STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

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 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide proper notification of room change for 1 of 3 residents (R21) reviewed for beneficiary notice. Findings include: R21's admission Minimum Data Set (MDS) dated , 6/24/20, identified R21 had intact cognition with [DIAGNOSES REDACTED]. During interview on 8/31/20 at 8:54 a.m., R21 verbalized being upset because she was moved from first floor to second floor. R21 became teary and repeatedly said, it's depressing up here. When asked what was depressing, R21 responded, it's just bad up here. R21 acknowledged she received a 7 day notice of the move but she was moved after only 4 days. R21 denied being offered an opportunity to see the new room or meet her new roommate. R21 was unsure of reason for room change but thought it had something to do with insurance. R21 verbalized she was so upset she did not let staff help her pack her belongings at the time of the move. During a follow-up interview on 9/3/20, at 12:17 p.m., R21 again verbalized being very upset at having to leave the first floor and expressed how depressing it was on second floor. R21's admission record, dated 6/17/20, indicated she was admitted to Station 1 (on first floor) for quarantine during first 14 days of admission. R21's progress note, dated 7/7/20, indicated she was notified of a move to Station 2 (still on first floor) after completion of quarantine and she had no concerns. R21's progress note, dated 7/8/20, indicated she was moved from room [ROOM NUMBER] to room [ROOM NUMBER]. R21's progress note, dated 8/20/20, indicated she was notified she would be moved that day to second floor and she was very upset because she had previously been told she would move on 8/24/20. The progress note also indicated R21 was to move to room [ROOM NUMBER]-1. R21's progress note, dated 8/21/20, indicated R21 was moved from room [ROOM NUMBER] to room [ROOM NUMBER]-2 because the room was not available the previous day. During interview on 9/2/20, at 2:33 p.m., social worker (SW)-A acknowledged R21 should have been given a 7 day notice for a room change. SW-A stated the room change was moved from 8/24/20 to 8/20/20 to accommodate the new admission of a male resident who was COVID-19 negative. SW-A acknowledged R21 had a right to be shown a new room and given the opportunity for refusal and accommodation. The assistant administrator (AA)-A stated this did not happen because someone was already in the room. AA-A further stated they needed to change the new room from 245-1 to 213-2 to accommodate R21's bariatric equipment. SW-A acknowledged R21 was not offered to see either room [ROOM NUMBER]-1 or 213-2 prior to the move. In follow-up interview on 9/3/20, at 9:21 a.m., AA-A stated the initial plan was to move R21 to second floor because her discharge plan was changed from going home to going to long-term care. AA-A suggested a new Notice of Room Change should have been completed when her room change was moved up to accommodate an admission. R21's care plan, dated 6/19/20, noted R21 would be discharged home with home health services. Care plan had not been updated since 6/19/20. A Notice of Room Change document, signed by R21 and social worker (SW)-A on 8/18/20 stipulated R21 would be moved on 8/24/20. The document also indicated a resident was required to have 7 day notice for a room change. Several exceptions were listed for when a 7 day notice could be shortened. The exception for R21's shortened notice for room change was marked as a change in resident's medical or treatment program. A Room Change Guideline, dated 11/28/17, indicated the facility would make every effort to minimize resident's stress during a room change, assess well-being, and resolve negative impact for a resident.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a homelike environment that protected 1 of 5 resident's (R3) property from loss or theft. Findings Include: R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set (MDS) indicated that R3 had intact cognition. On 8/31/20, at 1:29 p.m. R3 indicated she was missing a blouse and a dress. R3 further indicated that she had told staff about the missing items. On 9/2/20, at 3:17 p.m. the administrator indicated R3 had not reported she had any missing items and any items that were reported missing would be on the concern log. During a follow up interview with R3 on 9/3/20, at 8:51 a.m., R3 indicated she had told a lady with red hair that worked in laundry. On 9/3/20, at 9:23 a.m. during an interview with the laundry aide about R3's missing items, the laundry aide indicated R3 had told her