STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shirley Chapman Sholom Home East	740 Kay Avenue Saint Paul, MN 55102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow resident to safely administer their own medication for 1 of 2 residents (R101) observed with medications at bedside. Findings include: R101's admission Minimum Data Set (MDS) dated [DATE], indicated R101 was cognitively intact, hypertension, arthritis, and hip fracture. R101 required substantial and/or maximal assistance for toileting and toileting hygiene, dressing, bed mobility, and was dependent with chair/bed-to-chair transfers. R101's physician's orders did not include Tums during document review on 6/10/24. R101's SAM assessment dated [DATE], indicated R101 did not want to self-administer medications. During observation and interview on 6/10/24 at 3:05 p.m., a bottle of Tums (calcium carbonate chewable tablet) was observed on R101's bedside nightstand. The bottle was mostly empty and did not have a resident label on it. R101 stated they took the tums after eating too much candy. During interview on 6/10/24 at 3:42 p.m., nursing assistant (NA)-H stated R101 required assistance for day-to-day activities such as dressing and toileting. NA-H stated they would report to the nurse if they noticed medications in a resident's room. NA-H verified the bottle of Tums on R101's nightstand and stated they had not noticed them before. NA-H stated the Tums must have been a personal bottle and not from the facility. During interview on 6/10/24 at 7:26 p.m., registered nurse (RN)-F stated they needed an order from the provider for residents to administer their own medications and to leave medications in resident's rooms. Staff usually asked residents during admission and with comprehensive assessments if they wanted to take their own medications. Staff documented assessments under observations. RN-F verified R101 did not have an order for Tums or a self-administration assessment to indicate R101 was safe to administer their own medication. RN-F verified the tums in R101's room and took the Tums out of R101's room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/13/24 at 3:17 p.m., registered nurse (RN)-D stated residents needed an order and observation completed before self-administering medication and/or having medication at bedside. Sometimes family brought in medication without notifying staff or sometimes medication was not within sight for staff to observe. RN-D stated R101 had self-administration observations but none which indicated R101 could take Tums by himself. During interview on 6/13/24 at 4:37 p.m., director of nursing (DON) stated an observation was completed to assess if a resident could self-administer medication appropriately and safety, and then staff requested a provider order. Residents were asked upon admission and quarterly if they wanted to self-administer medication. DON stated there was a safety concern for residents who had medication in their room without a self-administering observation assessment and provider order to ensure resident knew the frequency and amount to take medication at and proper storage of medication. The facility's policy Self-Administration of Medications dated 11/18, directed unit nurses to complete the Self Administration of Medication observation, and the outcome of the assessment would be reviewed by IDT (interdisciplinary team) and the decision would be documented.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview, and document review, the facility failed to notify a provider for a significant weight gain for 1 of 1 resident (R104) reviewed for notification of change. Findings include: R104's admission Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and had diagnoses of heart failure, heart attack, coronary artery disease (CAD, a buildup of plaque that limits blood flow to the heart), chronic kidney disease and anxiety. R104's Care Area Assessment (CAA) for nutrition dated 6/3/24, indicated weight loss was not warranted and weight maintenance was the goal of his care. An initial nutrition assessment dated [DATE], indicated R104 received a cardiac diet with regular textures and thin liquids. The progress note indicated R104 had lost approximately 50 pounds over a year prior to his admission to the facility and his goal was weight maintenance. The nutrition assessment indicated R104 was agreeable to receiving a supplement beverage daily to promote adequate intake for weight maintenance and his weights would be monitored in addition to his intake and supplement acceptance. R104's physician orders included the following: - furosemide tablet 20 milligrams (mg); Give 20mg once a day for visible water retention, dated 05/29/2024. R104 lacked orders for weight monitoring and weight parameters guiding staff when to notify the provider. R104's medication administration record (MAR) and treatment administration record (TAR) dated 6/2024 lacked orders for weight monitoring and weight parameters guiding staff when to notify the provider. R104's care plan dated 6/4/24, indicated his potential cardiovascular complication related to his diagnoses of atrial fibrillation (an irregular and often rapid heart rate that can cause poor blood flow), CAD, heart failure, history of heart attack, scheduled cardiac medications, and his pacemaker (an implanted cardiac device that delivers electrical pulses to your heart to help it pump effectively). The care plan identified interventions of assessing and monitoring for signs of cardiac decompensation and monitoring vital signs and reporting alteration from baseline to the provider. Additionally, R104's care plan dated 5/22/24, identified his higher risk for adverse reactions related to his use of a diuretic (furosemide). The care identified interventions of observing for ineffective diuretic dose: increase in edema, shortness of breath, weight gain, absent or decreased breath sounds, and decreased oxygen saturation levels (a measure of the blood oxygen levels). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An after discharge order set dated 5/22/24, indicated the following under the When should you be concerned? header: Please call your health care provider if you have any of the following: - chest pain or discomfort similar to before your angiogram. - a tightening, pressure, squeezing, or aching in your chest or arms. - excessive swelling, extreme tenderness, pain that will not stop, or signs of bleeding at your wound site. - signs of infection (increasing redness, swelling, tenderness, warmth, change in appearance, or increased drainage). - discolored area at wound site becomes hard and painful. - numbness, tingling or change in color or affected leg or arm. - swollen feet, ankles, and legs more than usual. - lightheadedness, dizziness, sweating, fatigue, weakness, loss of energy. - fever of greater than 101 degrees Fahrenheit. - trouble breathing, usual tiredness; decreased ability to exercise. - a new or worsening shortness of breath. - trouble breathing when lying flat. - weight gain of 3 pounds in one day. - weight gain of 5 pounds in one week. R104's weights between 6/11/24 and 5/30/24 included the following readings: - 160.2 pounds (lbs) on 6/11/24. - A 8.8lbs weight gain in 7 days - 160.6lbs on 6/10/24. - 159.4lbs on 6/9/24. - 157.0lbs on 6/8/24. - 156.0ls on 6/7/24.