DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 18, 2024

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: CCN: 245424
Cycle Start Date: September 12, 2024

Dear Administrator:

On November 12, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 23, 2024

Administrator
Presbyterian Homes Of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: CCN: 245424
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 12, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 12, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	**3220 LAKE JOHANNA BOULEVARD** **ARDEN HILLS, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on September 11, 2024 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Presbyterian Homes of Arden Hills, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 09/29/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	**3220 LAKE JOHANNA BOULEVARD** **ARDEN HILLS, MN 55112**

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PRESBYTERIAN HOMES OF ARDEN HILLS is a 4-story building with full basement. The building was constructed at two different times. The original building was constructed in 1978 and was determined to be of Type II (222) construction. In 2006, an addition was constructed to the West side of the building that was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	**3220 LAKE JOHANNA BOULEVARD** **ARDEN HILLS, MN 55112**

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K 000	Continued From page 2 determined to be of Type II (222) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 128 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		10/15/24

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	245424	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2024**

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PRESBYTERIAN HOMES OF ARDEN HILLS	**3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112**

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K 351	Continued From page 3 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 09/11/2024 between 10:30 AM and 2:00 PM, it was revealed by observation that there were wires in contact with the sprinkler pipe above the ceiling near room 414 and the Dinning Room. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 351	The wires contacting the sprinkler pipe above the ceiling near room 414 and the dining room will be reconfigured to not contact the sprinkler pipe on or before 10/15/2024. The Environmental Services Director (ESD) or his proxy will be responsible for reconfiguring the wires to meet the requirements of NFPA 101 (12) Life Safety Code, and the requirements of NFPA 13 (10) The Standard for the Installation of Sprinkler Systems. The ESD will be responsible for training his staff on the requirements regarding sprinkler piping and instructing them to be aware of and to look for possible violations of the code requirements. The ESD or his proxy will inspect all areas where staff or contractors are working to ensure work done does not violate the Life Safety Code requirements. The Regional Engineering Manager (REM) will watch for such code violations while conducting the Annual Facility Review (AFR) and make the ESD aware of any that are found.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		10/15/24

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K 353	Continued From page 4 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/11/2024 between 10:30 and 2:00 PM, it was revealed by observation that storage of items in South Activity Closet were within 18" of the sprinkler system. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 353	The items stored in the South Activity Closet within 18 of the sprinkler system will be moved to meet the minimum 18 distance requirements of NFPA 101 (12) Life Safety Code and NFPA 25 (11) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The ESD will ensure the items are moved the correct distance away, will remove any shelving that does not meet the code requirements, and will install a line on the wall to indicate the distance items are to be kept away from the sprinkler system on or before 10/15/2024. The ESD will train the activities manager on correct storage practices on or before 10/15/2024 The REM will inspect for proper storage during the AFR.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101	K 362		10/15/24

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K 362	Continued From page 5 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/11/2024 between 10:30 and 2:00 PM, it was revealed by observation that there was a penetration in the firewall of the mechanical room on the 4th floor adjacent to the egress corridor. An interview with the Environmental Services	K 362	The ESD or his proxy will ensure the penetration of the firewall in the 4th-floor mechanical room adjacent to the egress corridor will be sealed using the correct fireproofing system on or before 10/15/2024. The ESD will train his staff to be aware of improper penetrations of firewalls. The ESD or his proxy will inspect all firewalls in areas where staff or contractors are working to ensure the requirements of NFPA 101 (12) Life Safety Code are met. The REM will inspect all firewalls for compliance during the AFR.	

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K 362	Continued From page 6 Director verified this deficient finding at the time of discovery.	K 362		

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	245424	A. BUILDING _____ B. WING _____	C 09/12/2024

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E 000	Initial Comments On 9/9/24 through 9/12/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/9/24, through 9/12/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H54248064C MN00106504 The following complaints were reviewed: H54247941C MN00106306 Deficient practice was identified related to incidental finding The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 09/28/2024

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.

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		10/29/24

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PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

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F 609	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the state agency (SA) allegations of potential neglect and verbal abuse for 2 of 3 residents (R30, R37). Findings include: R30's Optional State Assessment (OSA) dated 7/18/24, indicated R30 rarely made self understood, did not have behaviors or reject cares, required extensive assistance for all activities of daily living (ADLs), had aphasia (a language disorder that affects a person's ability to communicate), and hemiplegia or hemiparesis (paralysis or weakness on one side of the body). R30's annual Minimum Data Set (MDS) dated 7/18/24, indicated R30 had both a long-term and short-term memory problem, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers. R30's care plan dated 8/2/24, indicated R30 had an ADL self-care performance deficit and interventions included, R30 required two staff participation to dress, one staff person assist with personal hygiene, and one assist with eating. R30's care plan dated 8/2/24, indicated R30 required one to two staff assist for bed mobility, and required two assist with a full mechanical lift for transfers. R30's care plan dated 8/2/24, indicated R30 was at risk for abuse and or neglect related to	F 609	The facility reviewed the Vulnerable Adult Policy, which includes the definition of verbal abuse, physical abuse, and neglect. It also includes steps in stopping and reporting all forms of abuse. This policy is dated January 2023. This policy is still current & in effect. R30 had a change in condition on 9/24/2024 and expired on 9/26/2024. R30 was DNR/DNI with no hospitalization. R-30□s family was updated the same day of the occurrence with NA-F, and were happy with care being provided. They understood NA-F had accidentally forgotten this resident, there was no intent to harm her. No physical or mental harm occurred as a result of this incident. Her skin remained intact. Resident continued at baseline till her passing on 9/26/2024. NA-F has been terminated because of a different occurrence that was reported to OHFC. The facility reviewed R37□s care plan, which remains appropriate. The facility has offered ACP and Chaplain services, R37 did accept services. R37□s weight has been stable for 6 months and has not shown signs of weight loss. No physical or mental injury occurred as a result of this incident. She does not recall the incident. NA-F was terminated related to a different incident that was reported to OHFC.	

