STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Richfield	7727 Portland Avenue South Richfield, MN 55423

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to promote dignity while utilizing a mechanical lift sling for extended periods of time for 1 of 3 residents (R13) reviewed for dignity and who was dependent on staff for activities of daily living (ADL's) and required the use of a mechanical lift for transfers. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had moderate cognitive impairment and diagnoses which included: moderate intellectual disabilities, and Parkinsonism (movement symptoms related to Parkinson's disease). Indicated R13 was dependent on staff for chair/bed transfers, dressing, and personal hygiene. R13's Care Area Assessment (CAA) dated 3/18/24, identified R13 needed assistance with ADL's and had decreased mobility and cognition secondary to schizoaffective disorder (mental health condition with symptoms such as hallucinations, delusions, and mood disorders), failure to thrive, and moderate intellectual disabilities. R13 required extensive to total dependence with all ADL's. R13 was not always able to make his needs known. R13's Care Plan dated 11/2/23, identified R13 was a vulnerable adult and had ADL's self performance deficit with total assistance for bathing, dressing, and personal hygiene. Indicated R13 used an EZ stand (mechanical lift) for transfers as tolerated with assistance of two staff. During an observation on 8/19/24 at 3:27 p.m., R13 was in his wheelchair in his room. R13 had a mechanical lift sling placed under him in his wheelchair. The straps of the sling were observed to be draped over his thighs, approximately each six inches wide, and the sling hung approximately six inches on both sides out the back side of the wheelchair. R13 indicated the fact the sling could be visualized by others while he sat in his wheel chair bothered him. During a phone interview on 8/19/24 at 5:24 p.m., resident representative (RR)-A stated it would bother R13 very much if the mechanical lift sling was visible to others while R13 was in the wheelchair. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/20/24 at 8:32 a.m. R13 was in his wheelchair in the dining room. R13's mechanical lift sling was observed to again be draped over his thighs and hung out the back sides of the wheelchair approximately six inches on both sides. At 11:32 a.m., R14 was again in the dining room in his wheelchair. R13's mechanical lift sling was visible with straps over both thighs, and hung out the back sides of wheelchair approximately six inches on both sides. During an interview on 8/20/24 at 2:45 p.m., nursing assistant (NA)-C indicated had assisted R13 with transfers in the past and confirmed staff left the mechanical lift sling in R13's wheelchair while R13 was in the wheelchair. NA-C stated if it was difficult to remove the mechanical lift sling while a resident was in their wheelchair, they were supposed to tuck it in so it was not visible for dignity issues. Indicated NA-C had not assisted R13 with transfers that day. During an interview on 8/20/24 at 3:00 p.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R13 used a mechanical lift for transfers and indicated R13's sling should have been taken out of R13's wheelchair while he was in the wheelchair. LPN-A indicated when the mechanical lift was left in residents' wheelchairs while they were in them, it could have been uncomfortable and not dignified. During an interview on 8/21/24 at 8:10 a.m., director of nursing (DON) indicated mechanical lift slings should have been removed from the wheelchairs while residents were in them or hidden if kept in the wheelchair. DON stated this was her expectation to promote privacy and dignity. Review of the facility policy titled Resident Rights Policy dated 1/2024, identified it was the practice of the facility to uphold the rights of all residents.