- A 8.8lbs weight gain in one day - 147.2lbs on 6/6/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documented weight for 6/5/24. - 151.4lbs on 6/4/24. - No documented weight for 6/3/24. - 151.6lbs on 6/2/24. - No documented weight for 6/1/24. - No documented weight for 5/31/24. - 149.2lbs on 5/30/24. R104's admission weight on 5/22/24 was 148.6lbs. A review of R104's progress notes lacked documentation of an update to his provider regarding weight gain. During observation on 6/12/24 at 8:42 a.m., nursing assistant (NA)-D assisted R104 with morning cares and once he was finished dressing, NA-D offered oral hygiene prior to breakfast. R104 declined and NA-D told him he needed to be weighed before breakfast. NA-D provided standby assistance to R104 with a gait belt and walker to the scale. NA-D assisted R104 onto the scale and obtained his weight then assisted him back to his walker and to the breakfast table. During interview on 6/13/24 on 12:50 p.m., registered nurse (RN)-C stated residents taking diuretics like furosemide are monitored for weight gain and loss, swelling in the legs, hypotension (low blood pressure), dizziness and lightheadedness. RN-C stated its normally for residents taking diuretics, there is an associated order with a weight parameter that dictated when to notify the provider. RN-C was unable to locate a weight parameter order for R104. RN-C stated most residents on the transitional care unit (TCU) are weight daily. RN-C reviewed R104's documented weights since his admission and stated the discrepancies could be due to staff using a malfunctioning scale. RN-C stated maintenance was aware and working to repair the broken scale. RN-C stated if R104's documented weights were accurate, R104's provider should be updated about his weight gain. RN-C was unable to locate documentation of a provider notification of R104's weight gain in the progress notes. The facility's maintenance services requests for the second floor dated 3/15/24 through 6/13/24, were reviewed and did not reveal a repair service request for a scale. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/13/24 at 1:48 p.m., RN-D stated staff were expected to monitor daily weights, assess for shortness of breath and edema (swelling), and review ordered lab results for residents receiving diuretics. RN-D expected there to be an order with weight parameters and when to notify a provider for residents taking a diuretic and would expect staff to request this order as an order clarification if there was not from either an on-call provider or when the in-house provider was available the next business day. RN-D was unable to locate an order with weight parameters and when to update R104's provider and stated, he does not have parameters. RN-D was unable locate documentation that R104's provider was updated regarding his weight gain. RN-D stated staff were expected to weight residents on the TCU daily and ideally before breakfast. RN-D also stated staff were expected to document updates to providers in progress notes. During interview on 6/13/24 at 3:07 p.m., the director of nursing (DON) stated residents taking diuretics should have orders for monitoring their weight, parameters guiding staff about when to update providers with weight changes, and staff should monitor for edema. The DON expected staff to document their assessments and any updates to providers in the progress notes. The DON stated if a resident did not have the parameters in place, staff were expected to obtain clarification from a provider to see if they wanted a parameter in place for daily weights. The DON reviewed R104's orders and verified there was no order for weight parameters prior to the interview date. The DON reviewed R104's weights since admission and stated, I would expect a provider update with his weight gain. The DON stated the clinical significance could include weight gain and fluid retention which would put R104 at a higher risk of heart failure with his medical history. During interview on 6/13/24 at 4:48 p.m., R104's medical provider (MD) stated an order for weight parameters and when to notify a provider should be expected by the facility's staff for a resident discharging from the hospital with heart failure. R104's MD stated that due to his re-admission to a different hospital system, the discharge orders from that hospital system did not include a specific weight parameter order. The MD reviewed R104's weights for the previous week and did not believe the weight gain could be due to increased caloric intake. The MD stated, I would expect the update. I think the weight gain is too fast to be related to caloric intake and is probably related to fluid retention. The MD stated the clinical significance for R104 is a big deal and if the MD had received an update about his weights, the MD would have requested an appointment soon. The MD stated, it actually makes me want to have my nurse call and get him in soon. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Resident Change in Condition-Notification of Physician/Surrogate Decision Maker revised last on 3/2021, indicated a notification would be made in the event of a significant change in the resident's physical, mental, or psychosocial status. The policy indicated a significant change may be gradual or ongoing, sudden in onset, much more severe in relation to usual complaints or unrelieved by measures which have already been prescribed. The policy indicated an example of significant changes requiring immediate notification included symptoms consistent with cardio-vascular/respiratory compromise and/or exacerbation which requires medical treatment or intervention. Additionally, the policy indicated a notification would be made in the event of a need to alter treatment significantly. The policy provided examples that included unexpected changes in vital signs which were significantly abnormal, possible adverse drug reactions, a continuation of symptoms, and any other symptom (using nursing judgement) that was causing discomfort or may jeopardize health and/or safety. The policy also indicated documentation in the resident's medical record would include all information given to the physician, name of the physician, time of contact, response to concerns and new orders received, name of surrogate decision maker that was notified, all other policies/procedures for transcription of orders, updates to the plan of care, follow-up charting, and any changes in nursing assistant assignments would follow.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure grooming was offered and or provided for 2 of 3 residents (R16, R8) reviewed for shaving. The facility also failed to ensure nail care was provided for 1 of 1 resident (R8) reviewed for activitiy of daily living. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, did not reject cares, was dependent on staff for toileting hygiene, showering, dressing and required substantial to maximal assistance with personal hygiene which included combing hair, shaving, applying makeup, washing and drying face and hands. R16's Face Sheet form dated 6/13/24, indicated the following diagnoses: type two diabetes mellitus, atrial fibrillation, chronic diastolic heart failure, morbid obesity, depression, anxiety disorder, and preglaucoma. R16's Care Area Assessment (CAA) dated 1/25/24, indicated R16 was dependent on staff for activities of daily living (ADLs) and had impaired cognition which affected awareness of needs, safety needs, and ability to follow directions, complete tasks, and display of mood and behavioral indicators that may affect daily cares. R16's care plan dated 11/1/23, indicated R16 had an alteration in her self care ability related to dressing, grooming, personal hygiene, and bathing due to impaired mobility and interventions indicated R16 required an assist of 2 for transferring, assist of 1 for bathing, dressing, and assist of 1 with combing hair, washing face and hands for grooming. Additionally, the TAR indicated the nurse was to cut R16's nails after her bath due to having diabetes. The care plan lacked information regarding shaving. R16's care sheet undated, indicated R16 had a bath on Saturdays and lacked information regarding shaving. R16's physician's orders indicated the following orders: 1/29/23, skin assessment, vital signs, and nail care every week on bath day record vital signs and document skin condition in the progress notes, notify the health unit coordinator (HUC) and nurse manager if a podiatry referral is needed. 