

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Edenbrook of Rochester		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19th Street Northwest Rochester, MN 55901	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>49654</p> <p>Based on observation, interview and record review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 1 of 1 residents (R20) reviewed for medication administration.</p> <p>Findings include:</p> <p>R20's admission Minimum Data Set (MDS) assessment, dated 3/17/25 indicated R20 had intact cognition, with diagnoses of atrial fibrillation (an abnormal heartbeat), heart failure, respiratory failure, cataracts (clouding over the eyes lens), glaucoma or macular degeneration.</p> <p>R20's order summary indicated R20 had orders for the following medications: Brimonidine Tartrate Ophthalmic Solution 0.2% - instill 1 drop in both eyes two times a day related to glaucoma, and Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8mg/mg - instill 1 drop in both eyes two times a day related to glaucoma.</p> <p>R20's record lacked evidence an assessment was completed or a provider order obtained for R20 to self-administration medications.</p> <p>During an observation on 4/29/25 at 9:05 a.m., a white bottle with a blue cap was noted to be sitting on the bedside table and within reach of R20. Licensed practical nurse (LPN)-C entered the room, picked up the bottle and placed it in her front right pocket. R20 stated to LPN-C I finished the blue one. LPN-C then left the room. R20 stated staff would bring her eye drops into the room and leave them for her to self-administer.</p> <p>During an interview on 4/29/25 at 2:08 p.m., LPN-C stated she took both of R20's prescribed eye drops into R20's room during the morning medication administration and had left one sitting on the bedside table and identified the medications was Dorzolamide-Timolol eye drops. LPN-C then reached into her front right pocket and removed the white bottle with a blue lid labeled with R20's name and identified the medication as Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8mg/mg. LPN-C stated R20 did not have an order to self-administer medications.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/1/25 at 1:58 p.m., Director of Nursing (DON) stated any residents who wished to administer their own medications require a self-administration of medication assessment and a physician order to do so. DON confirmed R20 did not have an order to self-administer medications and expected staff to verify a SAM assessment was completed in order to determine is a resident was appropriate to safely self-administer medications. DON added a physician order was to be in place before leaving any medications at bedside. She went on to say this was important to ensure the resident knew how to safely administer their medications.</p> <p>Facility policy Medication Self Administration dated 2/12/24, indicated the resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. The ability to self-administer medications will indicate: A) able to self-administer medications independently, B) able to self-administer medications with supervision, cueing and/or set-up, C) not able to self-administer medications safely. Residents who have been deemed appropriate to self-administer medications independently or with supervision/cueing or after set-up shall have a physician order to do so. The self-administration of medications will be care planned with interventions specific to the individual resident.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation, interview and document review, the facility failed to ensure resident equipment was kept in a clean and in a sanitary manner to promote resident well-being for 1 of 1 resident (R31) observed for wheelchair cleanliness. In addition, the facility failed to provide comfortable sound levels for 1 of 1 resident (R44) observed for uncomfortable noise levels.</p> <p>Findings Include:</p> <p>R31</p> <p>R31's Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R31 is unable to speak and uses an iPad for communication needs. R31 has impaired vision requiring glasses, adequate hearing, and understands himself and others. R31's had intact cognition. R31 had functional impairment of both lower extremities requiring an electric wheelchair and functional limitations of both upper extremities requiring supervision and intermittently assistance for feeding task.</p> <p>R31 was admitted on [DATE] with a diagnosis of right-sided cerebrovascular disease (disease affecting blood flow to the brain), quadriplegia, dysphagia-orpharyngeal phase (difficulty swallowing, coughing, or choking when eating), muscle weakness, diffuse traumatic brain injury, and recurrent pneumonia.