butt was found. Licensed practical nurse (LPN)-A stated to IDON that he came in through the other entrance of the dining room. IDON stated he still got confused with directions throughout the facility. IDON was observed and exited the dining room and was asked if they entered the bathrooms by the dining room and stated he did not, IDON was observed and walked by the chapel and a trash can lined with a plastic trash bag was was observed and a cigarette butt was found in the garbage. On 4/10/24 at 9:06 a.m., R57 was lying in bed and confirmed he brought the cigarette butt back into the facility with him and stated he did not remember who threw it away and could not remember where he disposed the cigarette butt. On 4/10/24 at 9:16 a.m., the director of nursing (DON) stated the facility did not have a receptacle for R57 to dispose of the cigarette, stated the staff assisting R57 was responsible to ensure the cigarette was disposed of and the facility did not have a receptacle, a plan or designated area for R57 to dispose of his cigarette. The DON stated the cigarette was not expected to have been brought in the building. On 4/10/24 at 9:30 a.m., IDON stated staff were to supervise R57 across the street and attend to R57 while he smoked, IDON stated R57 was able to light his cigarette himself, ashed on the ground on the street, and he observed R57 scrape the cigarette on the side of the curb and street to put the cigarette out. IDON stated he assisted R57 back across the street into the building. IDON stated he thought R57 left the cigarette butt on the street, and confirmed a cigarette butt should not be brought back in the facility. IDON confirmed the facility did not have a smoking receptacle for R57. IDON stated the facility was a non smoking campus, however allowed R57 to smoke off facility property and further stated it was not well thought out plan about R57 smoking and was not aware of a plan to dispose of the cigarette. IDON stated it would be a fire safety concern for R57 disposing cigarette butts in the trash at the facility and not a receptacle outside. IDON stated he watched R57 fully put out the cigarette on the street prior to entering the facility. The IDON stated he was recently hired as the IDON and worked approximately 5 days last week, and three days the week before at the facility and still gets lost in the building. Observation on 4/10/24 at 9:45 a.m., outside the facility entrance doors confirmed no cigarette ash tray or receptacle located near R57's smoking area across the street or near the entrance of the facility. On 4/10/24 p.m. at 12:38 p.m., the DON stated the area across the street was observed and multiple cigarette butts found on the ground where R57 commonly smoked and was unsure why R57 brought the cigarette back in the facility today and would provide education to nursing and the resident regarding disposal of the cigarette. The facility Smoking Policy-Residents dated 8/22, indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility has established and maintains safe resident smoking practices. 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 4. Metal containers, with self closing cover devices, are available in smoking areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on interview, observation, and document review the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections, staff doffed (removed) personal protective equipment (PPE) incorrectly for 1 of 1 resident (R16), failed to ensure PPE was stored in a manner to prevent transmission of bacteria when PPE was observed stored directly on the floor for 18 of 18 residents (R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219) placed on enhanced barrier precautions (EBP) and the staff placed a meal tray on the floor for 1 of 1 resident (R27). This had the potential to affect all 56 residents who resided in the facility. Finding include: Enhanced Barrier Precautions Facility document titled Enhanced Barrier Precautions printed 4/10/24, indicated the following residents had Enhanced Barrier Precautions (EBP) R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. During an observation of private resident rooms on 4/9/24 at 8:46 a.m., through 9:33 a.m., R12, R52, R218, R3, R20, R36, R41, R16, R6, R8, R17, R19, R46, R21, R219 room door signage indicated the residents were on EBP. The residents identified on EBP had plastic gowns located directly inside the resident's room on the floor and there was not a place to dispose of the plastic gowns prior to leaving the resident's room. The facility failed to have PPE located near or outside of resident rooms. During observations of private resident rooms on 4/9/24 at 9:10 a.m., observed PPE directly on the floor in the following rooms of residents who were identified by signage on their doors as being in EBP: -- R15, room [ROOM NUMBER] - a box of plastic gowns was on the floor inside the door -- R27, room [ROOM NUMBER] - a box of plastic gowns was in a plastic dishpan on the floor inside the door -- R10, room [ROOM NUMBER] - a box of plastic gowns was in a plastic dishpan on the floor inside the door. On 4/9/24 at 7:41 a.m., occupational therapy assistant (OTA)-A stated residents on EBP had a sign on the door and staff were expected to wear a gown and gloves when providing hands on care. OTA-A stated the PPE was located in the resident bathrooms, and confirmed PPE was donned when staff entered EBP resident rooms. On 4/9/24 at 8:55 a.m., nursing assistant (NA)-D entered R17's room and stated it would be easier for staff if the gowns and gloves were mounted on the wall and she did not have to get the gowns off the resident floors and go into the bathroom to get the gloves. NA-D confirmed PPE was donned inside resident's room on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/24 at 2:35 p.m., assistant director of nursing (ADON), who is the facility infection prevention nurse, stated residents who are placed on EBP had signs posted on their door and confirmed the following residents were on EBP R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. The ADON stated residents with indwelling medical devices, wounds, or those colonized by or infected with a multi-drug resistant organism the staff were expected to wear gloves, gowns, when providing cares for residents with EBP and would expect staff to donn PPE immediately inside the resident door. RN-A stated the facility was still trying to work through the placement and location for the PPE for residents with EBP. The