2/28/23, nurse to cut nails after bath secondary to diabetes. 6/11/24, warfarin (a blood thinner) take 4 milligrams (MG) daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Saturday and 3 mg daily on Fridays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's treatment administration record (TAR) dated June 2024, indicated an open ended order from 1/29/23, for a skin assessment, vital signs and nail care every week on bath day, record vital signs and document skin condition in the progress notes, notify the health unit coordinator and nurse manager if a podiatry referral was needed. The order lacked information regarding shaving. R16's nursing progress notes were reviewed from 5/1/24, to 6/13/24, and indicated R16 received a bath on 5/4/24, 5/11/24, 5/18/24, and 6/8/24. The progress notes lacked documentation of any refusals. During observation on 6/10/24 at 2:46 p.m., R16 was in her room and was observed to have a mustache. Nursing assistant (NA)-F was in the room and donned gloves and a brief to assist R16. During interview and observation on 6/11/24 at 3:12 p.m., R16 still had a mustache and stated she would like to have her mustache shaved and stated the staff did not shave her on her bath day. During interview on 6/11/24 at 3:56 p.m., NA-F stated R16 never refused cares and if a resident refused, staff reapproached and if a resident refused the second time, NA-F would report the refusal to the nurse and the nurse would document the refusal. During observation on 6/12/24 from 7:08 a.m., to 7:37 a.m., NA-O washed R16's face and removed clothing from the wardrobe. R16 still had a visible mustache. NA-O washed R16's bottom and dressed R16 and positioned a full body lift sling under R16 to transfer her into the chair and left the room and did not shave R16. At 7:37 a.m., NA-O reported to the nurse R16 was short of breath. During interview on 6/12/24 at 8:52 a.m., NA-C stated she and another NA had just gotten R16 up and was taking the mechanical lift out of R16's room. At 8:53 a.m., R16 was brought out of her room and still had a mustache. During interview on 6/12/24 at 10:36 a.m., NA-C stated she looked at the care sheet to know what cares a resident required. NA-C stated R16 required total assist for cares and the care sheet did not indicate whether R16 had diabetes and stated nurses shaved residents who were diabetic. During interview and observation on 6/13/24 at 11:38 a.m., licensed practical nurse (LPN)-C stated resident on anticoagulant medications should have an electric shaver and stated if a resident was diabetic, the nurse shaved the resident and shaving was completed on bath day and if a resident is a female resident, they would choose a time based on a resident's cognition and attentiveness. LPN-C stated refusals would be documented and expected staff to offer to shave residents. LPN-C verified R16 had a mustache and stated it was about a week's growth and would have expected staff to shave R16 and stated he would add an intervention to the care plan. During interview on 6/13/24 at 2:20 p.m., the director of nursing (DON) stated residents were shaved on shower days and more frequently as indicated and in accordance with resident preferences and if a resident did not want to be shaved was indicated on the care plan. DON further stated she expected staff shave female residents if there were visible hairs. A policy, Shaving, dated 8/2017, indicated female residents would be shaved or stray hairs trimmed as needed and per the permission of the resident. All residents will have their own personal razor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42580 R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 was cognitively impaired, was dependent on staff for showers/baths, dependent on staff for dressing, personal hygiene and toilet use. R8 did not refuse cares during the assessment period. R8's face sheet printed 6/13/24, indicated diagnosis included Alzheimer's disease, dementia, and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) without dyskinesia (a movement disorder that often appears as uncontrolled shakes, tics, or tremors), and hyperglycemia. R8's dementia care plan updated 5/10/24, indicated interventions included be calm and reassuring in approaching resident; however, the care plan lacked indication for shaving and nail care for R8 and any refusals addressed. R8's nursing assistant care sheets printed 6/10/24, lacked indication for shaving and nail care completion with showers/baths or as needed for R8. R8's progress notes from 5/15/24, to 6/13/24, lacked documentation of R8's refusal of getting shaved or of getting nails trimmed. During interview on 6/10/24 at 3:26 p.m., family member (FM)-K stated they had been concerned about R8's facial hairs and nail cares not being attended to by the facility and this was bothersome to the family. FM-K further explained they had notified the facility and placed several requests for R8 to be shaved and nails trimmed, however the facility was not consistently getting R8's facial hairs shaved or nails trimmed. During observation on 6/12/24 at 8:50 a.m., R8 was in the dining room with hands resting on pillows while in wheelchair (W/C). Facial hairs noted to chin area approximately one to two centimeters long and scattered to lower chin. In addition, fingernails were about two to three centimeters above tip of fingers with jagged edges. During observation on 6/13/24 at 9:00 a.m., R8 was sitting in W/C in dining room, facing television, with fingernails noted about two to three centimeters above fingertips, with jagged rough edges. R8's facial hairs were noted unshaven, approximately one to two centimeters scattered to lower chin area. During interview on 6/13/24 at 9:08 a.m., registered nurse (RN)-A stated R8 had a shower in the morning and had completed R8's skin checks. RN-A verified R8 facial hairs to chin needed to be shaved and nails also needed to be trimmed and further clarified that the nursing assistants could trim R8's fingernails since she was not diabetic. During interview on 6/13/24 at 11:48 a.m., director of nursing (DON) stated residents should have their skin checked on bath days with the expectation that they got shaved and nails trimmed if needed. DON further explained the nursing assistant could shave residents with the facility provided shaver as well as trim resident's nails unless they were diabetic then the nurse would do. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Shaving Policy dated 8/2017, indicated female residents would be shaved or stray hairs trimmed as needed and per the permission of the resident. All residents will have their own personal razor. The facility Nail Care policy and procedure updated 7/2017, indicated nail care would be provided weekly on bath days and as needed unless contraindicated. Only license nursing personnel and or podiatrist may cut/trim diabetic residents.