about a green striped blouse missing about a month ago. When the laundry aide was asked what she did with the information from R3, the laundry aide indicated she came to the laundry room to look for them but did not find them. When surveyor asked if the laundry aide reported the missing items, she stated no, I didn't report it. On 9/3/20, at 9:31 a.m. the housekeeping manager stated the expectation of staff when items were reported missing by residents was staff are to search and report back to me if they were found or not, then I would report back to the resident and social services. On 9/3/20, at 9:41 a.m. the administrator stated the laundry aide should have reported the missing items so that a resident concern form or grievance could be filled out and a follow up would have been done with R3 about the missing items. A Grievance Guideline policy with a revision date of 4/23/18, indicated the facility would make prompt efforts (within 5 days) to resolve grievances a resident may have. The intent of the grievance process was to support resident rights about lost clothing and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and documentation review, the facility failed to ensure 1 of 5 residents (R3) who were reviewed for abuse, was free from verbal abuse from another resident (R31). Findings Include: On 8/31/20, at 1:13 p.m. during an interview, R3 reported to the surveyor that when she was going to the day room/living room area to sit, a tall gentleman cussed me out, he called me an F'in B. R3 explained that she reported the incident to a nurse the previous day and that the altercation had happened the week before. R3stated that she likes to sit in the living room/day room area and stated, I won't go down there if he's down there in that living room. R3 further stated I use to like to sit down there and explained that there used to be others, about five or six people at a time, sitting in the living room area but indicated not seeing anyone any more. R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period. R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or

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

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) suspected abuse, were to remove R3 from the aggressor and relocate R3 to a safe area and staff were to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines. A nurse's note dated 8/30/20, by licensed practical nurse (LPN)-A identified (R3) had reported that when she started to walk into the day room where resident (R31) was present, R31 yelled at her to get out of his room and got up to approach her. Resident reported she turned around and returned to her room. On 9/1/20, at 8:46 a.m. LPN-A stated R3 did tell her of the incident on 8/30/20 and indicated the resident who had yelled at R3 was identified as R31. LPN-A explained that staff will need to work with R31 to prevent further incidences of R31 yelling at R3 from occurring, however, a specific plan had not been implemented. R31's quarterly MDS, dated [DATE] identified a cognitive status of 15/15 with no behaviors noted. R31 admitted to the facility 4/20/20 with [DIAGNOSES REDACTED]. Observations were made on 9/2/20, from 9:49 a.m. to 10:10 a.m. R3 was up and dressed for the day, up and about in her room. R31 was observed sitting in the day room/living room area, using his cell phone. No altercations were observed between R31 and R3. On 9/3/20, at 9:57 a.m. R31 was again observed in the day room/ living room area, using his cell phone. R3 remained in her room. No altercations were observed between R31 and R3. Interview on 9/3/20, at 10:20 a.m. the administrator stated the verbal abuse did not get reported to her because she and the director of nursing (DON) came in late on Monday 8/31/20. The administrator identified that the incident needed to be reported to the State Agency and that the facility will need to begin their investigation to determine appropriate interventions. The Villa Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property policy dated 11/28/2017, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Section G of the policy directed the facility to ensure 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 involved abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and documentation, the facility failed to report timely an allegation of verbal abuse to the administrator and the State Agency (SA) for 1 of 5 residents (R3) reviewed for abuse allegations. Findings Include: The Villa Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property policy dated 11/28/2017, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Section G of the policy directed the facility