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	245424	A. BUILDING _____ B. WING _____	C 09/12/2024

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F 609	Continued From page 3 cognitive and functional deficits and interventions directed staff to follow the vulnerable adult policy, keep R30 safe at all times, and refer to resident services as needed. R37 R37's OSA dated 6/6/24, indicated R37 required extensive assistance with eating. R37's quarterly MDS dated 6/6/24, indicated a short-term and long-term memory problem, did not have behaviors, had a limitation in range of motion on one side of the upper and lower extremities, required setup or clean-up assistance with eating, had dementia, and hemiplegia or hemiparesis. R37's Medical Diagnosis form indicated R37 had unspecified dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, anxiety disorder, major depressive disorder, muscle weakness, and dysphagia (difficulty swallowing). R37's care plan dated 9/10/24, indicated R37 had a self-care performance deficit related to dementia, history of stroke with right sided hemiparesis and right hand contracture and required assistance to perform most ADLs. R37's interventions identified R37 required supervision with eating in the dining room during meals with set-up. R37's care plan dated 9/10/24, indicated an alteration in mood or behaviors due to dementia and a history of delusions an unknown person from outside the facility was attempting to kill or	F 609	Staff identified as not reporting timely completed education on timely reporting and what needs to be reported for these 2 incidences. Facility will educate all staff on our Vulnerable Adult policy to help ensure understanding of definitions and when to report abuse/neglect/maltreatment/major injury to OHFC. Audits will be initiated and will be completed on 10% of residents for compliance weekly for 4 weeks. These audits are to ensure facility is reporting all occurrences of abuse/neglect/maltreatment to OHFC and in a timely manner. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Care Center Administrator will be responsible for ongoing compliance. Date for compliance is 10/29/2024.	

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F 609	Continued From page 4 harm R37 or R37's family and interventions indicated encouragement to participate in activities of interest, intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from the situation and take to an alternate location as needed. R37's care plan dated 9/10/24, indicated R37 was at risk for abuse and neglect due to functional limitations and severe impaired cognition and dementia. Interventions directed staff to follow the vulnerable adult policy, keep R37 safe at all times, and refer to resident services specialist as needed. Nursing assistant's (NA)-F's Notice of Termination form indicated NA-F was overheard telling a resident to stop crying or NA-F would stop feeding them and a clinical coordinator informed NA-F they do not talk to residents like that and expected residents be treated with consideration, courtesy, and respect. Further, the form indicated on 8/14/24, NA-F forgot a resident in their room all morning and upon camera review, the resident was discovered at 11:04 a.m., still in bed and unattended to. NA-F took the resident to lunch at 12:10 p.m. The form indicated NA-F got busy and forgot and as a result the resident did not receive breakfast and did not receive morning cares. During interview on 9/12/24 at 9:44 a.m., the director of nursing stated the administrator had the video of the resident who was forgotten and further stated if there was confirmed abuse a staff person was terminated. During interview on 9/12/24 at 10:17 a.m., the	F 609		

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F 609	Continued From page 5 administrator stated the resident who NA-F told to stop crying or she would stop feeding in the Notice of Termination form was R37 and further, the resident NA-F forgot was R30. The administrator further stated she spoke with registered nurse (RN)-A who told NA-F she could not do that and stayed with R37 until she was done and helped feed R37 the remainder of the meal. The administrator stated there was no written follow up completed for R30, but RN-A spoke to NA-F to make sure she reported to someone if she was unable to get a resident up in time. The administrator stated she viewed the footage and R30 was not up until about 11:00 a.m., and did not review cameras for R37. The administrator further stated she did not think they followed up with R30 and stated they dropped the ball on that one unless RN-A followed up. During interview on 9/12/24 between 10:35 a.m., and 10:59 a.m., RN-A stated she was standing by the health unit coordinator station completing paperwork and R37 sat at the table and NA-F was feeding R37. RN-A stated R37 was upset that day and was often upset and NA-F stated, if you don't stop, I'm going to stop feeding you. RN-A stated she was standing about 2 or 3 feet away from NA-F and immediately went to NA-F and told her she couldn't speak to R37 like that and went back to where she was standing and continued to do paperwork. RN-A stated she was appalled and stated R37 did not need help eating and stated she stayed with R37 the whole time and added R37 was ok and tended to have behaviors of crying and being agitated. RN-A stated she reported the encounter to NA-F's supervisor, CCHC-G. RN-A stated she felt it was abusive and added you don't talk to someone like that and stated she did not know whether	F 609		

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F 609	Continued From page 6 CCHC-G reported the encounter to anyone other than human resources. RN-A stated R30 was non-verbal and stated they have an interdisciplinary team (IDT) meeting from 10:15 a.m., that ends about 11:00 a.m., and RN-A came upstairs and stated a staff person reported R30's food was in the kitchen and was thrown away because it was 11:00 a.m., and they forgot to feet R30. RN-A stated she asked NA-F what had happened and NA-F began to cry and told RN-A she got busy and missed R30. RN-A stated she contacted the director of nursing (DON) and the administrator right away along with CCHC-G and human resources and asked NA-F what she could do to make sure it didn't happen again. RN-A stated she contacted R30's daughter to explain staff forgot to give R30 breakfast and was not aware if any disciplinary action was completed. At 10:51 a.m., RN-A stated R30 did not have any pressure injuries and did not initiate a body audit because it did not make sense. RN-A stated R30 was incontinent and stated NA-F's shift started at 6:00 a.m. and R30 went about 5 hours by the time she got out of IDT R30 was up in the chair and thought it was around 10:30 a.m. RN-A further stated R30 was at risk of developing pressure ulcers and stated they were worried about R30's meal and did not look at the big picture about R30's skin. At 10:59 a.m., RN-A viewed R30's progress notes and verified there was no progress note indicating a skin assessment was completed for R30 on 8/14/24. During interview on 9/12/24 at 11:52 a.m., CCHC-G stated she was NA-F's supervisor and stated RN-A reported NA-F's statement to R37 on the same day it occurred and thought that incident occurred on 6/4/24. CCHC-G stated she	F 609		