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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** 37905 Based on observation, interview and document review, the facility failed to ensure medications were administered safely for 3 of 3 residents (R79, R74, R354) who had medications left at the bedside and had not been assessed as safe to self-administer those medications. Findings include: R79 R79's significant change in status Minimum Data Set (MDS) dated [DATE], identified R79 was cognitively intact, and had diagnoses which included: cancer, hypertension and diabetes mellitus. Identified R79 was independent with eating, bed mobility, and transfers, and required partial/moderate assistance with dressing. R79's care plan revised 8/7/24, identified R79 was receiving hospice services, and was independent with dressing, personal hygiene, and transfers. R79's care plan lacked instructions for self administration of medications. During an observation on 8/19/24 at 1:29 p.m., R79 was lying in her bed. Next to her bed was a bedside stand with two boxes of antibiotic and pain relief cream and a small tube of antibiotic ointment lying on the floor next to the bed. In addition, on R79's bed side stand, there were facility barrier cream ointments and lotions. Review of R79's Order Summary Report signed 8/21/24, lacked orders for antibiotic and pain relief cream, antibiotic ointment, or orders for self administration of medications (SAM). R79's medical record lacked documentation of a SAM assessment. During an observation on 8/20/24, at 11:45 a.m., R79 was lying in her bed. The two boxed antibiotic and pain relief cream, and antibiotic ointment were on R79's bedside stand. At 12:56 p.m. R79 was sitting up in her bed, with her meal tray in front of her on the bedside table. The medications continued to be lying on R79's bedside stand. During an interview on 8/20/24 at 2:50 p.m., nursing assistant (NA)-C indicated was unaware if R79 used the antibiotic and pain relief creams or antibiotic ointment independently. Stated NA-C had not applied the ointment or cream on R79. During an interview on 8/20/24 at 3:06 a.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R79's medications were administered by nursing staff and was not aware if R79 had a SAM assessment completed. LPN-A entered R79's room and confirmed R79 had the creams and ointments lying on her bedside table, and removed them from the room. LPN-A indicated R79's family member may have brought the medications. LPN-A confirmed R79 did not have an order for SAM or the creams or ointments. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) confirmed had been informed by LPN-A that R79 had medications at bedside that were not ordered, and did not have a SAM assessment or order for SAM. DON stated LPN-A had contacted R79's family member who would come in to pick up the medications that were observed in R79's room. DON indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons, too. 48740 R74 R74 admission MDS dated [DATE], identified R74 was cognitively intact and had diagnoses which included: hypertension (high blood pressure), anxiety disorder, depression, and respiratory failure. Indicated R74 was independent with bed mobility, transfers, personal hygiene, and dressing. R74's care plan revised on 7/12/24, identified R74 was to take pain medication as ordered by a medical doctor (MD). The care plan lacked documentation of a SAM or order to self-administer medication. During an observation on 8/20/24 at 12:03 p.m., registered nurse (RN)-B checked orders on the electron medication record (EMAR) which identified R74 received Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams affected joint topically four times a day for joint damage starting 7/11/24 at 8:00 p.m. RN-B took the Diclofenac Sodium External Gel and verified the medication with the EMR. RN-B took medication into R74's room and had R74 verify his name and date of birth. RN-B went to apply Diclofenac Sodium External Gel 1% to R74 shoulder. R74 opened the dresser drawer and pulled out a medication tube of Diclofenac Sodium External Gel 1%. R74 reported applying it to his shoulder three times a day on his own and would let staff know when the medication became low. R74 placed the medication back in the dresser. RN-B left the room and placed R74's medication that had been removed from the cart back into the medication cart. Review of R74's electronic medication administration record (EMAR) lacked an order for self-administration of medications or a SAM assessment being completed. In addition, the EMAR identified staff signing that Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams to affected joint topically four times had been applied by staff. During an interview on 8/20/24 at 2:54 p.m., NA-B stated none of the residents had medication in their room according to his knowledge. During an interview on 8/20/24 at 3:23 p.m., RN-C stated she had not received an order for R74 to self-administer medications. During a follow-up interview on 8/21/24 at 10:05 a.m., RN-C stated the process to have a medication left in the room for the resident to self-administer was to inform the provider a SAM had been completed by the facility and then an order for self-administration would be received from the provider. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 9:46 a.m., RN-B stated some residents came in with a supply of medications. RN-B indicated the process was a nurse would completed a SAM and if the results of the assessment determined the resident could safely self-administer their meds, an order would be obtained from the doctor. During an interview on 8/21/24 at 10:51 a.m. director of nursing (DON) stated the process is to do a self-administration assessment for medication and then requested an order from the physician. DON stated it would be her expectation would be for staff not to leave medication in the room without having done a self-administration of medication assessment and an order from the physician. R354 R354's admission MDS dated [DATE], identified R354 was cognitively intact. Diagnoses included orthopedic surgery, arthritis, dementia, anxiety disorder and dependent personality disorder. R354 needed assistance with transfers, dressing, and personal hygiene. R354's care plan dated 8/19/24 lacked information regarding self-administration of medication. The care plan did reveal R354 had a history of substance use disorder with opioids and alcohol. R354 had a goal for staff to make every reasonable attempt to keep the resident safe in the event of an opioid-related overdose. R354's medical record lacked an order for SAM and lacked evidence a SAM assessment had been completed. During an observation on 8/20/24 at 3:13 p.m., R354 had a cup of medications on his bedside table. R354 stated the cup with medications had been sitting on the bedside table for an hour. R354 was waiting to take the medications until the nurse could tell him what the medications were for. During an interview on 8/20/24 at 3:13 p.m., licensed practical nurse (LPN)-C reported the medications, which included oxycodone (an opioid used for pain) had been sitting on R354 bedside table since 2:38 p.m. R354 was on the phone when LPN-C went to give R354 the medications and left the medications on the bedside table. LPN-C verified that R354 did not have an order to leave medication at the bedside nor for R354 to self-administer his medications. During an interview on 8/20/24 at 3:32 p.m., registered nurse (RN)-C verified R354 did not have a self-administration medication order or a SAM assessment. During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons as well. Review of facility policy titled Self-Administration of Medications dated 2/2024, indicated residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37905 Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment for 4 of 4 residents (R79, R2, R81, R19) with a shared bathroom. Findings include: R79's Face Sheet, dated 8/21/24, identified R79 had diagnoses which included; malignant neoplasm of temporal lobe, depression, and diabetes mellitus. R79's care plan revised 8/7/24, identified R79 was independent with a walker for ambulation, transfers, and required assistance of one with toileting. R2's Face Sheet dated 8/21/24, identified R2 had diagnoses which included: Alzheimer's disease, diabetes mellitus, and delusional disorders. R2's care plan revised 6/5/24, identified R2 required two staff for assistance with transfers, wheelchair use for mobility, and required assistance of one with toileting. R81's Face Sheet dated 8/21/24, identified R81 had diagnoses which included: malignant neoplasm of unspecified site of right female breast, muscle weakness, and fracture of unspecified part of neck of the left femur, subsequent encounter for closed fracture with routine healing. R81's care plan revised 6/24/24, identified R81 required two staff for assistance with transfers, one assist with ambulation and required assistance of one with toileting. R19's Face Sheet dated 8/21/24, identified R19 had diagnoses which included: paranoid schizophrenia, generalized anxiety disorder, and difficulty in walking. R19's care plan revised 2/28/24, identified R19 required two staff for assistance with transfers, one staff for locomotion in wheelchair, and check and change every two to three hours for assistance of one with toileting. During an observation on 8/19/24 at 1:29 p.m., shared bathroom of R79, R2, R81, and R19, had an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was very sticky. During an observation on 8/20/24 at 8:23 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. During an observation on 8/20/24 at 11:48 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/24 at 11:52 a.m., housekeeper (HSK)-A stated was responsible to clean the resident's rooms and had not cleaned the shared bathroom of R79, R2, R81, and R19 yet that day. In addition, HSK-A had not cleaned the bathroom yesterday either. HSK-A indicated the usual practice was to check the rooms or staff informed the housekeeping staff when cleaning was needed. HSK-A and surveyor entered the shared bathroom of R79, R2, R81, and R19. HSK-A confirmed the bathroom had a brown substance on the wall and doorframe, the floor was sticky and indicated could also see the floor was soiled. HSK-A indicated would have expected someone to have informed housekeeping that the floor and wall needed to be cleaned. During an interview on 8/21/24 at 8:37 a.m., environmental director (ED)-A stated everyday she would complete an inspection of each floor, dining rooms, hallways, break rooms and talk to housekeeping staff to discuss what needed to be done and assist when needed. ED-A indicated she expected housekeeping staff to clean resident bathrooms every day, to check