</p> <p>During observation and interview on 4/28/25 at 12:29 p.m., R31 was going to lunch in a personal electric wheelchair. R31's wheelchair foot plate, under seat platform, and right wheel and wheel cover had a thick layer of a dried substance of varying colors. R31 communicated on his iPad the substance was food and covered the bottom right side of the wheelchair for some time. R31 indicated he is unable to control his food when he eats and spills onto his wheelchair. R31 indicated he sometimes drops partially chewed food from his mouth because of his dysphagia. R31 indicated he is unable to clean his wheelchair due to his physical disabilities. R31 indicated he does not like the dried foods on his wheelchair.</p> <p>During observation and interview on 4/29/25 at 8:18 a.m., R31 was returning to his room from the dining room. R31's wheelchair continued to have chewed or spilled food dried on his wheelchair. Nursing assistant (NA)-A stated R31's wheelchair often had spilled or chewed food on it . NA-A stated she thought the night shift was responsible for cleaning the wheelchairs. NA-A stated she does not know how often residents' wheelchairs are cleaned.</p> <p>During interview on 5/01/25 at 12:08 p.m., director of nursing (DON) stated she knew R31 had old dried partially chewed food on his personal wheelchair and verified it was there for a while. DON stated the facility has a policy to clean facility and resident wheelchairs on the night shift. DON was unable to confirm the last time R31's wheelchair was cleaned and stated it would be in a progress note if it was completed. DON stated R31's wheelchair looks unsightly after every meal. DON stated R31's wheelchair should be cleaned after every meal as he does spill a lot. DON confirmed there is no interventions in R31's care plan to protect the wheelchair during meals.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per facility policy titled Cleaning and Disinfection of Resident Care Equipment dated 5/8/24, how often resident equipment was cleaned was not specified.</p> <p>R44</p> <p>R44's Minimum Data Set (MDS) assessment dated [DATE] was incomplete, although included, R44 did not have any vision or hearing disabilities and was cognitively intact.</p> <p>R44 was observed using bilateral upper extremities, required assistance from staff for mobility and toileting.</p> <p>R44 was admitted on [DATE] with a diagnosis of muscle weakness, adult failure to thrive, severe obesity, chronic fatigue, rheumatoid arthritis, and need for assistance with person cares.</p> <p>During observation and interview on 4/28/25 at 4:20p.m., upon entering R44's room, the sound level in the room was loud and unpleasant. R44 stated her roommate's television (TV) was always very loud. R44 stated she had made multiple complaints about the noise of the roommate's television at all hours, but nothing has been done. R44 stated she told the social worker (SW) approximately one month ago about the unpleasant sound levels in her room. R44 stated she is unable to get up without assistance, or she would lower the volume herself. R44 stated her roommate leaves the room frequently throughout the day but she leaves the TV volume loud even when she's not in the room. R44 stated she will put her call light on during the day to have staff the lower the volume when the resident is not in the room; staff have told her they can't turn the volume down because it is the roommate's choice to have the TV volume up.</p> <p>During interview on 4/29/25 at 8:18 a.m., nursing assistant (NA)-A stated R44's roommate's TV is very loud; the roommate doesn't like to hear any of the other facility sounds. NA-A stated R44 will ask to have the volume turned down, informs R44 it is roommate's right to have her TV loud. NA-A stated if the staff notice the roommate is not in the room, they will try to turn the volume of the TV down, things are busy so they don't always notice when the roommate leaves the room. NA-A confirms R44 is unable to turn the volume down due to her physical limitations.</p> <p>During observation and interview on 4/29/25 at 2:00 p.m., R44's roommate's TV is very loud, and can be heard halfway down the hall. Upon entering the room, R44 had facial wincing, when asked indicated because of the volume of the TV. R44 stated she had asked staff to turn it down, but resident just turns it back up when she returned to the room.</p> <p>During interview on 4/30/25 at 1:25 p.m., social services (SS)-A stated she was aware the roommate's TV volume could be loud at times. SS-A stated she had asked facility staff to keep an eye on the volume and turn it down when the resident was not in the room. SS-A confirmed no other interventions were in place to reduce the sound levels. SS-A confirmed R44 had told her approximately one month ago she was not sleeping well due to the volume of the roommates TV. SS-A stated this was when she asked facility staff to turn the TV volume down; no other interventions were initiated.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/01/25 at 12:08 p.m., director of nursing (DON) confirmed she was not aware there was a potential roommate incompatibility with R44. DON confirmed R44's roommate leaves the room frequently as she can walk without assistance. DON stated social services would evaluate a situation; if the residents in the room aren't compatible, one resident can be moved to another room. DON confirmed there were no current plans to move either resident.