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F 609	Continued From page 7 had a log in for filing a vulnerable adult report, but stated their process was to call the administrator or DON who would direct staff how to proceed. CCHC-G further stated she started in her role as the CCHC on 6/3/24, but was an administrative intern at the facility prior. CCHC-G stated the administrator was out, but spoke to human resources about R37 if not the same day, the following day and the campus administrator was also involved. CCHC-G stated she received a report R30 did not receive breakfast and did not know if R30 did not get out of bed, but RN-A spoke to NA-F and handled the situation and stated the vulnerable adult report would be under the discretion of the administrator and the DON. During interview on 9/12/24 at 11:43 a.m., RN-A stated she did not notify R37's family and did not complete vulnerable adult reports and would contact the administrator or the DON and thought she notified both CCHC-G and the administrator regarding R37. During interview on 9/12/24 at 12:50 p.m., the administrator stated a vulnerable adult report was not completed for either resident and stated they should have been reported. A policy, Vulnerable Adult Abuse Prevention Plan, dated January 2023, indicated verbal abuse was the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability, neglect is the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Once abuse is suspected or identified, the facility will take all appropriate steps to stop	F 609		

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F 609	Continued From page 8 the abuse and protect residents from additional abuse immediately. These steps include but are not limited to reporting the alleged violation and investigation within required timeframes, conducting a thorough investigation of the alleged violation, taking appropriate corrective action, revising the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure R30 received a pillow for positioning for prevention of pressure ulcers and that aided in comfort associate with contractures. Findings include: R30's annual MDS dated 7/18/24, indicated R30 had severely impaired cognitive skills for daily decision making, had an impairment in range of motion to both upper and lower extremities, was dependent on staff for all activities of daily living, was at risk for pressure ulcers and had pressure	F 684	The facility continues to follow the Cares-AM and HS Cares Policy dated Sept 2020. Each resident is to have daily AM and HS cares completed, being mindful of any resident preferences that may be care planned. Including: complete any other personal care as requested by the resident or as indicated on the care plan. R30 had a change in condition on 9/24/2024 and expired on 9/26/2024. R30 was DNR/DNI with no hospitalization. Labs were completed on 9/12/2024 and were WNL. No injury came from these	10/29/24

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F 684	Continued From page 9 relieving devices for the chair and bed. R30's Medical Diagnosis form indicated the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side, vascular dementia, contracture of the right and left hand, abnormal posture, and osteoarthritis of unspecified site, R30's care plan dated 8/2/24, indicated R30 had limited physical mobility related to impaired balance, range of motion, dementia, right and left hand contractures, osteoarthritis and interventions included: R30 had positioning signs located in her room, observe for changes in mobility, contractures forming or worsening. R30's care plan dated 8/2/24, indicated R30 was at risk for impaired skin integrity and interventions included to float elbow on the pillow while in bed, and float elbow on U pillow when in the chair see picture. R30's care sheet dated 9/6/24, indicated float elbow on a pillow while in bed and in the chair. During interview and observation on 9/9/24 between 1:48 p.m., and 1:57 p.m.,R30 was in her black reclining wheelchair and R30's elbow was contracted along with the left wrist and fingers on the left hand were curled shut. Signage was located above the bed that indicated R30 was always supposed to have a pillow under her left elbow, however, R30 did not have a pillow located under her left elbow. At 1:57 p.m., nursing assistant (NA)-E stated R30 had a pink pillow and placed it under R30's right elbow. When asked which elbow the pillow was supposed to go, NA-E	F 684	incidents. Her skin remained intact. Family was very pleased with her care here. Staff involved were coached and are going through our survey education. The facility is reviewing all residents to ensure that care plans, care sheets, and assessments are up to date, with interventions being appropriate for all resident's current level of functions. Education on following the resident□s plan of care and updating with changes will be initiated with all nursing staff. Random audits will be initiated and completed on 10% of residents for compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator will be responsible for ongoing compliance. Date for compliance is 10/29/2024	

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F 684	Continued From page 10 placed the pillow under R30's left elbow. R30 did not decline to have the pillow. NA-E stated they liked the pillow put on in bed more than the chair but NA-E placed the pillow when R30 was in either location. During observation on 9/10/24 at 12:14 p.m., R30 was at the dining room table in her wheel chair and staff were assisting R30 with her meal. No pillow was located under R30's elbow. During observation on 9/10/24 at 12:42 p.m., an unidentified staff person brought R30 to her room. During observation on 9/10/24, between 12:43 p.m., and 12:55 p.m., NA-C and NA-D assisted R30 into bed with the full body lift. At 12:54 p.m., boots were applied to R30's feet and at 12:55 p.m., a bed pillow was placed under R30's right side and a leg positioning device was placed between R30's legs. NA-C did not apply the pillow under R30's left elbow and did not offer to apply the pillow. NA-C took R30's oxygen tubing out of the room. During interview on 9/10/24 at 1:04 p.m., registered nurse (RN)-B stated R30 was supposed to have a pillow under her elbow and would have expected the pillow to be in place in the chair and stated staff should have offered or placed the pillow under the elbow. RN-B verified after review of R30's care plan staff should have placed the pillow according to the care plan. During interview on 9/10/24 at 1:16 p.m., RN-A stated she thought R30 was supposed to have her elbows floated on any pillow because R30 had a history of pressure injuries and when	F 684		

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F 684	Continued From page 11 agitated, tends to dig elbows in. During interview on 9/10/24 at 10:11 a.m., the director of nursing stated staff were not following the plan of care and further, it was important to have the pillows in order to prevent skin issues and the pillow could help with contractures and offloading because R30 had very fragile skin. A policy, Cares-AM and HS, dated September 2020, indicated every resident was to have daily a.m., and bedtime cares completed, being mindful of any resident preferences that may be care planned. The procedure directed staff to review the care plan, nursing assistant assignment sheet for the amount of assistance required to provide care and resident's ability to participate, and complete any other personal cares as requested by the resident or as indicated on the care plan (nursing assistant assignment sheet).	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was properly maintained per professional	F 695	The facility has reviewed the Oxygen Equipment Care and Maintenance policy dated Oct 2011. The policy states, to	10/29/24