ADON stated the box of plastic gowns was not expected on the floor of resident rooms and would expect gloves readily available. The ADON confirmed the gloves were kept in residents bathrooms. On 4/9/24 at 2:40 p.m., during an interview the director of nursing (DON) stated PPE including the plastic gowns in boxes should not be placed on the floor inside the private resident room. On 4/9/24 at 3:00 p.m. through 3:20 p.m., during tour with the ADON the following rooms were observed: R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. The ADON confirmed the boxes of plastic gowns were located on the floor. The ADON stated the gowns on the floor were an infection control risk. The ADON confirmed there was not a garbage or place to dispose of the plastic gowns readily available next to the door for staff to doff PPE prior to exiting resident rooms on EBP. Infection Surveillance On 4/10/24 at 1:13 p.m. during an interview with the DON and the ADON, who was identified as infection preventionist, the ADON stated he started the position in January of this year [2024]. The ADON stated he was responsible for infection surveillance and confirmed tracking of the infections was not currently taking place, and was not aware when the last infection surveillance had occurred. The ADON stated he had training last week for infection surveillance, tracking, and trending of the data. The DON stated discussions were held at daily meetings of residents who were showing signs of infection and on antibiotics. The DON also explained the facility used electronic communication among staff for possible infection concerns and information. The DON confirmed ongoing surveillance had not been completed with incidence of infections determined or analyzed, and the infection control program had room for improvement. The ADON verified infection prevention was done on an informal basis and stated daily during staff meeting he discussed residents on antibiotics with facility staff; however, residents were not tracked or compared for trending's or patterns and the facility was not currently tracking the infection data. The ADON verified a monthly analysis of the illnesses and infections were important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. Meal Tray on floor During an observation on 4/8/24 at 5:48 p.m., NA-C was observed setting a meal tray on the floor outside R27's room who was in EBP, in order to don (put on) PPE prior to entering the room. During an interview on 4/8/24 at 5:56 p.m., NA-C stated she did not consider it an infection control breach to set a meal tray on the floor since the food and beverages were covered and she wiped off the bottom of the meal tray before setting it on R27's overbed table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Doffing During an observation on 4/10/24 at 6:35 a.m., observed signage on R16's door indicating he was in transmission-based precautions for Covid-19. A progress note indicated he had tested positive for Covid-19 late in the afternoon on 4/9/24. An isolation cart/organizer was observed outside R16's room. Signage on door indicated: 1. 7 - 14 DAY QUARANTINE - start date 4/9/24 through 4/19/24. 2. Droplet Precautions: N95 Mask, Face Shield, Gown, Gloves. Instructions for staff providing direct care: doff gown and gloves .prior to leaving the room. Doff N-95 outside of room. 3. CDC Enhance Barrier Precaution sign 4. Donning sign 5. Doffing sign which directed staff to remove gloves and gown in the resident's room prior to exiting and to remove face shield and respirator (N-95 mask) after exiting the room. During an observation and interview on 4/10/24 at 7:39 a.m., observed RN-G exit R16's room with all PPE already doffed. According to the doffing sign on the door, N95 mask should be doffed after exiting the room. Together with RN-G, read the doffing sign on the door which indicated to remove all PPE in room (except N95), before exiting the room. RN-G stated she hadn't done this [donning and doffing] for a while and forgot the sequence. During an observation and interview on 4/10/24 at 7:40 a.m., observed NA-B exit R16's room with full PPE on. NA-B stood and doffed the PPE outside the door - gloves, gown, mask and face shield, setting it all on the floor outside the room. NA-B then picked up the PPE and carried it across the hall to the dirty utility room. NA-B stated she did not have donning and doffing training yet and stated she didn't see the sign on the door about doffing. During an interview on 4/10/24 at 2:50 p.m., ADON who was also the infection preventionist stated for transmission-based precautions for Covid-19, staff were to doff all PPE inside the residents room except for the N-95 mask and face shield - which should be doffed after exiting the room. The ADON stated staff should have had donning and doffing training upon hire. The ADON acknowledged staff had not followed proper procedure for doffing. In addition, the ADON was informed of observation of NA-C setting R27's meal tray on the floor outside his room while she donned PPE. The ADON stated a meal tray should never be set on the floor and acknowledged there were no surfaces for staff to set items on as they donned/doffed PPE to enter/exit the rooms of residents in EBP. Documentation of donning and doffing education for RN-G and NA-B was provided by the ADON and indicated RN-G had received education with competency on 3/8/24, and NA-B had received donning and doffing education with competency on 3/22/24. The facility Enhanced Barrier Precautions policy dated 8/22, indicated: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug organisms (MDROs) to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Enhanced barrier precautions (EBPs) are used as infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ target gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing. b. bathing/showering c. transferring d. providing hygiene e. changing linens. f. changing briefs or assisting with toileting g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) h. wound care any skin opening requiring a dressing. 9. staff are trained prior to caring for residents on EBPs 11. PPE is available outside of the resident rooms. The facility Surveillance for Infections policy dated 9/17, indicated : That infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. 1. The purpose of this surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and health care associated infections to guide appropriate interventions and to prevent future infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	718 Mound Avenue Mankato, MN 56001