</p> <p>The facility does not have a policy regarding roommate incompatibility or appropriate sound levels in each room.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation, interview and document review, the facility failed to implement specific resident-centered interventions for 2 of 2 residents (R35, R20) reviewed for care plans.</p> <p>Findings Include:</p> <p>R35's minimum data set (MDS) assessment dated [DATE] indicated moderately impaired cognition and moderately severe depression. R35 had a history of refusing cares and treatments.</p> <p>R35 was admitted on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD, lung disease causing breathing problems), obstructive and reflex uropathy (blockage preventing urine from flowing normally), liver transplant, chronic kidney disease, major depressive disorder, and hydronephrosis with renal and ureteral calculous obstruction (urine buildup in the kidney due to blockage caused by kidney stones).</p> <p>R35's orders included, monitor for signs and symptoms of liver rejection including fever, pain in abdomen, yellowing skin, itching, increase in tiredness/weakness, swelling in abdomen or legs, and pale in color; notify provider and transplant coordinator immediately. Further, weigh every morning before breakfast; perform in the same manner (same scale, same method) every day and notify provider and transplant coordinator if weight increases by more than 5 pounds in one week.</p> <p>R35's daily weight record reviewed from 4/4/25 to 4/30/25 revealed R35 was not weighed daily and when completed was not according to provider orders (perform in same manner):</p> <p>-4/4/25 at 11:14 a.m. (166 pounds)</p> <p>-4/5/25 at 2:24 p.m. (166 pounds)</p> <p>-4/8/25 at 12:57 p.m. (165 pounds)</p> <p>-4/10/25 at 10:54 a.m. (164 pounds)</p> <p>-4/20/25 at 2:31 a.m. (166.5 pounds)</p> <p>-4/30/25 at 3:31 p.m. (165.8 pounds)</p> <p>R35's missed daily weights were documented as:</p> <p>-17 days were documented as refused</p> <p>R35's progress notes lacked a provider had been notified of R35's refusal of daily weights.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 4/29/25 at 2:12 p.m., licensed practical nurse (LPN)-A stated R35 does refuse cares and medications sometimes. LPN-A stated due to R35's poor kidney function, the provider team ordered to have weights done daily. LPN-A stated accurate daily weights are important because if R35 was gaining weight rapidly it could indicate liver transplant rejection or if his kidney function gets worse, he could also have a rapidly increase in weight. LPN-A confirmed it is an expectation when a resident refuses cares or medication more than 2 days in a row, the provider would be notified. LPN-A confirmed provider notification would be a progress note and phone call.</p> <p>During interview on 4/29/25 at 2:52 p.m., registered nurse (RN)-A stated R35 will agree to medications and cares if staff explain the purpose of the medications and cares to him. RN-A stated R35's liver transplant anti-rejection medications and daily weights are important. RN-A stated R35 likes to remain in bed a lot, and needs a lot of encouragement to get up for eating, weights, daily cares. RN-A confirmed the expectation is to notify the provider if R35 refuses medications and cares; providers are notified by a progress note and phone call.</p> <p>During interview on 4/30/25 at 10:50 a.m. RN-B stated she works with R35's transplant team. RN-B stated daily weights are important because a rapid increase in weight could indicate liver transplant rejection. RN-B confirmed she had not been notified of R35 refusals of daily weights up to 10 days in a row.</p> <p>During interview on 4/30/25 at 2:18 p.m., nurse practitioner (NP)-A stated she works with R35's nephrology (kidney) team. NP-A stated daily weights for R35 are very important; daily weights allow the nephrology team to make specific medication changes based on weight increases or decreases. NP-A stated an acute increase in weight could indicate a decrease in kidney function and the sooner the team is aware of weight changes, the sooner they can begin to make medication changes to help kidney function. NP-A confirmed she had not been notified of R35 refusals.</p> <p>During interview on 5/01/25 at 12:08 p.m., director of nursing, (DON) stated it is an expectation ordered daily weights are completed per provider instructions. DON confirmed daily weights are ordered in the morning for R35 as this is the most accurate time of day to obtain weights. DON confirmed R35 had daily weights ordered so his provider teams can monitor liver transplant status and kidney function status. DON confirmed if R35 was refusing daily weights, it is the expectation to notify the provider as soon as possible. DON stated the provider would be notified by progress note or phone call.</p> <p>Per facility policy titled Resident Height and Weight policy dated 1/7/25, the stated purpose of this document is to provide guidelines for MD notification and documentation of weight changes.