Electronically Delivered

November 26, 2024

Licensee
The Waters Of Plymouth
11305 Highway 55
Plymouth, MN 55441

RE: Project Number(s) SL29556017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

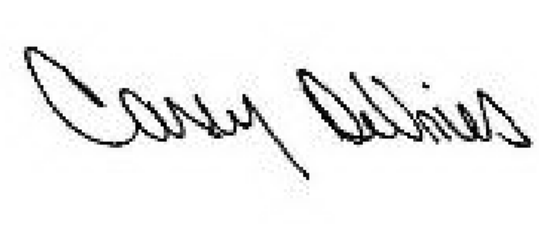
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29556	A. BUILDING: _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF PLYMOUTH	11305 HIGHWAY 55 PLYMOUTH, MN 55441

(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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29556017-0 On October 14, 2024, through October 18, 2024, the Minnesota Department of Health conducted a change of ownership survey at the above provider. At the time of the survey, there were 91 residents; 46 receiving services under the Assisted Living with Dementia Care license. As a result of the survey, the following orders were issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 1 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to implement and provide all services required by the current service plan for one of four residents (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01640		

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01640	Continued From page 2 R11's diagnoses included Alzheimer's disease, mild intermittent asthma, and metabolic encephalopathy. R11's Service Agreement/ Service Plan, dated April 1, 2024, indicated R11 received medication management, assistance with dressing, grooming, transferring with mechanical lift, showering, bathroom assistance, laundry, and safety checks. On October 15, 2024, at 9:13 a.m., the surveyor observed R11 sitting in their Broda chair (specialized wheelchair) at the table receiving assistance with breakfast in the first-floor secured unit dining room. On October 15, 2024, at 12:55 p.m., the surveyor observed R11 sitting in their Broda chair at the dining room table after lunch. On October 15, 2024, at 1:14 p.m., the surveyor observed unlicensed personnel (ULP)-O and ULP-P assist R11 to bed using a mechanical lift. When R11 was in their bed, the ULPs stood on each side of their bed, changed R11's wet disposable brief, cleaned R11's skin where the brief had been using premoistened disposable wipes. The ULPs positioned R11 in their bed with pillows and covered them with a blanket. The ULPs left R11's room at 1:32 p.m. ULP-O stated R11 would receive incontinence care if needed and would get up sometime before dinner. On October 15, 2024, at 1:30 p.m., ULP-O stated R11 got up in the morning before ULP-O and ULP-P started working at 7:00 a.m. ULP-O stated they thought the night shift got R11 up at around 5:00 a.m., every day. ULP-O stated R11's daily	01640		

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01640	Continued From page 3 routine was to watch television in their room or the dayroom until breakfast, eat breakfast in the dining room, then watch television or be included in an activity after breakfast, have lunch in the dining room, and then lay down until dinner time. ULP-O stated the ULPs do not check, change (R11's brief), or lay R11 down during the morning shift until after lunch. ULP-O verified R11 had been up in their Broda chair since before they arrived at 7:00 a.m., until the surveyor observed the ULPs putting R11 in their bed at 1:14 p.m. R11's Service Received record, dated October 13 to October 16, 2024, indicated ULP-O signed off on completing bathroom assistance for R11 at 8:00 a.m., 10:00 a.m., 12:00 p.m., and 2:00 p.m., on October 15, 2024. The Service Received document had a column for notes and another for reason services were cancelled. No notes or documentation about cancelled services were present for October 15, 2024. R11's Clinical Assessment, dated August 27, 2024, indicated R11 required assistance of a mechanical lift and was transferred an average of six times per day. R11 awakened at 5:00 a.m., and their usual bedtime was 8:00 p.m. The assessment indicated R11 was incontinent of bowel and bladder, was checked for incontinence, and changed when laying in their bed. The frequency of checking for incontinence was every two to three hours totaling ten to twelve times per day. R11's Service Agreement/ Service Plan, dated April 1, 2024, indicated R11 received "bathroom assistance" four times daily on the day shift, four times daily on the evening shift, one time daily on the overnight shift, and that they were turned and repositioned every two hours when in bed.	01640		