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F 695	Continued From page 12 standards for 1 of 1 resident (R30). Findings include: R30's Optional State Assessment (OSA) Minimum Data Set (MDS) dated 7/18/24, indicated R30 required extensive assist with bed mobility, transfers, eating, and toileting. R30's annual MDS dated 7/18/24, indicated R30 had severely impaired cognitive skills for daily decision making, did not identify whether R30 utilized oxygen therapy. R30's Medical Diagnoses form indicated the following diagnoses: chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). R30's physician's orders indicated the following order: 1/8/24, Ok to keep oxygen at 1 to 4 liters via nasal cannula (NC) to keep oxygen saturations greater than 88%, change tubing every week. R30's care plan revised 8/2/24, indicated R30 had chronic respiratory failure with hypoxia and R30's goal was to receive oxygen per physician's orders and interventions included to follow facility protocol for care and maintenance of equipment, provide oxygen per nasal cannula see physician orders for liters per minute. During observation on 9/9/24, at 1:52 p.m., R30's oxygen tubing had a sticker that indicated 8/29/24 and the bubbler for the oxygen was dated 8/29/24.	F 695	provide a safe, clean system for delivery of oxygen. To minimize the growth of pathogens. The policy does state the tubing is not to touch the floor, and tubing/cannulas/masks needs to be changed weekly. R30 signed on to hospice and expired on 9/26/2024. No injury/infections occurred with this resident after this incident occurred. Labs were obtained on 9/12/2024 and were WNL. A coaching was completed with the staff member who had put the cannula in her nose after it had touched the ground. Also, the facility spoke with the staff member who is responsible for changing the tubing weekly, to let the clinical administrator know if they are sick and unable to complete the tubing change as required, so other arrangements can be made. The facility has reviewed all other current residents with respiratory devices to ensure masks/tubing/cannulas do not hang on the floor and the equipment is being changed weekly. The facility bought hooks for the oxygen masks/ cannula/tubing, so the staff can safely hang without touching the floor. Education on proper safe, clean system for delivery of oxygen to help prevent growth of pathogens and ensuring oxygen equipment is changed weekly, and tubing/cannulas/masks are not touching	

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F 695	Continued From page 13 During interview and observation on 9/10/24 between 12:43 p.m., and 12:55 p.m., nursing assistant (NA)-C was getting ready to lay R30 down in the bed. R30's oxygen tubing was on the floor along with the cannula portion that goes into the nose and the oxygen was turned on at 2 liters. R30 also had portable oxygen with tubing on the back of the wheelchair, but was not in R30's nose and R30 was not using oxygen. At 12:55 p.m., NA-C picked up the oxygen tubing that was on the floor and placed the nasal cannula in R30's nose. NA-D stated the date on the humidifier and tubing was August 29th. NA-C stated she did not know the cannula was on the floor and stated she would call the nurse and took the oxygen tubing out of the room after being questioned whether the tubing should be placed on R30 after being on the floor. During interview on 9/10/24 at 1:04 p.m., registered nurse (RN)-B took off the bubbler and stated the humidifier was dated August 29th and added distilled water in the humidifier. RN-B stated oxygen tubing was changed every two weeks but would check to verify this and stated she did not expect staff to put the cannula in R30's nose after being on the floor. RN-B viewed the orders and verified the oxygen tubing should have been changed. During interview on 9/10/24 at 1:16 p.m., RN-A stated oxygen tubing was changed on a weekly basis and if it falls on the floor and stated if the tubing was dated August 29th, it should have been changed and stated staff should know if oxygen tubing was on the floor, the tubing should be thrown away. During interview on 9/12/24 at 10:11 a.m., the	F 695	the ground will be completed with all staff. The Staff member assigned to weekly tubing changes will continue to turn in weekly tubing change lists of residents to the clinical administrator ongoing. Random audits initiated and will be completed on 10% of residents with oxygen equipment for compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and actions plans initiated as appropriate. Clinical Administrator and/or Infection control nurse (and/or designee) will be responsible for ongoing compliance. Date for compliance is 10/29/2024.	

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F 695	Continued From page 14 director of nursing (DON) stated she had someone that came weekly to change oxygen tubing, but that person was ill and there wasn't a back up plan. DON further stated they should not apply the cannula if it was on the floor because of infection control. A policy, Oxygen Equipment Care and Maintenance, modified October 2011, indicated tubing was not to touch the floor and tubing was changed and dated weekly. Additionally, the humidifier bottles would be changed and dated weekly.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on inteview and document review the facility failed to identify potential triggers and offer specialized services for 1 of 1 resident (R275) who had a history of trauma. Findings include: R275's admission Minimum Data Set (MDS) dated 8/22/24, indicated intact cognition and diagnoses of major depressive and anxiety disorder. It further indicated R275 had a behavior of socially isolating herself, required substantial	F 699	The facility has reviewed the policy on Trauma Informed Care, dated 12/2022. This policy does state Presbyterian Homes and Services will ensure we assess a resident who displays or is diagnosed with mental disorder or psychological adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and	10/29/24

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F 699	Continued From page 15 assistance with toileting and partial assistance with mobility. R275's Long Term Care (LTC) Psychosocial assessment dated 8/28/24, indicated R275 had a dignoses of major depressive disorder, anxiey, and had a history of trauma. It also indicated R75 had felt numb, detached from others, activities and/or surroundings as a result of that trauma. It lacked documentation that triggers were assessed to prevent re-traumatization. R275's Comprehensive Nursing Assessment Data Collection dated 8/22/24, indicated R275 preferred female caregiver only. It lacked documentation that triggers were assessed to prevent re-traumatization. R275's care plan dated 8/22/24, indicated "I have a history of trauma. I was sexually abused for many years at a young age. I tend to isolate myself and can be quite shy due to this." It further indicated the following interventions: -I prefer females for personal cares -refer to resident services as needed -remind me that I am safe here R275's care plan lacked documentation of an assessment for triggers to prevent re-traumatization or other specialized services were offered or refused. R275's medical record lacked documentation ACP or other specialized services were offered or refused. R275's progress notes since admission lacked documentation of an assessment for triggers to prevent re-traumatization or specialized services were offered or refused.	F 699	psychological well-being. This policy remains accurate and current. Upon survey finding, the facility re-approached R275 and offered ACP services. R275 did not accept ACP services, stating they might want ACP services in the future. The household coordinator plans to offer ACP services to R275 quarterly and upon any significant change. Facility reassessed R275 to identify triggers to prevent re-traumatization. The facility has updated R275□s LTC psych assessment, care plan and care sheet to reflect these changes. The facility will review all residents to determine those affected by Trauma and assure they have appropriate triggers and interventions. LTC Psych assessment, care plan and care sheets will be updated with changes as appropriate. Education will be initiated for all staff on the importance of identifying trauma, triggers, and initiating appropriate interventions specific to each resident affected. Facility will initiate audits on 10% of residents to determine residents affected by Trauma for compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Care Center Administrator will be	