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to provide assistance to ensure eyeglasses were available in order to maintain vision needs for 1 of 1 resident (R20) reviewed for vision. Findings include: R20's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R20 had intact cognition, had adequate vision with corrective lenses, was dependent on staff for personal hygiene. R20's Face Sheet dated 6/13/24, indicated the following diagnoses: type two diabetes mellitus, had an intraocular lens, had a corneal transplant, and primary open angle glaucoma bilateral, severe stage. R20's Care Area Assessment (CAA) dated 5/7/24, indicated vision was adequate but had glaucoma and received multiple eye drops and her last eye appointment was on 5/2/24 and was fitted with new glasses. R20 had advanced left eye glaucoma with poor vision in the left eye with central vision loss, severe stage primary open angle glaucoma. R20 had a potential for decline in vision and changes in vision would affect risk for falling and her ability to participate in daily cares and activities and planned to care plan. R20's care plan dated 5/7/24, indicated R20 was at risk for alteration in vision due to severe glaucoma in both eyes and R20's vision was adequate with glasses. Interventions included arrange an eye exam, consult per physician orders, eye medications per orders, observe for changes in ability to see, remind and assist resident to put glasses on daily, assure lens is clean and in good repair. R20's care sheet undated, lacked information regarding glasses. R20's physician progress notes dated 4/11/24 at 3:15 p.m., indicated R20 had a 5 month follow up for her glaucoma and overall R20's vision was getting worse and R20 was having difficulty seeing prints on the TV and reading mail. The note further indicated R20 had presbyopia (eyes lose the ability to see things up close) and no prescription glasses. Additionally, R20 thought she would benefit from getting reading glasses and was having more headaches than previously she attributed to dialysis and not her vision. The note further provided an eyeglass prescription. R20's nursing progress notes dated 4/26/24 at 10:56 a.m., indicated R20 returned from a visit on 4/11/24 with a prescription for glasses and needed to go to the [NAME] Hills ophthalmology for a fitting and the frames would be ready two weeks later. R20's nursing progress notes dated 5/1/24 at 2:55 p.m., indicated R20 had an appointment set up on 5/2/23, to pick out glasses, get fitted and return to the facility. Further, R20 stated she did not go to the HP [NAME] Hills Clinic and gets her glasses from a shop near Regions hospital. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's nursing progress notes dated 5/13/24 at 4:34 p.m., indicated R20 needed to be fit for new glasses and no appointment was needed for the service as it was a walk in only at HealthPartners Specialty Center and transportation was set up for 5/21/24, with a pick up at 9 a.m. R20's nursing progress notes dated 5/22/24 at 6:41 a.m., indicated R20 had an appointment for a routine eye exam as well as receiving new glasses for 5/23/24 at 1:00 p.m at HealthPartners Specialty Center Eye Care. The note indicated the location of the appointment and that transportation had been set up. The note further indicated R20 was upset with appointment errors regarding incorrect dates or transportation issues and was reassured the appointments were confirmed and would not have any issues. R20's nursing progress notes dated 5/22/24 at 4:57 p.m., indicated R20 arrived at the HealthPartners Specialty Center Eye Care on 5/21/24 and was turned away because she did not have an appointment and a new eye exam was scheduled. R20's nursing progress notes dated 5/23/24 at 1:52 p.m., indicated Health Partners eye clinic canceled R20's appointment because R20 saw another eye clinic doctor recently and did not need to go in again and R20 would have another appointment 9/19/24. R20 was notified and told staff this was the third time they canceled her appointment and wanted to know why. The note further indicated the floor manager was notified. R20's nursing progress notes dated 6/6/24 at 9:58 p.m., indicated R20 was frustrated because she thought she was supposed to see an eye doctor, but had an audiologist appointment. The nurse indicated they could communicate with the manager for another appointment. R20's nursing progress notes dated 6/10/24 at 7:33 p.m., indicated the nurse had a discussion with R20 regarding glasses and hearing aides and would call the ophthalmology team the following day. The notes lacked information the ophthalmology was contacted the following day. During interview and observation on 6/10/24 at 4:14 p.m., R20 stated she was supposed to have new glasses and stated she keeps asking about her glasses and stated they had a new lady working and had reported this to the case manager but the case manager never came down to get to the bottom of things. R20 stated she needed glasses for reading and distance. R20 was not wearing any glasses. Further, R20 stated she went to dialysis Mondays, Wednesdays, and Fridays, and appointments needed to be on Tuesdays or Thursdays. During interview on 6/13/24 between 8:23 a.m., and 8:40 a.m., health unit coordinator (HUC)-G stated the HUCs followed up on appointments, made appointments, set up transportation, and got paperwork ready. If there were new orders, the nurse would process the order from the appointments. HUC-G went up to the 3rd floor and viewed the calendar and stated there was no follow up appointment for R20. HUC-G also stated HUC-H would enter a progress note. HUC-G further stated R20 was Very with it and could tell you if she got her glasses. HUC-G viewed R20's hard chart at 8:36 a.m., and located a prescription for R20's glasses from 4/11/24. HUC-G did not know if R20 received her glasses. HUC-G went to R20's room and asked R20 if she got her glasses and R20 stated she had gone and then the doctor wasn't there for some reason and R20 further stated they were supposed to make an appointment on the 21st and was told she didn't have an appointment and then the next time she tried to go for an appointment the doctor wasn't there and she has not had any further appointments. HUC-G stated she would work on getting R20 the appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/13/24 at 8:41 a.m., registered nurse (RN)-E stated the HUC followed up on appointments and was not aware of any fitting for glasses for R20. RN-E further stated they documented a progress note for eye appointments and include the date of the appointment and pass the message on to whoever was coming on. RN-E stated the nurses looked at the paperwork and took care of any orders and then send the paperwork to the HUC to schedule the appointment and transportation. RN-E further stated R20 can make her needs known and was alert and oriented times 4. During interview and observation on 6/13/24 at 9:27 a.m., licensed practical nurse (LPN)-D and HUC-G were talking to R20 about her eyeglasses. at 9:28 a.m., LPN-D stated R20 used to go to [NAME] Hills where she received her prescription for glasses in April and thought when HUC-H made the appointment she had to just walk in but the appointment at HealthPartners Specialty Center Eye Care thought she needed the prescription again and stated she would clarify and get an appointment set up and verified R20 did not have any glasses and stated HUC-H was new and thought there was a mix up. During interview on 6/13/24 at 9:46 a.m., the director of nursing (DON) stated medical records would set up appointments and transportation for appointments. A policy, Resident Appointments, dated 8/31/20, indicated the facility would assist residents with coordination of medical and dental appointments and transportation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview, and document review, the facility failed to ensure breakfast was provided to a resident prior to dialysis and failed to monitor food intakes for 1 of 3 residents (R20) reviewed for nutrition. Findings include: R20's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not reject cares, was very important to have snacks available between meals, required set up or clean up assistance with