to ensure 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 involved abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period. R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or suspected abuse, they were to remove R3 from the aggressor and relocate R3 to a safe area and staff was to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines. On 8/31/20, at 1:13 p.m. during an interview, R3 reported to the surveyor that, when she was going to the day room/living room area to sit, a tall gentleman cussed me out, he called me an F'in B. R3 explained that she reported the incident to a nurse the previous day and that the altercation had happened the week before. R 3 stated that she likes to sit in the living room/day room area and stated, I won't go down there if he's down there in that living room. R3 further stated I use to like to sit down there and explained that there used to be others, about five or six people at a time, sitting in the living room area but indicated not seeing anyone any more. R3's [DIAGNOSES REDACTED]. R3's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period. R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or suspected abuse, were to remove R3 from the aggressor and relocate R3 to a safe area and staff were to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines. A nurse's note dated 8/30/20, by licensed practical nurse (LPN)-A identified (R3) had reported that when she started to walk into the day room where another resident was present, the resident yelled at her (R3) to get out of his room and got up to approach her. Resident (R3) reported she turned around and returned to her room. On 9/1/20, at 8:46 a.m., during interview, LPN-A acknowledged that R3 told her of the incident on 8/30/20. On 9/3/20, at 10:20 a.m. the administrator stated the verbal abuse did not get reported to her because she and the director of nursing (DON) came in late on Monday, 8/31/20. The administrator then indicated they will have to report it to the State Agency (SA) and begin their investigation to determine appropriate interventions. The administrator acknowledged the allegation was reported late to the SA and that the facility planned on doing further education with staff about preventing and reporting abuse, despite that it had been conducted the previous month. On 9/3/20, at 11:05 a.m. the administrator stated reporting abuse to the State Agency is completed by either herself, the DON, social services or the charge nurse. The administrator also indicated that there is always a charge nurse on duty who can call the administrator to determine responsibilities about reporting abuse.
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** Based on observation, interview and document review the facility failed to provide assistance and encouragement with meals for 1 of 3 residents (R84) reviewed for nutrition. Findings include: R84's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R84 had severe cognitive impairment and required limited assistance of one person with eating. R84's care plan dated 8/11/20, identified R84 had actual activities of daily living (ADL) self-care performance deficit related to cognitive loss and [MEDICAL CONDITION]. The care plan directed staff to set up R84 with meals to eat, provide one assist to eat meals and strong encouragement for intake. On 8/31/20, at 4:55 p.m. R84's meal tray was delivered to her room and left on bedside table by nursing assistant (NA)-B. On 8/31/20, at 5:16 p.m. R84 was observed laying in bed with eyes closed. The bed was in a low position with the head of the bed elevated at 30 degrees. The meal tray remained on the bedside table untouched. On 8/31/20, at 5:20 p.m. NA-B was observed to pick up R84's uneaten meal tray from bedside table and placed the meal tray on the metal cart in the hallway where the finished trays were being collected after being taken out of the residents rooms. During an interview on 8/31/20, at 5:21 p.m. NA-B indicated R84 did not want to eat and she had removed the tray from the room. NA-B verified she had not offered R84 an alternate meal item from the menu and also she had not encouraged and/or offered assitance to R84 with eating prior to taking the food tray out of room, as directed by the care plan. On 8/31/20, at 5:28 p.m. registered nurse (RN)-A, also the unit nurse manager, stated R84 preferred minimal interaction however, indicated NA-B should have encouraged R84 to eat the meal or make an attempt to assist R84 prior to removing the tray. RN-A also stated staff were supposed to report to the nurse if R84 did not eat. RN-A verified NA-B did not report to the nurse that R84 had not eaten. On 9/3/20, at 2:00 p.m. the meal assistance policy was requested, but was not provided.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accommodate preferences for assistance with toileting, in accordance with the care plan, for 1 of 8 residents (R21) reviewed for activities of daily living (ADL). Findings include:

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) R21's admission Minimum Data Set ((MDS) dated [DATE], identified R21 had intact cognition, required extensive physical assistance of two staff with toilet assistance and was was occasionally incontinent of both bowel and bladder. R21's [DIAGNOSES REDACTED]. R21's care plan, dated 6/17/20, identified R21 had inability to do cares because of lower extremity difficulty. The care plan revised 9/2/20, indicated R21's preference to use the EZ Stand (a mechanical lift) to transfer to the commode for toileting. Also the care plan directed nurses to use the EZ Stand for all transfers when R21 used the commode. In addition, the care plan indicated R21 was Okay with a bedpan at night but still preferred to use the commode. During interview on 8/31/20, at 3:29 p.m. R21 expressed a preference to use the commode for toileting and with two staff needed to use the EZ Stand to transfer her to the commode. R21 stated when one person answered her call light, they had to leave to go get another person. R21 further stated I can't wait because I take [MEDICATION NAME], so I just use the bedpan. During observation on 9/1/20, at 2:47 p.m. nursing assistant (NA)-A and registered nurse (RN)-A nurse manager were observed use the EZ Stand to transfer R21 from the wheelchair to a commode. During the observation, it took both staff to put sling around R21 and to transfer R21 onto the commode. During interview on 9/2/20, at 9:46 a.m. NA-A stated R21 needed the EZ Stand for transferring from bed to toilet and it took two people to use the EZ Stand. NA-A then stated At night, there was only one NA on the unit and one nurse covered the 3 units on the floor. The nurse could sometimes help but if they were busy, a nursing assistant had to leave another unit to come assist. NA-A also stated R21 cannot hold her urine and if it took a long time to get a second person to assist, R21 would use a bedpan. NA-A also stated R21's preference was to use the EZ Stand to get on the commode and when R21 used the bedpan, it was difficult to get R21 off the bedpan without spilling urine. and they would have to clean R21 and change the bed linens because of the spilled urine. NA-A estimated she could get assistance to transfer R21 to the commode two out of five times during a shift. During interview on 9/2/20, at 11:38 a.m., RN-A stated R21 preferred to use the commode. RN-A explained being able to assist when available but otherwise two nursing assistants were needed to use the EZ stand to assist R21 on the commode. During interview on 9/2/20, at 2:02 p.m., RN-A acknowledged R21 preferred to use the commode versus a bedpan for her toileting needs.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce urinary incontinence or associated complications for 1 of 3 residents (R21) reviewed for bowel and bladder and who had repeated episodes of incontinence. Findings include: R21's admission Minimum Data Set (MDS), dated [DATE], identified R21 had intact cognition and required extensive assistance with toileting. Further, R21 was recorded as having occasional urinary incontinence (less than 7 episodes during the review period), however, had not been trailed on a toileting plan. R21's Nursing Evaluation - V4 assessment, dated 6/17/20, identified a section labeled, Section I: Bladder/Bowel/[MEDICAL TREATMENT], which identified R21 as being continent of bladder. Further, R21's care plan, revised 9/2/20, identified R21 had functional and stress incontinence. The care plan lacked evidence of R21's urinary incontinence, or subsequent interventions to reduce it, prior to 9/2/20. When interviewed on 9/2/20, at 9:46 a.m. nursing assistant (NA)-A stated R21 used a mechanical stand for toileting, however, if staff were not able to respond timely R21 would then be incontinent of urine. R21 was not on any scheduled toileting program to her knowledge, and NA-A verified R21 had sensation to feel the urge to void and could alert staff to it. On 9/2/20, at 10:15 a.m. R21 was seated in her wheelchair by the elevator, and had a noticeable urine odor on her. R21's POC (Point of Care) Response History, dated 8/20/20 to 9/2/20, identified R21 had a total of 14 episodes of urinary incontinence recorded. Further, R21's progress note(s), dated 8/30/20, identified R21 had been incontinent of urine and required a total bed change this shift X 2 