rooms often and clean as soon as possible when soiled. ED-A stated she had instructed housekeeping staff to check the bathrooms more frequently since bathrooms could become soiled more often, even right after they had been cleaned. ED-A stated all staff should check the bathrooms to ensure they are clean and indicated staff could call housekeeping and they would clean it right away. During an interview on 8/21/24 at 10:17 a.m., director of nursing (DON) indicated an expectation of the resident bathrooms to be cleaned daily, and when soiled, would expect nursing staff to clean it or notify housekeeping to come and clean the bathroom immediately. DON stated this was important for hygiene, infection control, and stated this was the resident's home. Review of the facility policy titled Daily Cleaning Procedures (DCP) undated, included instructions to spot clean walls that were visibly soiled. In addition. the policy included instructions to dust mop, then damp mop the perimeter of the room, including to not forget the restroom.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to provide a care conference for 1 of 1 residents (R68) to review and revise care plan with the interdisciplinary team (IDT), who was reviewed for care planning. R68's quarterly Minimum Data Set (MDS) dated [DATE], identified R68 was cognitively intact and had diagnoses which included: malnutrition, anxiety and depression. R68's care plan revised 7/26/24, identified R68 was a vulnerable adult, was at risk for harm related to suicidal thoughts and had started working with relocation services to assist with finding housing. R68 was independent with transfers, ambulation, dressing, bathing, and personal hygiene. R68's Care Conference Form dated 4/1/24, identified it was a quarterly care conference, and resident and family was involved in plan of care. Review of R68's medical record lacked documentation of a care conference completed after R68's quarterly MDS dated [DATE], was completed. During an interview on 8/19/24 at 2:40 p.m., R68 stated had not been offered or attended a care conference to discuss her plan of care for a while, and could not remember when the last care conference was held. During an interview on 8/20/24 at 5:06 p.m., director of social services licensed social worker (LSW)-A stated resident care conferences were held when a resident first arrived then every three months or more frequently if needed. LSW-A confirmed R68's last care conference was held 4/1/24, and confirmed the facility was a month behind for care conferences. LSW-A indicated care conferences with residents or resident representatives were important to ensure the facility was meeting their needs and working through their goals. LSW-A indicated R68 had went to the hospital and one care conference had been canceled, however had not been re-scheduled. During an interview on 8/21/24 at 8:07 a.m., interim administrator stated the expectation was that care conferences followed the resident's MDS calendar, and should have been held after admission, quarterly and when family members requested one. Interim administrator confirmed the facility had two licensed social workers and would have expected R68's care conference to have been rescheduled. Interim administrator indicated care conferences were important so residents could provide input and review their plan of care, any changes could be discussed as well as loved ones could advocate for the residents. A policy was requested, and on 8/21/24 at 2:39 p.m. DON confirmed the facility did not have a policy related to care plan or care conferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 2 of 5 residents(R30, R12). In addition the facility failed to provide assistance with dressing for 1 of 5 residents (R66) reviewed for activities of daily living (ADL)'s. Findings include: R30 R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had intact cognition and diagnoses which included hypertension, (elevated blood pressure), Renal insufficiency, and Diabetes Mellitus (DM). Identified R30 required physical assistance from staff with personal hygiene. R30's current care plan dated 7/23/23, indicated R30 had deficits with ADL's related to weakness, chronic pain and obesity. R30 required assistance with personal hygiene. R30's Comprehensive Care Area Assessment (CAA) dated 8/15/23, identified R30 had a self care deficit and required assistance with personal hygiene which included shaving facial hair. During an observation on 8/19/24 at 2:37 p.m., R30 was lying in bed and had several gray/white one inch long facial hairs on her chin. During an interview on 8/19/24 at 2:38 p.m., R30 stated she preferred to have her facial hair removed. R30 further stated she was able to shave them herself after staff provide her with the razor however, she preferred the staff help her to remove her facial hair. R30 stated she was unsure of when the last time she received staff assistance to remove her facial hair was. During an observation on 8/20/24 at 9:10 a.m., R30 was lying in bed eating breakfast and continued to have several gray/white one inch facial hairs on her chin. During an interview on 8/20/24 at 9:20 a.m., nursing assistant (NA)-A stated R30 required staff assistance to shave facial hair. NA-A stated she had not offered or assisted R30 with shaving recently and was unsure the last time R30 had been shaved. During an interview on 8/20/24 at 9:22 a.m., registered nurse (RN)-A stated R30 required staff assistance to shave facial hair. RN-A verified R30 had several long facial hairs and was unsure the last time R30 had been shaved. RN-A stated her expectation was R30 would have been shaved when facial hair was present. 