eating and oral hygiene, did not have weight loss or gain, was not on an altered diet or therapeutic diet, was 65 inches and weighed 210 pounds and had no natural teeth, took insulin, and was on dialysis. R20's Face Sheet form dated 6/13/24, indicated R20 had the following diagnoses: long term use of insulin, malignant neoplasm of vulva, secondary and unspecified malignant neoplasm of lymph node, osteoarthritis, primary open-angle glaucoma, bilateral severe stage, type two diabetes mellitus, end stage renal disease (ESRD), dependence on renal dialysis, acute on chronic diastolic congestive heart failure, and morbid obesity due to excess calories. R20's Care Area Assessment (CAA) dated 4/29/24, indicated R20's body mass index (BMI) was 34.9 which was above the ideal range however, R20 had diagnoses of chronic obstructive pulmonary disease (COPD), ESRD with dialysis, hypertension, and cancer and was advised to lose weight gradually if weight loss was desired. R20's care plan dated 5/7/24, indicated R20 had diabetes and was at risk for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) and interventions included document and report dietary non-compliance, explain to the resident the benefits of consuming a nutritionally balanced diet, explore with resident reasons for non-compliant behavior, monitor blood glucose per orders, offer available substitutes if resident has problems with the food being served. R20's care plan dated 5/7/24, indicated R20 received dialysis and interventions included night staff to get up on dialysis day, Monday, Wednesday, and Friday. dietitian consultation as needed, implement dietary orders including fluid restrictions per orders, the resident has signed a waiver for her diabetic diet and fluid restriction. R20's care plan dated 5/7/24, indicated R20 could complete some activities of daily living (ADLs) independently but gets short of breath (SOB) with exertion and her ability fluctuated due to weakness and tiredness after dialysis. Interventions included R20 was able to feed herself after staff provided a tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's care plan dated 4/29/24, indicated R20 was at risk for changes in nutritional stats related to increased needs due to dialysis and interventions included: built up utensils at all meals to increase independence with self-feeding, registered dietician following at high risk due to increased needs due to dialysis, prefers softer foods due to difficulty chewing harder foods, staff to encourage to eat three meals daily. The care plans lacked information on providing a meal tray prior to going to dialysis. R20's care sheet indicated R20 went to dialysis on Monday, Wednesday, and Friday and the night shift was to get resident up and upon return from dialysis staff were to allow R20 to go to the bathroom before taking vital signs etc. The care sheet lacked information regarding providing a breakfast meal prior to leaving to dialysis. R20's physician orders included the following orders: 9/14/23, novolog 100 units/milliliter (ML) per sliding scale; if blood sugar (BS) is 200 to 250, give 4 units. If BS is 251 to 300, give 6 units. If BS is 301 to 350, give 8 units. If BS is 351 to 400, give 10 units twice daily for diabetes. 9/15/23, document breakfast intake daily on the day shift. 9/18/23, fluid restriction: 1500 ml/day three times a day 5:30 a.m., 1:30 p.m., and 9:30 p.m. 1/25/24, regular diet, regular textures, thin liquids, provide meat sandwich for lunch Tuesdays and Thursdays continuous. 6/5/24, dialysis on Monday, Wednesday, Friday, transportation pick up at 5:50 a.m. R20's Comprehensive Nutritional Assessment form dated 4/29/24, indicated R20 was on a regular diet, regular textures, thin liquids; 1500 ml fluid restriction; and offer a bedtime snack, and R20 ate most meals in her room. The note further indicated documented intakes were variable, and was able to feed herself after set up and the registered dietician was following R20 at high risk due to dependence on dialysis. R20's breakfast intake was reviewed from 2/1/24, to 6/13/24, and indicated 10 entries: 2/1/24, (Thursday) ate 51 to 75% 2/4/24, (Sunday) ate 76 to 100% 2/23/24, (Friday) None was documented 4/25/24, (Thursday) ate 26 to 50% 4/27/24, (Saturday) ate 51 to 75% 5/15/24, (Wednesday) None was documented 5/22/24, (Wednesday) None was documented (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/31/24, (Friday) NPO (nothing by mouth) was documented 6/1/24, (Saturday) ate 51 to 75% 6/4/24, (Tuesday) ate 76 to 100% During interview on 6/10/24 at 4:40 p.m., R20 stated on dialysis days she does not receive breakfast and stated she can't get anything at the facility before going to dialysis and stated when she asks, she is told the kitchen is closed but can get coffee or a cookie. During interview on 6/12/24 at 8:11 a.m., nursing assistant (NA)-O stated R20 left for dialysis and stated she could leave her breakfast for when she returned and stated R20 was usually gone early maybe around 6:00 a.m. for dialysis and R20 had a refrigerator in her room and sometimes family brought food in. During interview on 6/13/24 at 8:59 a.m., registered dietician (RD)-I stated they visited with every resident upon admission and obtained their diet history, and weights, and follow up on residents on a regular basis if they are deemed high risk, are seen quarterly. RD-I further stated high risk residents included residents with significant weight loss, if they are on dialysis and stated food intakes were monitored and documented under the vitals section in the electronic medical record (EMR). RD-I further stated for the most part she expected staff document intakes and stated breakfast meal was served from 7:00 a.m., to 9:00 a.m., on the third floor. RD-I further stated if a resident went to dialysis they could provide a bag lunch for them and they had a chiller and could save for a resident when they returned from their appointment. RD-I stated nursing staff were responsible for giving packed lunches and refusals to take breakfast or lunch were documented in the progress notes. RD-I stated she would not expect a resident to be NPO prior to going to dialysis and stated R20 has a lot of food in her room. During interview on 6/13/24 at 9:11 a.m., RD-J stated he expected staff to provide resident breakfast and planned to communicate with nurse and stated nothing was set up for R20 to have a meal prior to going to dialysis and stated family brought in items but was not sure if was portable for breakfast and stated he would get that set up so R20 would receive a breakfast prior to going to dialysis and viewed R20's EMR and verified the lack of documentation for meal intakes and stated it was important in order to gauge what R20 is actually eating and because there is an order to document meal intakes daily and it is not being done and it is also important from a renal perspective especially if meal intake is not coming from meals served at the facility. RD-J stated R20 was able to provide reliable and accurate information. During interview on 6/13/24 at 8:41 a.m., registered nurse (RN)-E stated food intakes were located in the EMR under vitals and further stated the nursing assistants documented meal intakes and stated it was important to know how the resident was doing and viewed R20's breakfast intakes from 2/1/24 and verified there were only 10 entries and stated he expected there to be more information and further stated R20 was picked up for dialysis at 5:15 a.m. and did not come back until about 11:00 a.m. RN-E further stated the kitchen did not open until 7:00 a.m. RN-E further stated R20 can make her needs known and was alert and oriented times 4. During interview on 6/13/24 at 8:55 a.m., NA-C stated the aides were supposed to document meal intakes for every meal in the computer. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/13/24 at 9:46 a.m., the director of nursing (DON) stated she expected meal intakes to be documented every shift, and stated the kitchenettes had food and there was dry food as well and stated there should always be food up there for the residents. A policy was not provided that identified a process for preparing meals for residents prior to dialysis or documenting meal intakes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure food was properly stored, labeled, and dated. Additionally, the facility failed to ensure 2 of 2 dishwashers in the [NAME] and Macalester unit met minimum wash temperature. This had potential to affect all residents, staff, and visitors who eat food from the main kitchen and use dishes from the [NAME] and Macalester unit. Findings include: LABELING, STORAGE, PREPARATION During initial observation on 6/10/24 at 12:00 p.m. and Culinary Services Manager (CSM)-K interview at 1:00 p.m., a large walk-in freezer had a large blue bag of multiple frozen meat with no label or date. CSM-K stated they were turkey breasts and verified they did not have a label or date and stated the box may have been destroyed. There was a foil tin pan labeled 11/25 and when opened there were a few knishes. CSM-K stated they would probably be thrown out as more had been made since then. Another large walk-in freezer had a pan labeled 5/8 butterscotch bars lunch renal, french toast sticks in unopened and unlabeled clear packaging, and dough for knishes which were unlabeled and undated in plastic wrap. CSM-K stated 5/8 was the day the bars were made and keep them to use in the future, the dough for knishes should have a date label, and the french toast box may have been damaged and they go through breakfast items quickly. A meat cooler contained unopened fresh beef chuck labeled 5/29 and unopened deli brisket labeled 5/27. CSM-K stated most items have an expiration or best by date, and the order to a week's need. Dietary aide (DA)-D pulled meat out at the end of the week to thaw and be used Monday through Friday when food production occurs. CSM-K stated the dates reflected when items were pulled out of the freezer and into the cooler, frozen foods took a while to thaw out in the boxes, and the cooks knew what was in the cooler. CSM-K stated staff used most of the food in the cooler(s) or had a place to store the extra. During initial tour, cook (C)-A stated meat five or more days in the cooler would concern them. Dates on items in the meat cooler reflected when they were pulled out of the freezer, and the meat was usually used in the same week. C-A stated everyone was in charge of labeling food, and DA-D rotated the food. During interview on 6/11/24 at 1:35 p.m., DA-D stated C-A checked coolers for items which need to be thrown and keep items for three days. Opened items not dated were thrown away. DA-D stated they took out items from freezer and placed in cooler at the end of the week, so the items were thawed for cooking after the weekend. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 6/12/24 at 12:18 p.m., a unit freezer had pancakes in unopened clear packaging which was not labeled with the date or food item. DA-B stated dates on items in the unit refrigerators and freezers represented the dates in which items were made in the kitchen. DA-B verified the pancakes did not have a label or date on them and would have to ask CSM-L about the labeling requirements. DA-B stated items such as the pancakes were not brought to the unit unless they were going to use them. During interview on 6/12/24 at 2:17 p.m., culinary service manager (CSM)-L stated they pulled meats from freezer once a week, typically on Fridays, to use for the next week. CSM-L stated items were placed in the freezer if they had extra and every month they ran through the freezer and pulled items not used or anything with freezer burn. CSM-L stated the staff who normally rotated the pastries and desserts in the freezer was not at the facility so must have been missed. CSM-L confirmed muffins dated 3/8, brownies dated 3/13 and a crisp dessert dated 3/16 in the freezer. CSM-L stated items can last up to a year in the freezer.CSM-L stated staff brought pancakes and french toast to the units and used within the week but should have label if put back in freezer. CSM-L stated it was important to ensure food had proper labels so they could monitor food and use the older food first and did not want to serve food that had not been stored appropriately. The facility policy and procedure Food Storage dated 3/15/16, directed food would have delivery label from distributor that served as the date the item was shelved or staff would hand write a date if needed and old stock was used first. The date marked indicated the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded. Food stored in bins may be removed from its original packaging but would be labeled and dated. All foods should be covered, labeled, and dated, and leftovers were used within three days or discarded. Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing. DISH WASHER TEMPERATURE The Dish Washer Temperature Log for the [NAME] and Macalester units dated 3/1/24 to 5/31/24, identified wash and final rinse temperatures during breakfast, lunch, and supper. The log did not specify which dish washer the temperatures reflected or temperature record for a second dish washer. June 2024 logs were not provided. The wash temperature mostly showed 153 and the rinse temperatures were recorded as above 180. During interview on 6/12/24 at 11:12 a.m., Dietary aide (DA)-B stated the Electrolux WT30H208DU dish machine temperature started at 153 and the rinse temperature was usually 189 or 190. DA-B would report to maintenance if the dish washer did not get hot enough. DA-B reviewed dish washer temperature log which showed one set of wash and rinse temperatures every day for breakfast, lunch, and supper. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 12:26 p.m., the [NAME] and Macalester had two dish washers. One dish washer had a digital temperature reader and was an Electrolux model WT30H208DU, and the other was a [NAME] DishStar HT serial number 21/397844 with a dial thermometer. DA-B placed dishes such as plates and cups into the Electrolux dish washer. The temperature of the Electrolux dish washer started at 153 then dropped to 147 and switched to 189 during the rinse cycle. DA-B stated they did not observe as they usually turn the dish washer on and normally sees the temperature at 153 and walks away to complete other tasks. Another cycle was observed and confirmed to have wash temperature which started at 153 and decreased to 147 and rinse temperature of 190. Trays were loaded into the [NAME] dish washer and the wash temperature was observed at 146 and the rinse at 190. Another cycle was washed, and the wash temperature read 146 to 148 and 188 for the rinse. DA-B stated they could not squat down low enough to check the temperature of the [NAME] dish washer and checked the Electrolux dish washer temperature only. DA-B verified the temperature tracking for the dish machines had one set of temperatures and not another set for a second dish washer. During interview on 6/12/24 at 2:17 p.m., culinary service manager (CSM)-L stated servers checked dish washer temperatures on the units every day. CSM-L stated the [NAME] and Macalester area was the only units to have two dish washers and expected to see two sets of temperatures on the temperature log. CSM-L stated they must have placed one dish washer temperature log on the unit like all the other units which only had one dish washer. CSM-L expected the dish machines