STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bigfork Valley Communities	258 Pine Tree Drive Bigfork, MN 56628

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to assist with personal hygiene as directed by the care plan for 1 of 3 (R17) residents reviewed for activities of daily living (ADLs). Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 was cognitively aware with diagnoses that included malignant neoplasm of accessory sinus (sinus cavity cancer), type 2 diabetes, heart failure and hypertension. R17 required set up or clean up assistance with personal hygiene and R17 completed the activity. R17's care plan dated 7/1/24, identified R17 required extensive assist of one staff for personal hygiene. During an observation on 10/21/24 at 6:20 p.m., R17 was lying in bed on his left side. R17 had dried, dark red blood that had oozed from his left nostril to the left corner of his mouth and onto R17's beard. R17 hair was greasy and disheveled. During an observation on 10/22/24 at 9:36 a.m., RN-A administered R17's Lantus injection. R17 was lying in bed and was wearing the same long-sleeved t-shirt and sweatpants as the evening prior. R17's hair continued to be greasy and R17 continued to have the dried dark red blood from his left nostril to the corner of his mouth and bear. R17 attempted to move his pillow under his head but his pillowcase was coming off exposing half of the pillow with an approximately 6-inch diameter circle of dried blood. RN-A stated, let me help you with that and, without putting on gloves, replaced the soiled pillowcase on R17's pillow and put it under R17's head. RN-A administered R17's medication but did not offer personal hygiene to R17 nor offered clean linens. - At 11:45 a.m., R17 was observed outside sitting in his wheelchair with a visitor on the covered porch area. R17 continued to have dried blood from his left nostril down his mustache to the left corner of his mouth and R17's disheveled hair is sticking out of the hood of his [NAME] jacket. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Bigfork Valley Communities	258 Pine Tree Drive Bigfork, MN 56628

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 8:24 a.m., RN-B stated R17 had sinus cancer and often had blood draining from his nostril. Sometimes R17 couldn't feel it. RN-B would assist R17 with cleaning up or would ask a nursing assistant to help R17. You don't leave him like that. R17 was dirty, bloody and needed to be cleaned up after gowning and gloving. During an interview on 10/23/24 at 8:58 a.m., nursing assistant (NA)-D stated R17 was pretty independent with cares because he liked to do things on his own. Staff pretty much just needed to set R17 up. If R17 was dirty or had blood on his face, you just politely told him and offered a washcloth or asked if you could help him. Sometimes, R17 could tell you and other times you had to point it out. NA-D stated you always offer clean linens when a bed was soiled. Who wants to lie in a dirty bed? During an interview on 10/23/24 at 10:39 a.m., the director of nursing (DON) stated R17 had continuous nose bleeds due to his condition. The DON expected staff to provide immediate basic cares including clean linens for cleanliness and comfort. During an interview on 10/23/24 at 12:47 p.m., R17 was lying in bed, was clean, groomed and had clean bed linens. R17 stated he had a shower that morning. Staff him up and R17 took it from there. However, that did not happen every morning. It was more like every 2-3 days, whatever, I'm just really tired. A facility policy regarding ADLs was requested but not received.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on observation, interview and document review, the facility failed to ensure a transfer belt was utilized while transferring 1 of 1 residents (R11) reviewed for ambulation. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment and required supervision to touching assistance with walking (Helper provides verbal cues or touching/steadying assistance a resident completes activity). R11 had a diagnosis of Alzheimer's and identified a fall without injury since R11's assessment. R11's care plan dated 1/23/24, identified R11 was a limited to extensive assist of one for ambulation and to use a transfer belt. R11's physical therapy discharge note from 2/23/24, identified R11 needed contact guard assist (the caregiver places one or two hands on the patient's body to help with balance and assistance to perform the functional mobility task) with ambulation. R11's fall risk assessment dated [DATE], identified R11 was at risk for falls. During an observation on 10/21/24 at 2:15 p.m., activity staff (A)-B offered to assist R11 to walk to an activity. A-B took R11's hand and placed one arm behind R11's back and walked to the activity. R11 was steady on her feet. A transfer belt was not used while R11 ambulated. During an observation on 10/21/24 at 4:52 p.m., R11 was ambulated for 20 feet by trained medication