</p> <p>49654</p> <p>R20</p> <p>R20's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R20 admitted on [DATE], was cognitively intact, had no behaviors, did not refuse cares and had the following pertinent diagnoses: A-fib (irregular heartbeat), congestive heart failure (the heart does not pump enough to adequately supply the body with blood or oxygen), and high blood pressure.</p> <p>R20's order summary indicated the following cardiac related orders:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Apply gradient compression garments to lower extremities-on during the day and off at night</p> <p>-CHF monitoring: monitor respiratory status (i.e. Orthopnea and dyspnea), edema, (i.e. leg or abdominal swelling), fatigue, change in mental status every shift and document findings in PCC (Point Click Care). Update provider with any signs/symptoms of worsening CHF.</p> <p>-Daily weights upon admission for residents with heart failure unless directed otherwise by provider. Notify [provider] if weight greater than 198.41 lbs one time a day. Process for weight: every morning before breakfast, perform in same manner (e.g. use same scale, same method)</p> <p>R 20's medical record indicated 22 of 29 weights recorded exceeded 198.4 lbs. for the month of April 2025 :</p> <p>4/29/25 recorded weight 201.0 lbs.</p> <p>4/28/25 recorded weight 200.4 lbs.</p> <p>4/27/25 recorded weight 202.2 lbs.</p> <p>4/25/25 recorded weight 209.0 lbs.</p> <p>4/24/25 recorded weight 200.8 lbs.</p> <p>4/23/25 recorded weight 199.2 lbs.</p> <p>4/21/25 recorded weight 201.6 lbs.</p> <p>4/20/25 recorded weight 199.3 lbs.</p> <p>4/17/25 recorded weight 201.0 lbs.</p> <p>4/16/25 recorded weight 201.4 lbs.</p> <p>4/15/25 recorded weight 204.0 lbs.</p> <p>4/14/25 recorded weight 201.8 lbs.</p> <p>4/13/25 recorded weight 200.4 lbs.</p> <p>4/12/25 recorded weight 199.8 lbs.</p> <p>4/11/25 recorded weight 200.6 lbs.</p> <p>4/10/25 recorded weight 202.6 lbs.</p> <p>4/9/25 recorded weight 199.0 lbs.</p> <p>4/8/25 recorded weight 199.6 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49654</p> <p>Based on observation, interview and document review, the facility failed to ensure medications were properly labeled with open dates, expired medications were removed and disposed of properly and discharged and/or expired residents' medications were removed from the cart in a timely manner to decrease the potential for drug diversion for 2 of 2 medication carts reviewed for medication storage. This deficient practice had the potential to affect all residents receiving medications from these medications' carts.</p> <p>Findings include:</p> <p>On 4/29/25 during continuous observation from 2:41 p.m. through 3:01 p.m.,</p> <ul style="list-style-type: none"> -2:41 p.m. an unidentified staff wearing dark blue scrub pants and top and was not wearing a name badge was working at the north medication cart and walked away from the cart and left it unlocked -2:42 p.m. an unidentified resident and guest walked past the unlocked medication cart - 2:44 p.m. the unidentified staff member walked back to the north medication cart, placed box of gloves on cart and walked away but did not lock cart - 2:45 p.m. to 2:53 p.m., the north medication cart remained unlocked and unattended - 2:53 p.m. an unidentified staff member wearing black scrub pants and printed floral scrub top walked by the unlocked medication cart and entered a resident room - 2:53 p.m. registered nurse manager (NM) walked down hallway, passed the unlocked medication cart but did not lock cart - 2:55 p.m. the unidentified staff returned to cart with paper in his right hand, placed paper on top of medication cart and walked away. Medication cart remained unlocked. - 3:01 p.m. the unidentified male staff returned to cart, opened top drawer, locked cart and walked away <p>During an observation and interview on 4/30/25 at 7:10 a.m., licensed practical nurse (LPN)-C was administering medication from the north medication cart. LPN-C placed medications into med cup, did not lock the medication cart and walked into resident room. At 7:13 a.m., LPN-C returned to medication cart, locked the cart and walked away. Upon returning to the medication cart LPN-C acknowledged she had left the medication cart unattended when asked. LPN-C opened the north medication cart for a random review of medications and identified the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Edenbrook of Rochester		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19th Street Northwest Rochester, MN 55901	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R20's opened bottle of saline nasal gel lacked an opened-on date. An opened bottle of Vitamin C approximately one fourth full had an expiration date of 3/2025. LPN-C stated she did not use the expired bottle, and the bottle should have been removed and the medication destroyed.</p> <p>During an observation and interview on 4/30/25 at 10:08 a.m., NM was observed during a medication cart audit of the west medication cart. The following was revealed:</p> <p>R16's opened bottle of liquid Haloperidol lacked an open date.