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F 699	Continued From page 16 During interview on 9/9/24 at 5:35 p.m. R275 stated she had been a long time victim of child abuse and it was hard for her to have a male come in and change her brief, (especially at night) due to her past trauma. She understands they (the facility) may not have enough women (staff) but it seemed to be a problem during the overnight shift. R275 further stated she hadn't been assessed for triggers but her son told the facility about her past history of trauma when she was admitted. During a follow up interview on 9/10/24 at 10:23 a.m. R275 stated she hadn't been offered any specialized services (such as associated clinical physcology) to help her cope with past trauma. During interview on 9/11/24 at 12:24 p.m., household coordinator (HC)-A stated when a resident admits to the facility the household coordinators are responsible for completing an assessment titled Long-Term Care (LTC) Psychosocial assessment which included the questions regarding past trauma. The questions specifically assessed for triggers such as if the resident tends to isolate, detach from others and their surroundings, and if they had nightmares. The facility also offered ACP services and it should be documented if it was offered and if the resident accepted or declined it. HC-A further stated they spoke to R275 today, offered ACP services, and made a plan to check in on a quarterly basis to see how things were going. She also asked her about any triggers. HC-A stated ACP was offered at admission but hadn't been documented and added it today (9/11/24) to R275's care plan.	F 699	responsible for ongoing compliance. Date for compliance is 10/29/2024	

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F 699	Continued From page 17 During interview on 9/12/24 8:56 a.m., the director of nursing (DON) stated when a resident was admitted to the facility the household coordinators were responsible for completing all the paperwork and if something came up they would complete the assessment for trauma informed care. Once that was completed, it would be added to the residents care plan. The assessment used for trauma informed care was titled LTC Psychosocial assessment for any resident diagnosed with a behavioral health disorder or a history of trauma. The household coordinators should ask the residents about any triggers, unless asking about the trigger may be a trigger. They should be offering services such as ACP and documenting that services were offered and whether the resident accepted or refused the offer. The facility's policy on trauma informed care dated 12/2022, indicated Presbyterian Homes and Services will ensure we assess a resident who displays or is diagnosed with mental disorder or psychological adjustment difficulty, or who has a history of trauma and/or posttraumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The intent of this requirement is to ensure that the facility delivers care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent and account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.	F 699		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		10/29/24

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F 755	Continued From page 18 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide medication as ordered by the provider for 1 of 3 residents (R72) observed during medication administration.	F 755	The facility has reviewed the policy, Medication ordering and receiving from pharmacy, which states medications and related products are received from Radius Living RX on a timely basis. The facility	

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F 755	Continued From page 19 Findings include: R72's quarterly Minimum Data Set (MDS) dated 7/19/24, indicated R72 had cognitive impairment and diagnoses of dementia and delusional disorder. R72's provider order dated 1/9/24, indicated R72 required Seroquel (antipsychotic medication used to help treat delusional disorders) 25 milligrams (mg) daily at bedtime. R72's September medication administration record (MAR) indicated R72 did not receive the ordered Seroquel on 9/9/24 as the dose was not available. R72's nursing progress note dated 9/9/24 at 6:52 p.m., indicated R25's Seroquel was not available and follow up with pharmacy was needed. A facility form titled Refill Reorder Form dated 9/1/24, indicated R72's Seroquel was requested to be refilled. A facility form titled Refill Reorder Form dated 9/8/24, indicated R72's Seroquel was requested to be refilled. A facility form titled Refill Reorder Form dated 9/10/24, indicated R72's Seroquel was requested to be refilled. A pharmacy comment on re-order form indicated to send 3 doses to facility and ok to bill to the facility. An observation on 9/9/24 at 6:48 p.m., trained medication assistant (TMA)-A prepared to administer R72 medications. R72's Seroquel was not available for administration. TMA-A had	F 755	will maintain accurate records of medication order and receipt. Per the policy the medications should be reordered when a 5-day supply remains to assure an adequate quantity to dispense is available from Radius RX. R72 orders were reviewed. She remains appropriate to receive Seroquel to help treat delusional disorders. Her care plan, care sheet, tasks, and orders remain appropriate. A medication variance form was completed for this resident related to drug not given. Resident had no documented behaviors during this date. Pharmacy did send 3 days which facility did pay for. This medication was ordered on 9/1/2024 and again on 9/8/2024 indicating the staff were following the ordering procedures. Facility is working with pharmacy to ensure facility is being notified if a medication is too soon for refill to avoid a resident from going without their medications. Pharmacy/Nursing staff will notify the Clinical Coordinator(s)/Clinical Administrator to ensure there is appropriate follow up, if a prescription comes back too soon for refill for any resident residing at the facility. Education to ensure nurse□s and TMAs are notifying clinical coordinator, ADON, or clinical administrator when a medication is too soon to refill. Furthermore, education is being given to all nurses and TMAs, if a resident spits out/refuses dispensed meds/dropped on	

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F 755	Continued From page 20 administered R72's other medications however was not able to administer the Seroquel. When interviewed on 9/9/24 at 7:00 p.m., TMA-A stated the last dose of Seroquel was administered yesterday. TMA-A stated they re-ordered it yesterday and it still had not arrived. If a medication was needing to be refilled, a fax was sent to the pharmacy. The latest time of arrival was between 8:00 and 9:00 p.m. TMA-A further explained if the Seroquel was not on that delivery, it would come tomorrow morning. When interviewed on 9/11/24 at 7:58 p.m., registered nurse (RN)-A stated medications should be re-ordered when there was about a week's worth left. The last row of the blister pack was red and should be reordered when taking from that row. Seroquel was not a medication in the emergency kit and if the medication was not available it would be missed. When interviewed on 9/12/24 at 11:41 p.m., the Director of Nursing (DON) stated when a medication was re-ordered, the hope was for it to be delivered the following day. DON further stated the facility had been working with pharmacy on this process and trying to ensure medications were received timely. When interviewed on 9/12/24 at 1:01 p.m., pharmacist-A stated R72's initial request was sent on 9/1/24, which was too soon to refill. Pharmacist-A stated insurance will not cover if the medication is refilled too soon. The facility was typically notified that the requested medication was too soon to fill via fax. The pharmacy then puts a notation in their system that will prompt pharmacy to fill when able. Pharmacist-A stated	F 755	the floor that the medication card would be initialed and dated by the staff member administering the medication. Random audits on re-ordering process will be completed on 10% of resident□s for compliance weekly for 4 weeks with medication orders and reorders to ensure we are getting medications timely. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator will be responsible for ongoing compliance. Date for compliance is 10/29/2024.	