on the overnight shift. R21's medical record was reviewed and lacked evidence R21 had been comprehensively assessed for her urinary incontinence despite multiple recorded episodes of incontinence which, at times, required total linen changes. Further, there was no evidence the facility had attempted or trialed a toileting program to reduce R21's incontinence. During interview on 9/2/20, at 11:38 a.m., registered nurse (RN)-A stated she was unaware if R21 had the sensation to void or not, and felt any incontinence could be a sign of urge incontinence. RN-A voiced urinary incontinence should be assessed upon admission and then quarterly thereafter. RN-A reviewed R21's medical record and verified her admission assessment (Nursing Evaluation - V4) identified R21 to be continent and added she was unaware R21 was having repeated episodes of urinary incontinence despite them being recorded in the medical record. RN-A reviewed R21's medical record and verified a comprehensive bladder assessment had never been completed for R21 and should have been adding the NA should have been reporting the incontinence to the nurses so it could be addressed. During interview on 9/2/20, at 2:02 p.m. assistant director of nursing/nurse manager (ADON) verified residents should be assessed for bladder incontinence upon admission through a three-day observation period. ADON also stated the care plan would then be updated to reflect the incontinence and subsequent interventions to reduce it. ADON reviewed R21's medical record and verified a comprehensive bladder assessment had not been completed for R21 since she was identified to have urinary incontinence and should have been. A policy on bladder assessment was requested, however, was not received on 9/3/20.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident's (R69) Bilevel Positive Airway Pressure ([MEDICAL CONDITION]) mask was properly cleaned related to respiratory care. Findings include: R69's [DIAGNOSES REDACTED]. R69's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R69 had intact cognition, and needed extensive assist of one to two staff with activities of daily living (ADL's). On 8/31/20, at 2:36 p.m. during an interview R69 stated she wore a [MEDICAL CONDITION] at night and that staff did not clean the [MEDICAL CONDITION] mask. R69 then stated since being re-admitted to the facility on [DATE], staff had not cleaned her [MEDICAL CONDITION]. During interview the [MEDICAL CONDITION] mask was observed having dried white crusted particles on the inside of the mask. On 9/2/20, at 10:24 a.m. R69's [MEDICAL CONDITION] mask was observed again to have spotty cloudy thick white particle build-up on the inside of the mask. On 9/2/20, at 12:25 p.m. during an interview with the director of nursing (DON) indicated that the [MEDICAL CONDITION] is supposed to be cleaned every day. After observation of the [MEDICAL CONDITION] mask, the DON indicated that the face area on [MEDICAL CONDITION] needs to be cleaned and that it needs to be cleaned every day. The August 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. In addition, R69's care plan did not indicate R69 used a [MEDICAL CONDITION]. A procedure manual for Resmed Airfit/Airtouch full face mask directed daily after each use the mask was to be disassembled, the frame, elbow and cushion was to be ran under water and cleaned with a soft brush until dirt is removed. In addition, the procedure directed staff to soak the components in warm water with a mild liquid detergent for up to 10 minutes, brushing the moving parts of the elbow and around the vent holes. Then leave the components to air dry.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and documentation the facility failed to ensure that a significant medication error did not occur for 1 of 2 resident (R592) observed to receive insulin from a [MEDICATION NAME]. Findings Include: R592's [DIAGNOSES REDACTED]. R592's admission Minimum Data Set ((MDS) dated [DATE], indicated R592 had severely impaired cognition. R592's care plan dated of 8/12/20, identified R592 had a nutritional problem or potential for nutritional problem due to diabetes and the care plan directed staff to administer medications as ordered. On 8/31/20, at 4:20 p.m. the surveyor intervened prior to registered nurse (RN)-A administering [MEDICATION NAME]via [MEDICATION NAME] to R592. When asked if she had primed the insulin pen, RN-A stated I was taught that when the pen is new, you do it. RN-A also stated no, we prime the pen when it's first new. When surveyor explained to RN-A when and why the [MEDICATION NAME] was primed, RN-A responded with oh ok but still proceeded to give insulin to R592 without priming it despite