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment b. available processes and procedures that prevent or reduce the spread of infection c. clinically significant morbidity or mortality associated with infection (e.g pneumonia, UTIs, C. difficile; d. Pathogens associated with serious outbreaks 4. Infections that may be considered in surveillance include those with limited transmissibility and health care environment and/or limited prevention strategies Gathering Surveillance Data 1. Correction preventionist are designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and or QAPI committee may be involved in interpretation of data 2. if surveillance should include a review of any or all of the following information to help identify possible indicators of infection: a. laboratory records b. skin care sheets c. infection control rounds or interviews d. verbal reports from staff infection documentation records e. temperature logs f. pharmacy records g. antibiotic review h. transfer log/summaries 3. laboratory reports are used to identify relevant information the following findings merit further evaluation: a. positive blood cultures b. positive cultures that do not just represent surface colonization (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. positive urine cultures with corresponding signs and symptoms that suggest infection d. positive sputum culture e. other positive cultures f. all cultures positive for Group A streptococcus 4. In addition to collecting data on the incidence of infections the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted for example focus surveillance data may be gathered for residents with high risk for infection or those with their recent hospital stay. Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance collect the following data as appropriate: identifying information, diagnosis, admitted date of onset of infection, infection site, pathogens invasive procedures are risk factors, pertinent remarks, treatment measures and precautions. Calculating infection rates Interpreting Surveillance Data 1. Analyze the data to identify trends The facility Infection Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 11. Prevention of Infection 3. educating staff and ensuring that they adhere to proper techniques and procedures. 42073 .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 44630 Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 56 residents who had infections requiring antibiotic use. Findings include: During interview on 4/10/24, 1:13 p.m., with the director of nursing (DON) and assistant director of nursing (ADON), who was the infection prevention nurse. The DON stated the nurses completed monitoring of symptoms if resident had a possible infection and report that information to the providers. The provider identified potential infections and order testing and review the cultures. The DON further stated the nursing staff also were responsible to review lab and culture results to ensure resident is taking proper antibiotic. The ADON stated he was the infection prevention nurse and was responsible for the infection control program, including antibiotic stewardship. The ADON confirmed education completion of infection control/prevention and antibiotic stewardship program and received specific facility training last week for tracking infections and antibiotics and stated he planned to implement the training next week for antibiotic tracking. The ADON stated awareness of any resident infections, new symptoms or residents placed on antibiotics was discussed during daily stand-up meetings to keep up with resident status. The ADON confirmed the facility was not tracking and monitoring process for residents placed on an antibiotic The DON stated the facility used electronic communication for staff to track residents who were on an antibiotic and if cultures were received. The DON stated the health unit coordinator received the culture results via fax, would alert the nursing staff and the nurse would contact the doctor if the culture result indicated a change in the antibiotic was needed. The DON and ADON verified the facility did not have a formal process or tracking to include the requirements for Antibiotic Stewardship and confirmed the antibiotics were not tracked for cultures, source, location of infection, symptoms when placed on antibiotic. The ADON stated he does not review or track culture results to ensure proper antibiotics were prescribed or have a tracking log. The facility Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 8. Antibiotics stewardship a. Culture reports sensitivity data and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standard definitions are of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40614 Based on observation and interview, the facility failed to provide a sanitary environment in the kitchen serving food preparation area and drying pots/pans area. This had the potential to affect all 56 residents currently residing in the facility. Findings include: On 4/8/24 at 12:00 p.m., during initial tour of the kitchen, a vent with 2 rungs present had dark fuzzy material on the top rung. This was over the pots and pans dishwashing area and where pots and pans were left to dry. Above the food serving area, 3 plugs were present in a wire mesh that extended down approximately 5-6 inches that had gray fuzzy debris present. A white flat printer cord extended from ceiling to the printer and was covered in gray, fuzzy debris. These cords were located above the clean plates and near the steam table area on the left and next to a food prep area on the right. During observation and interview on 4/9/24 at 11:33 a.m., the vent remained covered in dark fuzzy debris along with the wire mesh and white printer cord. Cook (C)-A indicated the dietary staff clean the vents but maintenance would be responsible for cleaning the cords extending from the ceiling. C-A confirmed they were dirty and covered in debris and needed to be cleaned. During observation and interview on 4/9/24 at 11:35 a.m., maintenance director (MD)-A confirmed the 3 plugs wire mesh and printer cord was covered in in dust and debris and needed to be cleaned. On interview 4/10/24 at 9:43 a.m., the culinary director (CD) indicated there should not be any dirt or debris on the cords, or wires holding the cords or vents above the food serving or clean areas in the kitchen.