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01640	Continued From page 4 On October 16, 2024, at 5:00 p.m., CNS-A stated their expectation was that staff assisted R11 to lay down after breakfast to check for incontinence every day and that R11 was checked and changed at least every two hours. The licensee's Resident Service Plans policy, revised July 13, 2021, indicated licensee would "meet all regulatory requirements for service plan development and modification as well as design and implement service plans that identify and fulfill the varying physiological, psychosocial, health-related, environmental, and other individual needs, goals, or preferences of the resident." The policy indicated the (registered nurse) RN would conduct an assessment and develop the service plan based on identified needs and resident preference. The RN entered the service plan into the resident record and communicated availability of the plan to team members to provide services as stated on the plan. The service plan was reviewed and modified based on resident condition change and at the time of resident reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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01750	Continued From page 5 and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had instructed the unlicensed personnel (ULP) in the proper methods to administer medications and verified the ULP had demonstrated the ability to competently follow the procedures for ULPs who administered topical medications for two of five employees (ULP-L, ULP-O). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-L ULP-L had a hire date of June 11, 2024, ULP-L provided direct services to residents. On October 15, 2024, at 9:43 a.m., licensed practical nurse (LPN)-K was at the medication cart when ULP-L and ULP-M walked past the desk. The ULPs asked LPN-K if the found the	01750		

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01750	Continued From page 6 powder they left at the desk while LPN-K was in a room with a resident. They pointed to a prescription powder bottle set on the desk. The bottle was R1's Klayesta (mycostatin) topical powder 100,000 units per gram. LPN-K stated the ULPs had gotten the powder from them before they assisted R1 to get cleaned up, dressed, and up in their chair. LPN-K stated the ULPs applied the topical powder during cares and returned the powder to them when they had finished using it. On October 15, 2024, at 10:00 a.m., LPN-K stated the ULPs also administered topical medications for R12 and R13. LPN-K stated they had already gotten R13's Eucerin cream, applied it, and returned the bottle to LPN-K on that day, but they still needed to apply R12's topical medication. On October 15, 2024, at 10:18 a.m., LPN-K found ULP-M seated in a dayroom at the end of the hallway. ULP-M stated ULP-L had just gone for break and when they returned the ULPs would assist R12 with cares and be able to apply R12's topicals. LPN-K stated, "okay, just come and get his creams when you need them". ULP-M responded, "did you leave them on the desk?". LPN-K looked at the surveyor then back at ULP-M and stated, "no, ask me for them and I will get them for you". On October 15, 2024, at 10:35 a.m., the surveyor entered R12's room with ULP-L and ULP-M. ULP-M left the room to get the mechanical lift from another resident's room. At 10:53 a.m., ULP-M returned to the room with the mechanical lift and a prescription lotion bottle they stated they got from LPN-K. ULP-M stated there was only one topical because LPN-K had told them R12 was out of nystatin, and it needed to be ordered	01750		

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01750	Continued From page 7 from the pharmacy. After providing an incontinence brief change and peri care, ULP-L applied the topical they had gotten from LPN-K to R12's buttocks. The topical bottle's manufacturer label indicated it was anti-itch original formula lotion. The prescription label on the bottle indicated it was R12's prescription anti-itch lotion in place of Sarna lotion to be applied topically to body rash twice daily. The ULPs finished getting R12 dressed and up into the chair. ULP-M left the room with the prescription lotion bottle and stated they were going to return it to LPN-K. On October 15, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated ULP-L had not received medication training and had not been competency tested on medication administration via any route. On October 15, 2024, at 1:41 p.m., ULP-L stated their training consisted of computer modules, classroom education, and time spent shadowing other employees on the floor with residents. ULP-L stated they spent seven days in classroom training. When asked how they learned how to pass medications, ULP-L stated they did not administer medications. The surveyor asked about the topical medication they observed ULP-L administer and other topicals they had heard about. ULP-L stated they did administer topical medications and were trained by one of the medication passers but did not remember specifically who trained them. ULP-L stated the topicals were easy because they just read the label and did whatever it indicated on the label. ULP-O ULP-O had a hire date of August 27, 2024, ULP-O provided direct services to residents.	01750		