48740 R12 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's admission MDS dated [DATE] indicated. R12 had short and long-term memory problems and had poor decision making skills requiring guidance from staff. R12 had diagnoses which included Hypertension (high blood pressure), diabetes mellitus, dementia, and seizure disorder. R12 was dependent on staff for personal hygiene, dressing, and mobility. R12's care plan dated 7/12/24, indicated R12's goal was to be dressed, groomed, and bathed per preferences. R12 required assist of two staff for personal hygiene, and assist of two staff for dressing. During an observation on 8/19/24 at 1:51 p.m., R12 was in bed and had facial hair approximately 3 cubic centimeters (cm) long. R12 stated he would like to be shaved and that having long facial hair bothered him. During an observation on 8/20/24 at 9:15 a.m., R12 was in bed and continued to have facial hair approximately 3 cm. long. During an observation on 8/20/24 at 12:00 p.m., R12 was in bed and stated no one had offered to shave him since the previous week. During an observation on 8/21/24 at 8:06 a.m., R12 continued to have facial hair 3 cm in length. During an interview on 8/21/24 at 8:08 a.m., NA-E stated R12 could not shave himself. NA-E confirmed that R12's facial hair was long and should have been shaved off. During an interview on 8/21/24 at 8:16 a.m., NA-B stated R12 needed assistance with shaving and dressing. NA-B stated staff shaved R12 when needed and R12 would request when he would wanted to be shaved. NA-B confirmed R12's facial hair was long and staff should have asked R12 if he wanted to be shaved. During an interview on 8/21/24 at 9:49 a.m., RN-B stated R12 was able to make his needs known. RN-B confirmed that R12's facial hair was long and staff should have offered shaving care. 49620 R66 R66's quarterly MDS dated [DATE], identified R66 had severe cognitive impairment and diagnoses which included diabetes, dementia, anxiety, dysphagia (difficulty swallowing) following a cerebrovascular accident (stroke). Indicated R66 required total assistance of two staff with ADL's; personal hygiene, toileting, bathing, bed mobility, transfers. R66's care plan dated 9/21/23, identified R66 had an alteration in communication related to being non-verbal and not interactive. R66's primary language was Somalia. Indicated R66 was unable to use a translator due to cognitive impairment and for staff to speak to R66 in simple to understand terms. Identified R66 would be dressed, groomed and bathed per preferences and was dependent with ADL's. During an observation on 8/19/24 at 2:26 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Villas at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 7727 Portland Avenue South Richfield, MN 55423	

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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	During an observation on 8/19/24 at 6:17 p.m., R66 was sitting in the wheelchair in the dining area and continued to wear a hospital gown and slipper socks. During an observation on 8/21/24 at 12:11 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks. R66's right hip, thigh and partial buttock area were exposed approximately one foot in length down R66's leg by six inches wide on R66's hip/thigh area. Two other residents were observed to be in the dining room and R66's family member. During an interview on 8/21/24 at 12:53 p.m., with family member (FM)-A utilizing the Somali [NAME] Translation Service, FM-A stated it bothered her that R66 was not dressed and R66's skin was exposed in the dining room. FM-A stated she had requested staff to put trousers on R66 and to dress R66. FM-A verified R66 was usually wearing a hospital gown and it would bother him. During an interview on 8/21/24 at 1:06 p.m., NA-D verified R66 required total assistance of two staff with personal cares. NA-D stated R66 had clothing available and that staff usually dressed R66. During an interview on 8/21/24 at 1:16 p.m., licensed practical nurse (LPN)-B stated R66 resisted cares at times and it was more appropriate for R66 to wear a hospital gown so R66 was comfortable and staff would not strain themselves. During an interview on 8/20/24 at 4:16 a.m., director of nursing (DON) indicated R30 required staff assistance with shaving. DON stated her expectation was R30 would have been shaved at least weekly or when facial hair was present. During a follow-up interview on 8/21/24 at 2:31 p.m., the director of nursing (DON) verified the expectation of staff was to follow the daily ADL's on the care plan for each resident and to document if a resident refused cares, to notify the nurse, attempt ADL's again, and make a note in the resident's chart. The DON confirmed staff were to respect resident/family wishes. Review of a facility policy titled Activities of Daily Living (ADL's) /Maintain Abilities Policy updated 5/9/24, indicated the facility would provide care and services for hygiene, dressing and grooming. Identified a resident who was unable to carry out ADL's would have received the necessary services to maintain grooming and personal hygiene.