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F 755	Continued From page 21 R72 had a 30-day supply of Seroquel last sent on 8/15/24 which should be good until 9/15/24. Pharmacist-A stated a refill request for the Seroquel was again sent on 9/8/24 and 9/10/4. On 9/10/24, the facility ok'd to pay for 3 days' worth until the refill could be completed. On 9/10/24, the pharmacy sent 3 days' worth of R72's Seroquel. A follow up interview on 9/12/24 at 1:25 p.m., the DON was asked if there was a process to track or understand why a medication would run out before the ability to refill. The DON stated they would need to look into that and get back however no further information was provided. A facility policy titled Medication ordering and receiving from pharmacy no date, directed staff to reorder medications when a 5-day supply remains to assure delivery can be timely.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medication errors were prevented for 2 of 4 residents (R72, R109) observed during medication administration. This resulted in a medication error rate of 7.69%. Findings include:	F 759	Facility reviewed the medication administration policy dated May 2021 and it is still current and in effect. The policy helps to ensure safe, effective, and timely drug therapy, to provide for an accurate and concise documentation system. The policy reviews the 8 rights of medication administration and also states,	10/29/24

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F 759	Continued From page 22 R72 R72's quarterly Minimum Data Set (MDS) dated 7/19/24, indicated R72 had cognitive impairment and diagnoses of dementia and delusional disorder. R72's provider order dated 1/9/24, indicated R72 required Seroquel (antipsychotic medication used to help treat delusional disorders) 25 milligrams (mg) daily at bedtime. R72's September medication administration record (MAR) indicated R72 did not receive the ordered Seroquel on 9/9/24 as the dose was not available. R72's nursing progress note dated 9/9/24 at 6:52 p.m., indicated R25's Seroquel was not available and follow up with pharmacy was needed. An observation on 9/9/24 at 6:48 p.m., trained medication assistant (TMA)-A prepared to administer R72 medications. R72's Seroquel was not available for administration. TMA-A had administered R72's other medications however was not able to administer the Seroquel. When interviewed on 9/9/24 at 7:00 p.m., TMA-A stated the last dose of Seroquel was administered yesterday. TMA-A stated they re-ordered it yesterday and it still had not arrived. If a medication was needing to be refilled, a fax was sent to the pharmacy. The latest time of arrival was between 8:00 and 9:00 p.m. TMA-A further explained if the Seroquel was not on that delivery, it would come tomorrow morning. R109	F 759	All medications will be administered according to medication label instructions unless specifically ordered by the NP/MD. R72 orders were reviewed and remain appropriate. Resident missed a dose of Seroquel, related to pharmacy not delivering as it was too soon to refill. This resulted in a missed dose of Seroquel. A medication variance form was completed. Resident did not have a change in her behaviors or mood because of the missed dose. Pharmacy/Nursing staff will notify the Clinical Coordinator(s)/Clinical administrator to ensure there is appropriate follow up, if a prescription comes back too soon for any resident residing at the facility. R109 has an order for Synthroid medication related to her hypothyroidism diagnosis which remains appropriate. The TMA gave the medication when resident was finishing breakfast, however the medication order stated for the medication to be given on an empty stomach. Provider/pharmacist were consulted, neither felt this error caused the resident harm/injury. The facility did change the order to be given at 7:00am. TMA was coached on this and has demonstrated success in the past. A medication variance form was completed for this error. Facility will be completing medication order reviews for all residents and ensure	

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F 759	Continued From page 23 R109's admission MDS dated 6/13/24, indicated R109 was cognitively intact with diagnoses of Parkinson's disease, and hypothyroid (low thyroid hormone). R109's provider order dated 6/7/24, indicated R109 required levothyroxine 50 micrograms (MCG) daily for hypothyroidism. An observation on 9/10/24 at 8:40 p.m., TMA-B prepared R109's morning medications. R109's Synthroid medication pack was observed. There was a label placed that instructed the medication to be taken on an empty stomach. After R109's medications were prepared, TMA-B entered R109's room. R109 was up out of bed seated in a wheelchair finishing breakfast with the assistance of staff. TMA-B waited a few moments until R109 was done with breakfast and then administered R109's morning medications including Synthroid. When interviewed on 9/10/24 at 9:10 a.m., TMA-B acknowledged the Synthroid was given as R109 was finishing up with breakfast and the medication instructions from pharmacy to administer on an empty stomach. TMA-A stated they try to follow the directions; however, it was not always given before breakfast. TMA-B stated the medication was not scheduled at a specific time and was ordered as an 8:00 a.m. medication. Medications ordered at this time had a larger window of administration. TMA-B further stated if it was a priority to be given earlier due to the empty stomach instructions, the Synthroid would be scheduled for 7:00 a.m. When interviewed on 9/11/24 at 7:58 p.m.,	F 759	that all special directions and times are properly put into the MAR, for nursing staff to follow. Education on medication administration, the 8 rights of drug administration will be provided for all Nurses, HUCs, and TMAs. Furthermore, education on reordering medications is also occurring to all Nurses and TMAs.(mentioned in F755) Random medication audits will be initiated and will be completed on 10% of residents weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator or designee will be responsible for ongoing compliance. Date for compliance 10/29/2024.	