surveyor explanation. August Medication Administration Record [REDACTED]. From the dates of 8/18/20, through 8/31/20, of August's MAR, R592's blood sugars ranged from 101 to 360. On 9/2/20, at 8:41 a.m. RN-B stated during an insulin administration she primed every time a new needle is added to the [MEDICATION NAME]. RN-B further stated I heard I don't have too, but I do each time. During an interview on 9/3/20, at 11:01 a.m. the consultant pharmacist stated I always refer back to facility policy, but the standard is to prime with two units prior to administration, this ensures that the dose that is dialed is the dose that is administered. During an interview on 9/3/20, at 11:08 a.m. the director of nursing (DON) stated the expectation for

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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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) [MEDICATION NAME] was all insulin pens would be primed with two units prior to administration to ensure that there is no air in the system. The Insulin Administration policy/procedure revised 10/2010, was reviewed but lacked documentation on instructions on priming an insulin [MEDICATION NAME]. Instructions for use of [MEDICATION NAME] with a revision date of 11/2019, indicated step by step instructions on giving the airshot before each injection. The instructions indicated before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing the following steps were to be taken: E. Turn the dose selector to select two units. F. Hold the [MEDICATION NAME] with the needle point up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to ensure appropriate hand hygiene/gloving, donning of personal protective equipment (PPE), and cleaning equipment in a manner to prevent the potential spread of infection for 4 of 5 residents (R36, R35, R14, R58) reviewed for infection control. Findings include: R36 who resided on a unit for COVID exposure observation, was observed on 9/2/20, at 7:33 a.m. during morning cares. Nursing assistant (NA)-C was observed to enter R36's room, after applying a gown and gloves outside the room in the hallway. -At 7:38 a.m. as NA-C applied socks on R36's feet, R36 reported she was experiencing pain. NA then stated to R36 I can get the nurse for you. NA-C finished to apply the socks and as she stood by the bed registered nurse (RN)-D came into the room carrying a medication in a small cup with water as she approached R36. -At 7:40 a.m. as RN-D approached R36 who stated to RN-D she was experiencing pain to both her legs. RN-D gave the medication at hand and told R36 she was going to get the cream for her legs and would be right back. Before leaving the room the pain cream was noted to be on top of the counter by the sink.RN-D squeezed cream out of the bottle, approached R36's bed and applied the cream to both knees on the top and under the knees, per R36's request. RN-D's scrubs were observed to touch R36's legs and bedding. RN-D was not wearing a gown despite R36 being on droplet precautions due to Covid exposure. RN-D then removed her gloves, washed hands before she left R36's room and continued with the medication pass for other residents. -At 7:46 a.m. NA-C assisted R36 to sit on the edge of the bed and put her shoes on. As NA-C applied the shirt, R36 stated to NA-C she wanted Asper cream to be applied to her left arm. RN-D returned to the room, did not apply a gown, and again RN-D's scrubs were observed to touch R36 and the bedding as she applied the Asper cream to both of R36's arms. RN-D then removed gloves and washed hands before leaving the room. -At 7:50 a.m. NA-C cued R36 she was going to assist her to the commode using a mechanical machine. NA-C looked at the lift sheet for the machine and stated the one in the room was too big. NA-C then removed the PPE, washed hands, and left the room. -At 7:53 a.m. NA-C came back into R36's room and stated another staff was getting her the right size lift sheet to use to transfer R36. -At 7:57 a.m. NA-C applied the correct lift sheet to R36's torso then hooked it to the mechanical lift and then was observed to get R36 off the bed into a standing position using the mechanical lift and then sat R36 on the commode which was next to the bed. -At 8:04 a.m. NA-C cued R36 she was going to get her to a standing position as she brought her up. NA-C then was observed to provide front pericare then proceeded to do the pericare in the back. NA-C then with the same gloves adjusted R36's adult dignity pad and pants then went over and grabbed the wheelchair still with the same gloves and put it behind R36. NA-C then removed the right glove, lowered R36 into the wheelchair then removed