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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** 45844 Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. This deficient practice had the potential to affect 87 residents who received food and beverages from the refrigerators. Findings include: On [DATE] at 12:45 p.m., during the final tour of the kitchen area with the dietary manager(DM), the following concerns were identified.: Kitchen Freezer: -six veggie burgers in an opened plastic bag without notation of a date. Kitchen refrigerator: -large plastic container ,d+[DATE] full of Asian salad dressing with black crusty substance around the lid without any notation of the date it had been opened. -plastic carton ,d+[DATE] full of thickened milk without notation of a date it was opened and a manufacturer's best by date of [DATE]. -large container ,d+[DATE] full of Orange Marmalade without notation of a date it had been opened. -large plastic container ,d+[DATE] full of Blue Cheese salad dressing with black crusty particles inside the container without any notation of the date it had been opened. - Large container ,d+[DATE] full of French salad dressing with black crusty particles inside the container without any notation of the date it had been opened. - Large container ,d+[DATE] full of Vinaigrette salad dressing with black crusty particles inside the container and on the outside of the container with an opened date of [DATE]. -Large container of ,d+[DATE] full container molasses with black crusty particles inside the container and on the outside of the container with an opened date of [DATE]. During an interview on [DATE] at 1:15 p.m., DM confirmed the above findings and indicated the residents had recently been served the above items. DM stated all the above items should have been discarded. DM stated the resident fridge was the responsibility of dietary and was unsure the last time it had been checked for dated or expired items. DM stated they had a water leak a few weeks ago in the kitchen refrigerator which may have been why the above items contained the black substance inside and outside of the containers. DM stated her expectation was all items would have been dated and discarded per facility policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:06 p.m., registered dietician (RD) stated she was unaware of the items that had not been dated or discarded. DM stated she was aware of the water leak in the refrigerator a few weeks ago and that maintenance had fixed the leak however would have expected staff to review the refrigerator again to ensure the issue had been resolved. RD further stated her expectation was all above items would have been discarded per facility policy. Review of a facility policy titled Food Storage and Shelf Life: Cold Food Storage undated, indicated all opened containers should have had a date opened marked to assure correct rotation. Policy further indicated thickened liquids should have been discarded after manufacturer's use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 1 residents (R26) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings include: Review of Centers for Disease Control and Prevention(CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R26 R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 had severe cognitive impairment and had diagnoses which included: unspecified intracranial injury, depression, other symptoms and signs involving cognitive functions and awareness, schizoaffective disorder, traumatic brain injury, anxiety, convulsions. Indicated R26 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, toileting, and dressing. Identified R26 had a feeding tube. R26's care plan dated 9/5/20, identified R26 had a feeding tube. R26's care plan dated 4/3/24, identified R26 was on EBP related to having a feeding tube. The care plan instructed staff to follow EBP and to wear PPE per EBP when providing cares. R26's Order Summary Report dated 8/21/24, identified R26 received medications and feedings through a feeding tube. The order summary report identified the following: staff to follow: enhanced barrier precautions while providing tube feedings including when handling the feeding tube and associated equipment, performing insertion site care and other high contact care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation/interview on 8/21/24 at 9:37 a.m., licensed practical nurse (LPN)-B entered R26's room with medications and set the medications on R26's bedside table. LPN-B applied gloves and did not apply a gown, raised the bed using the bed control, filled a basin with water from R26's bathroom, lifted the bedside mat off of the floor, folded the bedside mat and placed the mat next to the foot of R26's bed. LPN-B pulled back the sheets covering R26, lifted the