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F 759	Continued From page 24 registered nurse (RN)-A stated medications should be re-ordered when there was about a week's worth left. The last row of the blister pack was red and should be reordered when taking from that row. Seroquel was not a medication in the emergency kit and if the medication was not available it would be missed. RN-A stated the medication order and the medication label on the packet or bottle should match up. If there were further administration instructions from pharmacy listed, they should be followed, and the medication order or schedule should reflect the medication administration instructions. When interviewed on 9/12/24 at 11:41 p.m., the Director of Nursing (DON) stated when a medication was re-ordered, the hope was for it to be delivered the following day. DON further stated the facility had been working with pharmacy on this process and trying to ensure medications were received timely. Furthermore, the DON expected staff to follow medication instructions listed from pharmacy on the medication card. When interviewed on 9/12/24 at 12:44 p.m., the consultant pharmacist (CP) stated Synthroid has a better absorption if given on an empty stomach and if given with meals, it may not be absorbed as well. A facility policy titled Medication Administration revised 5/2021, directed medications ordered to be given on an empty stomach will be administered at least 30 minutes prior to a meal.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/29/24

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F 812	Continued From page 25 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was properly disposed of after their best by dates in 2 of 4 serving kitchens and failed to ensure food was properly stored in 2 of 4 of the serving kitchens reviewed. This had the potential to impact residents who reside on the unit the serving kitchen is located. Findings include: An observation on 9/9/24 at 1:21 p.m., the 3rd floor serving kitchen was reviewed. Server (S)-A was in the serving kitchen cleaning up after lunch. In the cupboard was a box containing 2 individual packets of instant cream of wheat. The top of the box was torn off. There was no use by date on the box. A second un-opened box of cream of	F 812	The □Food Storage Policy□ dated 05/2019 was reviewed and remains in effect. The facility continues to strive to ensure that foods are properly dated, labeled, and stored. All unlabeled products were disposed of at the time of the initial kitchen tour. In the facility□s third and second floor pantries, all undated and unlabeled containers were disposed of at the time of the survey. Education will be initiated to culinary staff on proper handling, dating, and labeling of both refrigerated foods, and dry storage foods. Education on properly dating, labeling,	

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F 812	Continued From page 26 wheat was next to the open box. The top of the box included best if used by date of 4/18/24. An interview on 9/9/24 at 1:30, S-A verified there was no best by date on the opened box of cream of wheat and the April date on the unopened box. S-A further stated lead server (LS) who was responsible for checking the dates of food items daily. S-A further stated most of the items were served by the kitchen and the individual items were made for residents by the nursing staff. S-A stated she wasn't sure how it was determined if the opened box was any good and further stated both should have been removed. An observation on 9/9/24 at 1:43 p.m., the 2nd floor serving kitchen was reviewed. S-B was in the serving kitchen cleaning up after lunch. Upon review of the refrigerator, there were two half-gallon containers of Kemps skim milk sitting next to each other. One milk container was approximately ¼ full and had a best by date of 9/16/24. The second milk container was less than ¼ of milk left and had a best used by date of 9/3/24, 6 days prior this observation. The milk had just a small amount left. When interviewed on 9/9/24 at 1:50 p.m., S-B verified the milk had a best used by date of 9/3/24 and stated usually LS made rounds on the units to ensure items were stocked, labeled and to check if any food items needed to be removed. S-B further stated she was not sure which jug of milk was used as it was usually the nursing assistants who assist with the beverages. S-B stated everyone should be checking dates and acknowledged they had not as it was so busy and disposed of the milk.	F 812	and storing food will occur to all staff, with emphasis to culinary and nursing staff. Weekly audits of the affected areas will be completed for 4 weeks , with monthly audits to follow. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Culinary Director or designee will be responsible for ongoing compliance. Date for compliance is 10/29/2024.	

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F 812	Continued From page 27 An observation on 9/9/24 at 2:18 p.m., S-C was in the 4 north serving kitchen. Inside the refrigerator was two large trays with multiple glasses of milk and apple juice. The juice and milk were not covered and not dated. When interviewed on 9/9/24 at 2:25 p.m., S-C verified the uncovered glasses and stated the juice and milk were prepped for evening shift a little while ago. S-C was not aware of the glasses needing to be covered. S-C then started to cover the beverages. When interviewed on 9/9/24 at 2:05 p.m., LS stated she has a process for ensuring items are stocked and when items expire and had a list of items for the main storage and the pantry kitchens (kitchenettes separate from the serving kitchen). Furthermore, LS stated she was responsible for the pantry kitchens on the units however, the servers who worked in the serving kitchens were responsible to review the food items and ensure proper storage. When interviewed on 9/11/24, the Assistant Dietary Director (ADD) expected those working in the serving kitchen to be checking food items daily to ensure they were used by the best-by dates. If no date was found the items should be thrown. ADD further stated staff were expected to date and cover all items stored or prepped for future use. When interviewed on 9/12/24 at 11:49 a.m., the administrator expected staff to follow the processes in place to ensure food is stored properly and removed if past the best by date. A facility policy titled Safe Food Storage Policy	F 812		

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F 812	Continued From page 28 revised 5/2019, directed staff to label, date and properly cover all food items upon opening of package. The policy directed staff to ensure food is rotated by placing new items behind older items in a first in, first out system, however did not indicate a method of checking dates to ensure food items had not expired.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		10/29/24

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F 880	Continued From page 29 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate	F 880	The Infection Control Policy and the Policy on Transmission-Based	

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F 880	Continued From page 30 transmission-based precautions (TBP) were used for 3 of 3 residents (R69, R108, R4) who had COVID-19. Furthermore, the facility failed to ensure proper hand hygiene was used for 1 of 1 residents (R72) observed during personal care. Findings include: R69 significant change Minimum Data Set (MDS) dated 8/19/24, indicated R69 had severe cognitive impairment and diagnoses of dementia. R69's MDS further indicated R69 was dependent on staff for eating. R69's nursing progress note dated 9/1/24 at 5:07 p.m., indicated R69 had tested positive for COVID-19. R69's nursing order dated 9/1/24, indicated R69 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation. R108's quarterly MDS dated 6/26/24, indicated R108 was cognitively intact and had diagnoses of cancer of the spine and diabetes. R108's nursing progress note dated 9/10/24 at 9:22 a.m., indicated R108 tested positive for COVID-19. R108's nursing order dated 9/10/24, indicated R108 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation.	F 880	Precautions and Hand Hygiene were reviewed and remain in effect. Johanna Shores continues to prevent the spread of infections by following the Infection control policy. It also remains the expectation for staff to follow the hand hygiene policy, and to follow the PPE guidance for transmission-based precautions according to the Infection Control Policy. R69, R108, R4 all remain in the facility and have not experienced negative outcomes as a result of not having appropriate PPE worn by staff members while they were all covid positive. Outbreak testing for residents and staff have been completed and there were no further cases or spread of covid to report. R69, R108, R4 are cleared and no longer on transmission-based precautions for covid. R46 remains a resident in the facility and has no negative outcome due to the lack of hand hygiene and infection control noted during the survey. Nursing staff that were identified as not following transmission-based precautions were coached on appropriate PPE. The facility did change the quarantine sign, to take away the confusion the staff were having related to high contact. Lastly, the staff member who did not wash their hands, was coached and was made aware that this was a step she missed. Education on the infection Control Policy and Procedure, Hand Hygiene Policy and	