assistant (TMA)-A and nursing assistant (NA)-A. A transfer belt was not used until they noticed the surveyor was present. R11 was taking short steps, was unbalanced and had two staff assisting her. TMA-A and NA-A then stopped and placed a transfer belt on R11 before they continued to the dining room. During an observation on 10/22/24 at 9:47 a.m., R11 was assisted with ambulation by NA-B from the dining room to the common area by holding R11's hand and an arm around her back. R11 was steady during transfer. A transfer belt was not used while R11 ambulated. During observation on 10/22/24 at 1:49 p.m., R11 was assisted to bingo by A-A who held R11's hand and had one arm behind R11's back. When they got to bingo, A-A assisted resident to sit in a chair. But R11 attempted to sit before the chair was under her and A-A had to grab at R11's waist band on her pants to guide her to sit in the chair without R11 falling to the floor. A transfer belt was not used. During an interview on 10/23/24 at 9:08 a.m., NA-C stated R11 was a limited to extensive assist for ambulation and required the use of a transfer belt while ambulated due to risk of falls or for sudden weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 1:15 p.m., A-B stated she was trained as a NA and had her certification. A-B said she would assist residents to walk to activities when she was able to. When normally assisting R11 to walk, A-B would assist resident to stand and then place one arm behind her back and hold R11's hand. A-B was unsure of what the care plan stated for ambulation with the resident. A-B had not used a gait belt with R11 because R11 could be resistive, therefore A-B did not offer for R11 to use it. A-B was unable to explain the importance of using the gait belt for R11's safety. During an interview on 10/23/24 at 2:11 p.m., the director of nursing (DON) stated it was the expectation that all staff would follow the residents care plan with ambulation to remain safe. R11 should have been wearing a gait belt to ensure her safety. All staff had initial orientation and annual training regarding patient care and ambulation. The facility's Care Plan policy dated 5/2023 identified the staff would implement the interventions to assist the resident to achieve care plan goals and objectives.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to ensure they received an appropriate physician response to a gradual dose reduction for use for 1 of 5 (R9) residents reviewed for unnecessary medication. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 had a moderate cognitive impairment and had diagnoses that included Alzheimer's disease, anxiety and depression. R9's physician orders dated 11/20/23, lorazepam (an antianxiety medication) 0.5 milligram (mg). Give 0.5 mg orally three times a day related to anxiety disorder. R9's Consultant Pharmacist's Medication Review dated 11/8/23, identified R9 was due for a second request for lorazepam GDR. R9's last GDR was rejected by family earlier this year. R9 currently takes lorazepam 0.5 mg orally three times a day for anxiety. Would you like to attempt a lower dose at this time or continue as is? (Could try lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon.) A physician response dated 11/8/23, identified to change to lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon. R9's Pharmacy Medication Review dated 11/16/23 at 12:15 p.m., identified staff spoke on the phone with family member (FM)-A regarding R9's Gradual Dose Reduction Request by Pharmacy and R9's medical provider: decrease lorazepam from 0.5mg three times a day to 0.5mg twice a day with 0.25mg at noon. The GDR request was rejected by FM-A. A fax sent to R9's provider with above text regarding GDR rejection by FM-A. R9's physician order dated 11/20/23, identified lorazepam 0.5 mg orally three times a day. R9's physician progress notes dated 11/20/23 to 10/23/24, identified R9 had major depression and anxiety with orders to continue to administer lorazepam. However, the physician progress notes failed to identify a justification of use for R9's lorazepam. During an interview on 10/23/24 at 10:33 a.m., registered nurse (RN)-B stated R9's lorazepam order was a long standing thing. R9 was in a bad accident years prior and family reported R9 had been taking it since then. Family refused the GDR. During interview on 10/23/24 at 10:35 a.m., the director of nursing (DON) stated the pharmacist sends all recommendations to the provider who then sends their response to us and I take care of them after I receive them. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/23/24 at 12:54 p.m., consultant pharmacist (CP)-A stated a pharmacist did medication reviews for the facility every month. Upon review of R9's 11/16/23, GDR request, CP-A stated R9's family didn't want R9's medications touched. If a family refused a resident's attempt at GDR, the pharmacist relied on the physician's response. As long as an order to continue the medication was received, the pharmacist would not request further review of the medication until the next GDR was recommended. CP-A stated she believed the family refusing GDR was a justifiable reason for continued lorazepam use. However, CP-A stated, after a perod of time, a physician documented justification of use and education would be warranted. During an interview on 10/23/24 at 1:21 p.m., the director of nursing (DON) stated she had never spoken with R9's family regarding R9's medication. The nurses call the family to get the psychotropic medication consent. The DON stated if the family refused the GDR, they would refuse to sign a consent for lorazepam and, without the consent, R9 would not receive her medication. The DON had not addressed a documented justified use with R9's physician. The facility policy Monitoring of Psychotropic Medications effective date 2/2024, identified the consultant pharmacist shall monitor the use of psychotropic medications at least once monthly during the monthly Medication Regimen Review (MRR) and upon request between MRRs. The monitoring hall include, but is not limited to, the review of Behavior and Side Effect Monthly Flow Sheets. - During the monthly MRR, the pharmacist will identify a list of residents receiving psychoactive medications. This list may be obtained from the electronic medical record system. Each of the identified residents shall have Behavior and Side Effect Monthly Flow Sheets that are in PCC. - The Behavior and Side Effect Monthly Flow Sheets are located in the EMR in PCC under POC charting. The pharmacist must review the Flow Sheets, in addition to any other related documentation, and report any irregularities to the attending physician and Director of Nursing as outlined in the Consultant Pharmacist Services policy. Irregularities may include, but are not limited to, the following: - Lack of rationale identifying why a medication is required - Inappropriate diagnosis code(s) - Lack of care planning - Lack of resident specific monitoring - Inconsistent monitoring of side effects or behaviors - Lack of rationale identifying why a gradual dose reduction (GDR) is clinically contraindicated - Unnecessary drug, in which the drug is used: - in excessive dose (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- for excessive duration - without adequate monitoring or without adequate indications for use - in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued without specific target symptoms.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to ensure behavior monitoring and gradual dose reduction (GDR) or justification of continued use was identified for 1 of 5 (R9) residents reviewed for unnecessary medication who were on a psychotropic medication. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 had a moderate cognitive impairment and had diagnoses that included Alzheimer's disease, anxiety and depression. R9's physician orders dated 11/20/23, lorazepam (an antianxiety medication) 0.5 milligram (mg). Give 0.5 mg orally three times a day related to anxiety disorder. R9's Consultant Pharmacist's Medication Review dated 11/8/23, identified R9 was due for a second request for lorazepam GDR. R9's last GDR was rejected by family earlier this year. R9 currently takes lorazepam 0.5 mg orally three times a day for anxiety. Would you like to attempt a lower dose at this time or continue as is? (Could try lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon.) A physician response dated 11/8/23, identified to change to lorazepam 0.5 mg every morning and at bedtime with 0.25 mg at noon. R9's Pharmacy Medication Review dated 11/16/23 at 12:15 p.m., identified staff spoke on the phone with family member (FM)-A regarding R9's Gradual Dose Reduction Request by Pharmacy and R9's medical provider: decrease lorazepam from 0.5mg three times a day to 0.5mg twice a day with 0.25mg at noon. The GDR request was rejected by FM-A. A fax sent to R9's provider with above text regarding GDR rejection by FM-A. R9's physician order dated 11/20/23, identified lorazepam 0.5 mg orally three times a day. R9's physician progress notes dated 11/20/23 to 10/23/24, identified R9 had major depression and anxiety with orders to continue to administer lorazepam. However, the physician progress notes failed to identify a justification of use for R9's lorazepam. R9's medical record failed to identify behavior monitoring and corresponding nursing assessment either supporting the continuation of the lorazepam does or recommending a dose reduction. During an interview on 10/23/24 at 10:33 a.m., registered nurse (RN)-B stated R9's lorazepam order was a long standing thing. R9 was in a bad accident years prior and family reported R9 had been taking it since then. Family refused the GDR. During an observation on 10/22/24 at 1:54 p.m., R9 was playing a bingo during a large group activity. R9 was relaxed, smiling and joking with the staff and other residents. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/23/24 at 7:13 a.m., R9 was awake and dressed for the day. R9 rang a bell on her overbed table. Trained medication aide (TMA)-A entered R9's room R9 stated her floor needed to be swept. TMA-A had housekeeping go into R9's room and clean. R9 was calm. TMA-A stated R9 just needed reassurance that she was safe, that staff were always there to help and staff just needed to try to figure out what R9 needed/wanted. During an observation on 10/23/24 at 8:36 a.m., nursing assistant (NA)-D provided morning cares for R9. NA-D explained each step in a calm voice and short, simple cues. R9 chose her clothing after NA-D gave her choices and participated during cares. R9 remained calm and smiling throughout cares. During interview on 10/23/24 at 10:35 a.m., the director of nursing (DON) stated the pharmacist sends all recommendations to the provider who then sends their response to us and I take care of them after I receive them. During a telephone interview on 10/23/24 at 10:50 a.m., R9's physician had never spoken to R9's family regarding R9's lorazepam order nor had provided education regarding lorazepam. During a telephone interview on 10/23/24 at 12:54 p.m., consultant pharmacist (CP)-A stated a pharmacist did medication reviews for the facility every month. Upon review of R9's 11/16/23 GDR request, CP-A stated R9's family didn't want R9's medications touched. If a family refused a resident's attempt at GDR, the pharmacist relied on the physician's response. As long as an order to continue the medication was received, the pharmacist would not request further review of the medication until the next GDR was recommended. CP-A stated she believed the family refusing GDR was a justifiable reason for continued lorazepam use. However, CP-A stated, after a perod of time, a physician documented justification of use and education would be warranted. During an interview on 10/23/24 at 1:04 p.m., NA-D stated R9 did not exhibit any behaviors. R9 could get a little confused but normally was not anxious, agitated, restless or anything like that. R9 was just normal. During an interview on 10/23/24 at 1:13 p.m., NA-C and NA-E stated R9 was pretty easy going. NA-E stated R9 had a lot of anxiety when she was first admitted to the facility but that had been a while. R9 did like to watch everything staff did during cares. If R9 didn't see you do it, it didn't happen. Staff just needed to let R9 do her thing. Staff needed to tell her or show her every step of the way and it usually went well. If R9 questioned anything, staff just did it again and it was all good. During an interview on 10/23/24 at 1:18 p.m., registered nurse (RN)-C stated R9 was pleasant, but forgetful. Other than that, R9 really didn't have any negative behaviors. During an interview on 10/23/24 at 1:21 p.m., the director of nursing (DON) stated she had never spoken with R9's family regarding R9's medication. The nurses call the family to get the psychotropic medication consent. The DON stated if the family refused the GDR, they would refuse to sign a consent for lorazepam and, without the consent, R9 would not receive her medication. The DON had not addressed a documented justified use with R9's physician and felt the familiies refusals were enough. Staff were expected document R9's behavior and assess R9 for possible interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Monitoring of Psychotropic Medications effective date 2/2024, identified the consultant pharmacist shall monitor the use of psychotropic medications at least once monthly during the monthly Medication Regimen Review (MRR) and upon request between MRRs. The monitoring hall include, but is not limited to, the review of Behavior and Side Effect Monthly Flow Sheets. - During the monthly MRR, the pharmacist will identify a list of residents receiving psychoactive medications. This list may be obtained from the electronic medical record system. Each of the identified residents shall have Behavior and Side Effect Monthly Flow Sheets that are in PCC. - The Behavior and Side Effect Monthly Flow Sheets are located in the EMR in PCC under POC charting. The pharmacist must review the Flow Sheets, in addition to any other related documentation, and report any irregularities to the attending physician and Director of Nursing as outlined in the Consultant Pharmacist Services policy. Irregularities may include, but are not limited to, the following: - Lack of rationale identifying why a medication is required - Inappropriate diagnosis code(s) - Lack of care planning - Lack of resident specific monitoring - Inconsistent monitoring of side effects or behaviors - Lack of rationale identifying why a gradual dose reduction (GDR) is clinically contraindicated - Unnecessary drug, in which the drug is used: - in excessive dose - for excessive duration - without adequate monitoring or without adequate indications for use - in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued without specific target symptoms.