feeding tube and proceeded to give R26 medications through the feeding tube. LPN-B wiped the end of the feeding tube with a 4x4 gauze and threw the used supplies and gloves into the garbage. LPN-B applied gloves, got a mouth swab wet in R26's bathroom and proceeded to clean in and around R26's mouth. LPN-B repeated this step, threw swabs into the garbage, removed Vaseline from the bedside table, squeezed a small amount of Vaseline onto her gloved hand and placed onto R26's lips. LPN-B removed gloves and threw the gloves into the garbage. LPN-B lowered R26's bed using the bed control, placed the bedside mat onto the floor next to R26's bed, sanitized her hands and exited R26's room. LPN-B stated EBP were required when completing cares for residents. LPN-B confined she had only worn gloves when administering medications via R26's feeding tube. LPN-B stated she was only required to wear gloves when administering medications via the feeding tube and was not required to wear a gown. During an interview on 8/21/24 at 2:25 p.m., director of nursing (DON) confirmed R26 was on EBP related to having a feeding tube and that the expectation of staff was to wear PPE and follow EBP. DON verified it was important to follow EBP to prevent infections from being passed to other residents and staff. Review of a facility policy revised 4/1/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. Indicated EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. Identified the facility would make gowns and gloves available near or outside of the resident's room; PPE for enhanced barrier precautions was necessary when performing high-contact care activities and EBP would be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was removed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 1 residents (R27) who were reviewed for call light accessibility. Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively impaired and had diagnoses of depression and schizophrenia (a serious mental health condition). Identified R27 was dependent on staff for activities of daily living (ADL) and mobility. R27's care plan dated 7/19/23, lacked documentation of the use or placement of R27's call light. During an observation on 8/20/24 at 12:18 p.m., R27 was sitting in his wheelchair watching television. R27's call light was laying on a pillow on the nightstand table behind R27. R27 was not able to move his wheelchair or turn around independently to reach his call light off of the nightstand table. During an observation on 8/20/24 at 12:28 p.m., R27 remained in the same position as above. R27's call light remained laying on a pillow on the nightstand table and was covered with a blanket. R27 continued to not have access to his call light. During an observation on 8/20/24 at 3:52 p.m., R27 had been transferred from this wheelchair to his bed. R27 was laying in his bed covered with a white bed sheet. R27's call light continued to lay on a pillow and the nightstand covered with a blanket. R27 was not able to reach his call light while laying in bed. During an interview on 8/20/24 at 12:37 p.m., R27 stated he could use the flat style call light for staff assistance if it was placed on the right spot on his legs for him to tap it with his left hand. R27 further stated, I can not hit it unless it is right here (R27 demonstrated where the call light needed to be placed for him to hit it). R27's call light was not within reach for R27 to call for assistance. During an interview on 8/20/24 at 4:02 p.m., nursing assistant (NA)-E stated R27 could use his call light if it was placed next to his head while lying in bed. NA-E further stated call lights should have always been within reach of the residents when they were in their rooms so they could call for assistance. During an interview on 8/20/24 at 4:06 p.m., licensed practical nurse (LPN)-C walked into R27's room and confirmed R27's call light was laying on the nightstand on top of pillows covered with a blanket. LPN-C also confirmed R27 did not have access to his call light while laying in bed. LPN-C indicated R27 could use his call light to ask for assistance from staff. LPN-C stated R27's call light should have been placed within reach when staff put R27 to bed. LPN-C stated her expectations were for staff to place call lights next to residents and explain to the resident where the call light was so they could call for assistance. (continued on next page)

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	245492	A. Building B. Wing	08/21/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/24 at 4:09 p.m., director of nursing (DON) was not aware R27's call light was not within reach. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Requested a facility policy on call lights however, it was indicated the facility did not have a call light policy.