rinse temperature to be 180 but would have to refer to the manuals for the wash temperature. CSM-L stated dish washers dropped in temperature when water cycled but did not know if they should drop to 147. CSM-L stated the wash temperature was important but the final rinse at 180 was the final sanitation. CSM-L stated it was important to make sure the dishes were washed at appropriate temperatures to ensure dishes were clean and no one got sick. During interview on 6/13/24 at 12:34 p.m., DA-C stated both dish washers on the [NAME] and Macalester unit washed dishes such as plates and cups but one washed dishes which contacted meat and the other dishes which contacted dairy food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on interview, observation, and document review the facility failed to ensure the least restrictive infection control measures were implemented for 1 of 1 resident (R21) reviewed for covid-19 exposure. Additionally the facility failed to ensure hand hygiene was completed for 1 of 1 residents (R104) observed during contact precautions, failed to ensure standards of practice were followed for catheter care for 1 of 1 resident (R408) and failed to ensure proper storage of clean linen with the potential to impact 25 residents on two wings were implemented. Findings include: The Center for Disease Control (CDC) guidance dated 3/18/24, identified asymptomatic patients do not require empiric use of transmission-based precautions (TBP) while being evaluated for SARS-CoV-2 (covid-19) following close contact with someone with covid-19 infection. Examples of when empiric TBP following close contact may be considered include: - Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure - Patient is moderately to severely immunocompromised - Patient is residing on a unit with others who are moderately to severely immunocompromised - Patient is residing on a unit experiencing ongoing covid-19 transmission that is not controlled with initial interventions R21's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, no rejection of cares, diagnoses of ataxia (progressive neurological disease affecting a person's ability to walk, talk, and use fine motor skills) and depression. R21 required extensive assist of two staff for transfers. R21's annual MDS dated [DATE], identified it was very important to do things in groups of people, do favorite activities, and go outside for fresh air when weather is good. R21's annual activities of daily living (ADL) Care Area Assessment (CAA) dated 2/23/24, identified her need for assistance fluctuated with cares related to chronic health status. R21 had impaired cognition which affected awareness of needs, safety needs, and ability to follow directions, complete tasks, and display of mood or behavioral indicators. R21's care plan dated 5/20/24, identified she enjoyed sitting out in common areas, family visits, and watching TV (television). Additionally, she enjoyed group programs such as bingo, music, active games, and happy hour. R21's therapeutic recreation attendance logs dated 5/1/24 - 6/11/24, identified 25 group activities attended 5/1/24 through 5/31/24, and three group activities attended 6/1/24 through 6/3/24. From 6/3/24 through 6/11/24, only TV was marked as therapeutic recreation activity. (continued on next page)

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	245411	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R21's progress notes identified: - 6/4/24 at 12:54 p.m., No new symptoms and appetite within normal limits. R21 was on isolation until covid-19 test results were back. - 6/4/24 at 9:43 p.m., Post covid-19 exposure, vital signs are stable, resident at baseline. No cough, fever, headache, or any signs of infection. Appetite within normal limits. Awaiting covid-19 test results. - 6/5/24 at 2:08 p.m., Covid-19, influenza, respiratory syncytial virus (RSV) tests results were all negative. Resident to continue with isolation. - 6/6/24 at 6:20 a.m., No signs or symptoms of covid-19. Remains on isolation. - 6/6/24 at 10:56 a.m., Rapid test for covid-19 completed and was negative. Remains on isolation. - 6/7/24 at 2:44 p.m., Continues isolation due to exposure, no signs, or symptoms of covid-19. - 6/8/24 at 10:18 p.m., Continues isolation due to exposure, no signs, or symptoms of covid-19. - 6/9/24 at 1:51 p.m., Rapid test for covid-19 completed and was negative. Remains on isolation. No signs or symptoms of covid-19. - 6/10/24 at 2:51 p.m., Continues isolation due to exposure, no signs, or symptoms of covid-19. During an observation on 6/10/24 at 12:30 p.m., R21's room door was closed and had four signs on it which identified: 1. Stop, please see nurse before entering room 2. The resident is on precautions starting 6/4/24 until TBD to be determined. 3. A list of infection control definitions 4. Enhanced respiratory precautions in place. Personal protective equipment requirements (PPE) included: gown, facemask, N95 respirator, eye protection, gloves, and optional hair cover. During an interview on 6/10/24 at 12:30 p.m., registered nurse (RN)-B stated R21 had a covid-19 exposure and was on isolation. During an interview on 6/10/24 at 4:47 p.m., R21 was in her room watching TV, stated she felt okay and when asked she stated would have liked to attend activities out of her room today, however it was not offered. During an interview on 6/10/24 at 4:51 p.m., family member (FM)-A stated she was informed R21 was on isolation due to a covid-19 exposure even though several negative tests were completed. FM-A stated it was not good for R21's psyche to be isolated. FM-A stated R21 could wear a mask with assistance and did so without issues on previous outings and activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/24 at 5:20 p.m., nursing assistant (NA)-B stated she worked with R21 routinely. R21 was on isolation after a covid-19 exposure and had not shown any symptoms of covid-19. NA-B stated the door sign had not identified how long the isolation was to continue. During an interview on 6/10/24 at 5:24 p.m., RN-A stated R21 had no signs or symptoms of covid-19. RN-A stated R21 could wear a face mask. When asked how long the isolation was in place, RN-A stated the door sign and medical record had not identified how long the isolation was to continue. During an observation and interview on 6/11/24 at 9:28 a.m., R21's FM-B stood outside the room door reading the four signs regarding isolation. FM-B asked surveyor What is going on with her room? FM-B was directed to the nurse who explained the process to put on PPE to enter the room. During an interview on 6/11/24 at 3:17 p.m., the director of therapeutic recreation (DTR) stated R21 attended activities routinely and enjoyed them. R21 had been on isolation since 6/4/24, so individual activities of TV were in place. The DTR stated R21 attended group activities for music on 6/1/24, bingo on 6/2/24 and 6/3/24, and R21 liked to attend resident council, raffles, happy hour, bowling, and bingo. During an interview on 6/11/24 at 3:25 p.m., RN-B stated she was unsure how long R21 needed to remain on isolation. RN-B stated R21 could wear a mask if she needed to. The CDC guidelines following a covid-19 exposure were reviewed and RN-B stated R21 had not appeared to [NAME] the criteria. RN-B stated the decision was directed by the infection preventionist (IP). During an interview with licensed practical nurse (LPN)-A and the IP together on 6/11/24 at 3:33 p.m., the IP stated a risk assessment was completed to determine isolation following a covid-19 exposure. The IP reviewed a spreadsheet which identified R21 had an exposure on 6/3/24, had three negative tests on 6/4/24, 6/6/24 and 6/9/24, and no symptoms were present. The CDC guidelines following a