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F 880	Continued From page 31 R4's annual MDS dated 8/24/24, indicated R4 was cognitively intact and had diagnoses of chronic lung disease and diabetes. R4's nursing progress note dated 9/10/24 at 1:23 p.m., indicated R4 tested positive for COVID-19. R4's nursing order dated 9/1024, indicated R4 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation. An observation on 9/11/24 at 8:25 a.m., R69's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R69 was in quarantine from 9/1/24-9/11/24 and instructed staff a gown was required during all high contact cares such as personal cares and transfers. At 8:29 a.m., nursing assistant (NA)-A delivered breakfast to R69. Before entering R69's room, NA-A performed hand hygiene, removed their surgical mask, and donned a N-95 respirator and gloves. Without donning a gown or eye protection, NA-A entered R69's room and closed the door. Forty minutes later at 9:10 a.m., NA-A exited R69's room wearing an N-95 mask and carrying a bag of trash. NA-A went directly to the soiled utility room to dispose of trash, washed hands and had replaced the N-95 mask with a new surgical mask. When interviewed on 9/11/24 at 9:13, NA-A	F 880	Transmission-Based Precautions will be completed with ALL staff/ALL departments. Random audits will be completed on 10% of residents regarding infection control practices and hand hygiene compliance weekly for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. Clinical Administrator, in coordination with Infection Control Nurse, will be responsible for ongoing compliance. Date certain for ongoing compliance is 10/29/2024.	

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F 880	Continued From page 32 verified R69 was on TBP for COVID-19 and was assisting R69 with breakfast. R69 acknowledged they had not had a gown on and only had personal eyeglasses onto assist with breakfast. NA-A stated a gown was not needed to help with meals and was only required for close contact such as transferring and personal cares. NA-A stated their personal eyeglasses could be used as eye protection. An observation on 9/11/24 at 11:50 a.m., R108's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R108 was in quarantine from 9/10/24-9/21/24, and instructed staff a gown was required during all high contact cares such as personal cares and transfers. At 11:54 a.m., NA-B delivered lunch to R108's room. Upon entering NA-B performed hand hygiene and donned a gown and gloves. Without donning an N-95 respirator or eye protection, NA-B entered R108's room and left the door open. NA-B talked with R108 as they set up lunch on R108's bedside table. At 11:59 a.m., NA-B removed the gown and gloves and performed hand hygiene upon exit of R108's room. At 12:00 p.m., R4's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R4 was in quarantine from 9/10/24-9/21/24, and instructed staff a gown was required during all high contact cares such as personal cares and transfers. 12:01 p.m., NA-B continued to R4's room to deliver lunch. NA-B	F 880		

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F 880	Continued From page 33	F 880		

performed hand hygiene and donned a gown and gloves. Without donning a N-95 respirator or eye protection, NA-B entered R4's room leaving the door open. At 12:03 p.m., NA-B removed the gown and gloves, performed hand hygiene and exited R108's room.

When interviewed on 9/11/24 at 12:15 p.m., NA-B verified R108 and R4 were on TBP due to COVID-19. NA-B acknowledged a N-95 respirator and eye protection was not in place as NA-B was just delivering trays. NA-B further stated eye protection and an N-95 respirator was needed during close contact cares such as helping to the bathroom.

Hand Hygiene

R46's quarterly MDS dated 7/26/24, indicated R46 was cognitively intact and had diagnoses of vascular disease and bladder dysfunction. Furthermore, R46 was always incontinent.

R46's care plan revised 5/18/24, indicated R46 was incontinent and required assistance of one person for hygiene and incontinent cares.

An observation on 9/11/24 at 12:06 p.m., NA-B entered R46's room to assist with incontinent cares. NA-B performed hand hygiene and donned gloves. NA-B unfastened R46's soiled brief and cleaned the front of R46 with wipes and then tucked the front side of the brief down and underneath R46. R46 was able to turn to the right side. NA-B then wiped R46's backside and removed the soiled brief and placed in the garbage. Without glove exchange or hand hygiene, NA-B took a clean brief and assisted R46 to turn and place the clean brief. NA-B then

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F 880	Continued From page 34	F 880		

fastened the brief and removed the soiled gloves. Without hand hygiene NA-B assisted to pull down R46's dress and adjusted R46's sock. NA-A then bagged up the garbage and performed hand hygiene before leaving the room.

When interviewed on 9/11/24 at 12:15 p.m., NA-B acknowledged they had not removed gloves or performed hand hygiene after removing R46's soiled brief and placing the new one. NA-B stated they should have performed hand hygiene and exchanged gloves after removing the soiled brief and before assisting with the clean brief and clothing.

When interviewed on 9/12/24 at 10:36 a.m., the infection preventionist (IP) stated when a resident is positive for COVID-19, TBP for droplet with N-95 use was initiated right away. IP further stated the dates of quarantine were posted on the resident rooms along with the droplet isolation signs. IP acknowledged the quarantine signs indicated gowns with close contact cares and stated that could cause confusion. IP expected staff to have gowns, gloves, N-95 respirator, and eye protection on every time they enter a room of a resident with COVID-19. IP stated staff were expected to perform hand hygiene when moving from dirty or soiled items to clean items and after each glove removal. This will help minimize risk of spreading bacteria.

When interviewed on 9/12/24 at 11:41 a.m., the Director of Nursing (DON) expected staff to perform hand hygiene and exchange gloves when moving from dirty or soiled items to clean items and after any glove removal. Staff were also expected to follow the signage on the doors and wear all the required personal protective

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F 880	Continued From page 35 equipment every time entering a room for residents on TBP. A facility policy titled COVID-19 revised 8/2023, directed staff to implement TBP when caring for a resident with COVID-19. Staff who enter the room should wear a N-95 mask, gown, gloves and eye protection that covers the front and sides of face. A facility policy titled Infection Control Hand Hygiene dated 2020, directed staff to perform hand hygiene after contact with visibly soiled items, and after removing gloves.	F 880		