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01750	Continued From page 8 On October 15, 2024, at 1:22 p.m., the surveyor asked ULP-O if they helped the medication passer with topical medication application for any residents. ULP-O stated they did get any topicals the residents had from the medication passer, apply them during cares, and return the topical to the medication passer. On October 16, 2024, at 5:00 p.m., CNS-A verified ULP-L, ULP-M, and ULP-O had not been trained or received competency evaluations on medication administration via any route including administration of topical medications. CNS-A stated the medication passer should be administering all medications including the topicals and other ULPs should not be administering any medications. The licensee's Delegated Nursing Services, Treatments, or Therapy Tasks and Supervision policy, revised July 26, 2021, indicated the RN would delegate tasks to staff that were competent and possessed the knowledge and skills consistent with the complexity of the tasks being delegated. ULPs received training in proper methods of performing delegated tasks, demonstrated competency of training, and received supervision within thirty days of starting to perform the delegated tasks. In addition, the ULP received periodic supervision "to verify that the work was being performed safely and competently and to identify problems and solutions to address issues relating to the team member's ability to provide the services". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 9	01760		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation for medication administration included the signature and title of the person who administered medications for three of five residents (R1, R13, R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01760		

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01760	Continued From page 10 R1 R1's diagnoses included type II Diabetes, lymphedema, Alzheimer's disease, hypertension, and hypothyroidism. R1's Service Agreement/ Service Plan, dated April 1, 2024, indicated R1 received medication management, assistance with dressing, grooming, transferring with mechanical lift, showering, laundry, and safety checks. On October 15, 2024, at 9:43 a.m., the surveyor observed licensed practical nurse (LPN)-K was at the medication cart when unlicensed personnel (ULP)-L and ULP-M walked past the desk. The ULPs asked LPN-K if the found the powder they left at the desk while LPN-K was in a room with a resident. They pointed to a prescription powder bottle set on the desk. The bottle was R1's Klayesta (mycostatin) topical powder 100,000 units per gram. LPN-K stated the ULPs had gotten the powder from them before they assisted R1 to get cleaned up, dressed, and up in their chair. LPN-K stated the ULPs applied the topical powder during cares and returned the powder to them when they had finished using it. R1's Medication Administration Record (MAR), dated October 2024, indicated mycostatin powder 100,000 units per gram was administered twice daily at 8:00 a.m., and 8:00 p.m., to the affected areas of pink skin folds. On October 15, 2024, LPN-K's initials on the MAR for the 8:00 a.m., dose indicated LPN-K documented they were the one that administered the mycostatin powder. On October 15, 2024, at 10:00 a.m., LPN-K stated the ULPs also administered topical medications for R12 and R13. LPN-K stated they had already gotten R13's Eucerin cream, applied	01760		

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(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) COMPLETE DATE
01760	Continued From page 11 it, and returned the bottle to LPN-K on that day, but they still needed to apply R12's topical medication. R13 R13's diagnoses included Type II Diabetes, chronic kidney disease, hypertension, and depression with anxiety. R13's Service Agreement/ Service Plan, dated March 22, 2024, indicated R13 received medication management, assistance with dressing, grooming, bathing, transfers, toileting, and bed mobility. R13's MAR, dated October 2024, indicated Eucerin cream was applied topically to lower extremities twice daily at 8:00 a.m., and 7:00 p.m. On October 15, 2024, LPN-K's initials on the MAR for the 8:00 a.m., dose indicated LPN-K documented they were the one that administered the Eucerin cream to R13. On October 15, 2024, at 10:18 a.m., the surveyor observed LPN-K approach ULP-M who was seated in a dayroom at the end of the hallway. ULP-M stated ULP-L had just gone for break and when they returned the ULPs would assist R12 with cares and be able to apply R12's topicals. LPN-K stated, "okay, just come and get his creams when you need them". ULP-M responded, "did you leave them on the desk?". LPN-K looked at the surveyor then back at ULP-M and stated, "no, ask me for them and I will get them for you". R12 R12's diagnoses included chronic diastolic congestive heart failure, hypertension, chronic kidney disease, and depression.	01760		

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	29556	A. BUILDING: _____ B. WING _____	10/18/2024