</p> <p>R5's opened bottle of Prednisolone eye drops lacked an opened-on date.</p> <p>R40's opened bottle of Lantoprost eye drops, an opened bottle of Dorzolamide eye drops, an opened bottle of Deep-Sea nasal spray and an opened bottle of Flonase nasal spray all lacked an opened-on date.</p> <p>Additionally, R16's-25 tabs lorazepam 1mg, 20 tabs lorazepam 0.5 mg, 51 tabs hydromorphone 2mg, 60mL hydromorphone 2mg/ml, and 12mL hydromorphone 1mg/ml was identified in the locked narcotic box of the medication cart. NM stated R16 had expired the previous day, and the medications should have been removed and destroyed at that time to prevent potential diversion.</p> <p>During interview on 5/1/25 at 1:58 p.m. director of nursing (DON) stated she expected multi dose medications like eye drops, nasal sprays and creams to be dated with the date it was opened for use. DON stated this practice is important because medications are good for a limited amount of time after opening and the open date ensures the resident is not getting expired medications. DON stated the NM audits carts to look for outdated/expired medications, undated medications and general cleanliness. She stated this was to be completed at least monthly and as needed. DON stated she expected medications for expired residents to be removed and destroyed the same shift as the resident expired on. She went on to state this was to avoid potential medications errors and drug diversion.</p> <p>Facility policy titled Policy and Procedure Medication Storage with revision date of 2/12/24, indicated the following:</p> <p>No discontinued, outdated, or deteriorated medications should be available for use in the facility. All such medications are destroyed per policy. Expired medications are to be removed from areas/medication carts prior to or at the time of expiration.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Edenbrook of Rochester		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19th Street Northwest Rochester, MN 55901	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation and interview the facility failed to ensure a mechanical transfer lift was cleaned after resident use for 1 of 1 resident (R14), observed for infection control practices.</p> <p>Findings Include:</p> <p>R14's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R14 was cognitively intact, dependent on staff for toileting, required substantial/maximal assistance with transfers, personal hygiene, and dressing and used a wheelchair for mobility.</p> <p>R14's care plan dated 4/30/24, indicated R14 required the use of a standup lift (EZ stand) for transfers.</p> <p>During observation on 4/30/25 at 7:38 a.m., nursing assistant (NA)-A entered R14's room to answer his call light. NA-A went out of room and retrieved the EZ stand from the hall and brought into R14's room. The EZ stand had debris of a white flaky substance on it. NA-A and NA-B both assisted R14 from bed to the commode with the EZ stand. After completing task, NA-A removed EZ stand from R14's room and placed in hallway. The EZ stand was not cleaned after use.</p> <p>During observation on 4/30/25 at 9:09 a.m., NA-B removed the previously used EZ stand from the hallway and took into another resident room, the EZ stand was not cleaned prior to using it or after use on the other resident.</p> <p>During interview on 4/30/25 at 12:28 p.m., NA-B stated standard precautions are used to prevent the spread of infection from resident to resident. NA-B stated it is important to clean equipment in between use to prevent infection. NA-B stated it is an expectation to clean equipment such as an EZ stand after use. NA-B confirmed she did not wipe down the EZ stand after use with R14 or before use with second resident. NA-B confirmed staff receive infection control training at hire and annually thereafter.</p> <p>During interview on 4/30/25 at 8:40 a.m., licensed practical nurse (LPN)-A stated standard precautions are used to prevent infection, are used for every resident regardless of infection status, including hand washing, gloves, and cleaning commonly used equipment in between residents. LPN-A stated standard precautions are important because they protect residents from getting infections. LPN-A confirmed it is an expectation to clean commonly used equipment, like the EZ stand, after each use. LPN-A confirmed staff receive infection control training as a new employee and annually thereafter.</p> <p>During interview on 5/01/25 at 12:08 p.m., director of nursing (DON) stated standard precautions are a set of measures, they are the same for all residents, they are used to prevent infection. DON stated it is an expectation all commonly used equipment, such as an EZ stand, are cleaned after each use.</p> <p>Per facility policy titled Disinfection of Resident Care Equipment dated 5/8/24, reusable equipment will be cleaned and disinfected after each use of resident and before use with another resident.</p>		