the left glove. NA-C still without washing hands applied another pair of gloves and proceeded to clean the mechanical lift. When questioned, NA-C acknowledged she was supposed to remove gloves and wash hands before continuing with tasks. -At 8:12 a.m. NA-B entered R36's room and was observed to wheel the mechanical lift and lift sheet used for R36 to the hallway. NA-B proceeded to take the lift and the lift sheet out of Station 3 which was a quarantine unit, due to Covid exposure, and went down the Station 4 hallway. -R35, at 8:18 a.m., NA-B entered R35's room as NA-D pushed the mechanical lift with the lift sheet into the room and shut the door. -At 8:20 a.m. surveyor entered R35's room and did not see any other lift sheet except the one on top of the mechanical lift from R36's room. -At 8:27 surveyor re-entered R35's room to observe the transfer. When NA's were asked if residents were supposed to share lift sheets NA-B stated yes we do. we do clean it between residents which we did as she pointed to the garbage to show the wipes used. NA's then applied the lift sheet used for R36 around R35's torso and hooked R35 into the mechanical lift and and both NA's were observed to transfer R35 into the wheelchair. After transferring R35 to the wheelchair NA-B was observed to clean the mechanical lift and wiped down the cloth material lift sheet before taking it out of R35's room. On 9/2/20, at 9:09 a.m. registered nurse (RN)-A nurse manager stated each person should have their own sling sheet. Regarding hand hygiene RN-A stated staff was supposed to remove gloves, wash hands and put clean gloves on before they continued with cares when staff went from dirty to clean and after pericare. Also RN-A stated If staff was doing direct care they are to apply gloves and gown and remove when leaving room in Station 3, which was quarantine unit. On 9/3/20, at 1:27 p.m. the director of nursing (DON) stated staff was supposed to perform hand hygiene before and after providing cares. Also staff was to wash hands prior and after they removed gloves. The DON further stated staff was supposed to wear a gown and gloves when they provided direct care for a resident in the quarantine unit Station 3. R14, on 9/2/20, at 7:08 a.m. nursing assistant (NA)-A was observed to apply a gown in the hallway with the opening towards the front as she stood outside R14's room who was on quarantine due to a recent COVID exposure. As NA-A entered R14's room the gown was observed to be partially open in the front as she approached R14 to transfer her from bed to the wheelchair. During the observation, NA-A scrubs were touching R14's clothing. During an interview on 9/2/20, at 7:12 a.m. NA-A stated she had been provided education on donning and doffing protective personal equipment months prior and indicated the gown was applied properly. R58, on 9/2/20, at 7:46 a.m. NA-A again was observed apply a gown in the hallway with the opening towards the front and gown was partially opened as NA-A entered R58's room who was on quarantine due to a recent Covid exposure. NA-A then was observed to approach R58 to assist with getting dressed for the day. During the observation, NA-A scrubs were observed to touch R58's body and then clothing after R58 was dressed. During an interview on 9/2/20, at 8:03 a.m. NA-A indicated the PPE gown was put on backwards with the opening toward the front since there was not any available staff to help tie the gown and she did not want to remove gown to find another staff member to help to tie it. NA-A acknowledged her scrubs were exposed as she assisted R58 and R14's while providing direct contact care. NA-A verified the proper donning of the PPE gown was to don the gown with the opening to the back and tied it to prevent her scrubs being exposed. During an interview on 9/2/20, at 8:35 a.m. registered nurse (RN)-A indicated R58, R14 and the entire Station 3 was on droplet precautions due to an exposure from a positive Covid staff. RN-A stated the proper way to don a PPE gown was to have the opening to the back and was supposed to be tied to ensure clothing was fully covered. RN-A also stated the staff had been educated several months ago regarding donning and doffing of PPE and there were signs posted by every room on how to don and doff PPE for reminders. During interview on 9/3/20, at 9:09 a.m. the DON indicated the proper way to don a PPE gown was with the opening toward the back and was to be tied to not expose clothing. The DON also stated staff was supposed to properly apply PPE to prevent the spread of infection. The DON further stated the facility used the Centers for Disease Control (CDC) guidelines for donning and doffing of PPE.