covid-19 exposure were reviewed and the IP was not able to verify if R21 met the criteria for isolation. LPN-A stated R21's isolation was discussed as a group; however, no documentation of the assessment was completed regarding the rationale for the isolation. The IP and LPN-A directed surveyor to the director of nursing (DON). During an interview on 6/11/24 at 4:06 p.m., the DON stated R21 was on quarantine for seven days, not isolation, due to a high-risk exposure to covid-19. The DON confirmed R21 had three negative covid-19 tests and no symptoms. The DON stated the facility followed CDC recommendations and would have to discuss with the IP. R21's progress notes identified (after discussion with the DON and IP), on 6/11/24 at 4:46 p.m., precautions for covid-19 exposure were removed. During an observation on 6/12/24 at 7:10 a.m., R21 was in her room with the door open, the door signs were gone along with the PPE supplies. During an observation on 6/12/24 at 9:18 a.m., R21 was in the dining room with another resident and staff, R21 agreed it felt good to be out of her room. During an observation on 6/12/24 at 10:19 a.m., R21 was observed smiling and participating in a therapeutic recreation group activity. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/12/24 at 1:42 p.m., R21 was observed smiling and participating in another in a therapeutic recreation group activity. During a follow up interview on 6/13/24 at 11:04 a.m., the DON stated after further review, quarantine or isolation would not need to be implemented going forward, following a covid-19 exposure if not necessary, and in accordance with the CDC guidelines. The DON stated R21 could have worn a mask to go out of her room instead of implementing the quarantine. The facility policy for COVID-19 dated 5/13/23, identified residents that had close contact with someone with covid-19 and were unable to be tested , unable to wear a mask, were moderately to severely immunocompromised, or on a unit with moderately to severely immunocompromised residents or on a unit with uncontrolled covid-19 would require quarantine. The policy had not identified to quarantine or implement isolation for a resident who was able to wear a mask and had not meet the additional criteria. 48299 CATHETER R408's facesheet printed 6/13/24, indicated R408 admitted to facility on 6/6/24 and had diagnoses of left humerus fracture, right mandible fracture, and personal history of malignant neoplasm of prostate (prostate cancer). R408's comprehensive nursing observation dated 6/6/24, indicated R408 had OK short and long-term memory and made self understood and understood others. R408's care plan dated 6/6/24, indicated R408 required assistance with bathing, bed mobility, donning pants after toileting and personal hygiene and stand by assistance with transfers. During observation on 6/10/24 at 2:05 p.m., nursing assistant (NA)-I wore a gown and gloves into R408's room. R408 was laying in bed, and NA-I opened the catheter bag drainage spigot to drain urine into a urinal. NA-I placed the urinal on the floor without a barrier and wiped the drainage spigot with an alcohol wipe. During subsequent interview, NA-I stated they used an alcohol wipe to clean the drainage spigot after emptying the urine from catheter bag. NA-I stated they did not want to set the urinal down on the bed without a barrier so set on the floor, so they could wipe the drainage spigot with the alcohol wipe. During interview on 6/13/24 at 3:14 p.m., registered nurse (RN)-D stated an alcohol wipe should be used to the catheter bag drainage spigot before and after emptying the urine to prevent infection. RN-D stated a urinal or other catheter bag emptying device should not be on the floor and have a barrier between. RN-D stated they had basins which could be used as a barrier. During interview on 6/13/24 at 4:37 p.m., the director of nursing (DON) stated catheter bag should be drained every shift or more if needed by opening the catheter bag drainage spigot to drain the urine out and then using an alcohol wipe. DON stated there should be a barrier between a urinal and the floor and not using a barrier was an infection control concern. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Urinary Catheter Care- Closed System dated 5/7/18, directed staff to empty the collection bag at least every eight hours. The policy and procedure directed staff to empty the drainage bag regularly using a separate, clean collection container for each resident and to avoid splashing and prevent contact of the drainage spigot with the nonsterile container. The policy and procedure directed to keep catheter tubing and drainage bag off the floor but did not specify to keep collection container off the floor or use of barrier between floor and collection container. The policy and procedure directed staff to the procedure for emptying of leg bag, but the facility policy and procedure for emptying catheter bag was not provided. 49617 HAND HYGIENE R104's admission Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and had diagnoses of heart failure, heart attack, coronary artery disease (CAD, a buildup of plaque that limits blood flow to the heart), chronic kidney disease and anxiety. During observation on 6/12/24 8:42 a.m., nursing assistant (NA)-D exited R104's room with gloved hands and did not perform hand hygiene. NA-D walked up to the kitchenette and gave dietary aide (DA)-A a slip of paper before returning to R104's room with the same gloved hands. NA-D re-entered the room without changing gloves or performing hand hygiene. NA-D helped R104 put his shoes on and applied a gait belt to help him stand up. Once R104 stood up, he pulled his pants up and NA-D offered oral hygiene. R104 declined and NA-D told him he needed to be weighed before breakfast. NA-D provided standby assistance to R104 as he used the walker to walk out of his room. NA-D doffed the gloves at the doorway but did not perform hand hygiene. NA-D obtained his weight and assisted R104 to the dining room table to sit. NA-D then walked back to R104's room. NA-D verified no hand hygiene was performed after exiting R104's room with gloved hands or before entering his room and after exiting a second time. NA-D stated, I just didn't think of it. I didn't remember this morning, going out of his room. I was dealing only with him, and I didn't touch any other residents. NA-D stated that was not a normal process and stated hygiene should be performed before entering a resident's room and before exiting a resident's room. During interview on 6/12/24 at 8:57 a.m., licensed practical nurse (LPN)-B stated staff were expected the perform hand hygiene before going in a resident's room and when coming out of a resident's room, so they don't spread infection. LPN-B stated staff should not be coming out of resident rooms with gloves on and doing other things because they could be bringing bacteria from room to room or wherever they go. During interview on 6/13/24 at 12:06 p.m., the director of nursing (DON) and infection preventionist (IP), stated hand hygiene was reviewed with staff during general orientation, annually during a skills fair, and during ongoing audits. The DON and IP stated staff wearing gloves in the hallway outside of a resident's room was not appropriate and the expectation was for staff to follow policy. A facility policy titled Handwashing/Hand Hygiene last updated 5/1/23, indicated the facility considered hand hygiene the primary means to prevent the spread of infections. The policy indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Furthermore, the policy indicated the use of gloves does not replace hand washing/hand hygiene. (continued on next page)

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