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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** 40943 Based on observation, interview and document review, the facility failed to use standard and enhanced barrier precautions (EBP); and failed to maintain proper infection control procedures for insulin administration for 1 of 3 (R17) residents reviewed for activities of daily living (ADL's). Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 was cognitively aware and had diagnoses that included malignant neoplasm of accessory sinus (sinus cavity cancer), type 2 diabetes, heart failure and hypertension. R17 required set up or clean up assistance with personal hygiene and R17 completed the activity. R17 had indwelling urinary catheter. R17's care plan dated 10/1/24, identified R17 required extensive assist of one staff for personal hygiene. R17 had a diagnosis of left-sided sinonasal squamous cell carcinoma with left orbital involvement (a rare tumor that affected the nasal and sinus cavity). R17 had his sinus's irrigated twice daily and contact precautions needed to be taken. R17 used an indwelling urinary catheter and staff were directed catheter every shift and as needed. The care plan did not address R17's need for EBP precautions due to an indwelling device. During an observation on 10/22/24 at 9:36 a.m., registered nurse (RN)-A did not clean the rubber stopper at the end of R17's Lantus (a long-acting insulin that helped manage blood sugars levels in certain people) pen, applied a needle and dialed R17's dose of medication. RN-A entered R17's room without donning a gown and/or gloves and approached R17. R17 was lying in bed on his left side and had dried dark red blood from his left nostril to the corner of his mouth and beard. R17 attempted to move his pillow under his head but his pillowcase was coming off exposing half of the pillow with an approximately 6-inch diameter circle of dried blood. RN-A stated, let me help you with that and, without putting on gloves, replaced the soiled bloody pillowcase on R17's pillow and put it under R17's head. R17 rolled onto his back using his trapeze bar and stated to use the right side of his abdomen because everyone always used the left side. RN-A failed to don gloves, then cleansed R17's injection site with an alcohol wipe and administered R17's Lantus injection. RN-A withdrew the needle and wiped the area again with an alcohol wipe. - At 9:45 a.m., RN-A stated she did not need to clean the rubber stopper of R17's Lantus pen because she assumed the person before her had cleaned the pen with an alcohol wipe before putting it back into the cart when they were done. I guess you should never assume because they might not have done it. RN-A stated she did not wear gloves and never wore gloves with R17 because she thought it intimated him. RN-A stated if she had cleaned the blood from his face, she would have worn gloves then but not for this. RN-A then stated it didn't matter because she used hand sanitizer before going into R17's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245529	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bigfork Valley Communities	258 Pine Tree Drive Bigfork, MN 56628

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 8:11 a.m., RN-C stated she cleaned the insulin pen rubber stopper before and after every use. You don't know where it's been. Even when it's capped. Disinfecting of the rubber stopper was to prevent bacteria from entering the pen and causing an infection. R17 had EBP due to having an indwelling foley catheter. Staff needed to don a gown, gloves and/or a mask and eye protection when they did catheter care. RN-C wouldn't necessarily put on a gown when she administered medications to R17 because you weren't coming into contact with R17. However, if RN-C needed to help R17 with changing his bedding or if you needed to get close to him and touch him, then RN-C would need to don a gown and gloves, especially with touching bodily fluids. That's just what you do. During an interview on 10/23/24 at 8:24 a.m., RN-B stated staff needed to don a gown and gloves during catheter care. RN-B stated if he was only administering medications or insulin, RN-B would not don a gown because RN-B would not come into contact with R17. However, if providing any type of direct care to R17, staff would need to don gown, gloves, mask and the whole works because you were coming into direct contact with R17. If it's bloody or wet and it's not yours, wear PPE to protect yourself and others. RN-B would clean the rubber stopper on the Lantus pen before applying the needle to prevent infection. During an interview on 10/23/24 at 10:39 a.m., the director of nursing (DON) stated R17 on EBP because R17 had a foley catheter. Staff were expected to clean the rubber stopper of an insulin pen prior to applying the needle to prevent bacteria from entering the pen. Staff were expected to don a gown and gloves during direct care and whenever in contact with bodily fluids to prevent infection. The facility policy Infection Control Practices: Standard Precautions Transmission Based Precautions dated 8/2024, identified EBP were an infection control intervention designed to reduce transmission of resistant organisms that employed targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and/or infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.