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01760	Continued From page 12 R12's Service Agreement/ Service Plan, dated April 1, 2024, indicated R12 received medication management, assistance with dressing, grooming, transferring, and laundry. On October 15, 2024, at 10:35 a.m., the surveyor entered R12's room with ULP-L and ULP-M. ULP-L brought the wheelchair out of the bathroom. ULP-M left the room to get the mechanical lift from R13's room. At 10:53 a.m., ULP-M returned to the room with the mechanical lift and a prescription lotion bottle they stated they got from LPN-K. ULP-M stated there was only one topical because LPN-K had told them R12 was out of nystatin, and it needed to be ordered from the pharmacy. After providing an incontinence brief change and peri care, ULP-L applied the topical they had gotten from LPN-K to R12's buttocks. The topical bottle's manufacturer label indicated it was anti-itch original formula lotion. The prescription label on the bottle indicated it was R12's prescription anti-itch lotion in place of Sarna lotion to be applied topically to body rash twice daily. The ULPs finished getting R12 dressed and up into the chair. ULP-M left the room with the prescription lotion bottle and stated they were going to return it to LPN-K. R12's MAR, dated October 2024, indicated anti-itch lotion 0.5% (Sarna Lotion) was applied topically to R12's body rash twice daily at 10:00 a.m., and 8:00 p.m. On October 15, 2024, LPN-K's initials on the MAR for the 10:00 a.m., dose indicated LPN-K documented they were the one that administered the anti-itch lotion. On October 15, 2024, at 12:30 p.m., CNS-A stated their expectation was that the ULP or LPN assigned as the medication passer was the one	01760		

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01760	Continued From page 13 who applied all of the topical medications and documented administration immediately after application. CNS-A stated it was okay for them to administer the topicals separately from the resident's other medication pass but documentation for the medication administered needed to be completed when it was administered. The licensee's Medication Administration-Documentation policy, dated July 8, 2014 (last revised November 18, 2015), indicated each employee who administered medications was responsible to ensure accurate and complete documentation of medication administration. Documentation of medication administration would be completed by the person who performed the task immediately after the medication administration was performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a	02410		

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02410	Continued From page 14 staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the resident's rights were respected when staff failed to provide privacy while providing confidential treatment and assisting with activities of personal hygiene. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Unlicensed personnel (ULP)-J ULP-J had a hire date of March 30, 2022, ULP-J provided direct services to residents. On October 14, 2024, at 3:18 p.m., the surveyor observed the medication cart to be in an open	02410		

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02410	Continued From page 15 room where two hallways of resident rooms intersected. On one side of the intersection there was a small dayroom and the other side there was a large nurse's station type desk. The medication cart was behind the desk. ULP-J went to get R7 from their room and stated they planned to bring them to the medication cart. At 3:20 p.m., ULP-J came back to the cart walking with R8 instead of R7. ULP-J directed R8 to sit down in a chair in the dayroom. ULP-J prepared and administered eye drops for R8 while R8 was sitting in the dayroom. No other residents were sitting in the dayroom, but other employees and residents were walking past in the hallway. At 3:30 p.m., R7 propelled their wheelchair from the hallway to the dayroom. ULP-J directed R7 to wheel themselves toward the desk. ULP-J prepared and administered famotidine 20 milligrams by mouth to R7. R7 started to back their wheelchair away from the desk, ULP-J asked them to stay so they could check their blood glucose level. During the time ULP-J was working with R7 to test their blood glucose level, R8 had gotten up from their chair in the dayroom and walked up to the desk. R8 was looking over the desk and over R7's back to see what was going on and asking the surveyor for help to find a jacket R8 was looking for. R8 told the surveyor they needed to check and make sure their "friend" R7 was okay. On October 16, 2024, at 5:00 p.m., clinical nurse supervisor (CNS)-A stated blood glucose testing should be completed in resident's apartments to ensure privacy. Registered nurse (RN)-N RN-N had a hire date of April 1, 2024, RN-N provided oversite to unlicensed personnel and	02410		

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02410	Continued From page 16 direct services to residents. On October 15, 2024, at 12:58 p.m., the surveyor observed R9 sitting in their wheelchair in the dining room of the first-floor secured unit with three other residents and RN-N at their table. There were two residents at the table next to them. RN-N asked R9 what they were picking at on their finger. R9 stated they had a hangnail. RN-N stated they would fix that for them. RN-N washed their hands, left the dining room toward the nurse's office door, and returned with a nail care kit. At 1:00 p.m., RN-N sat down next to R9 at the table, put gloves on, opened the nail care kit, clipped, and filed the hangnail on R9's finger. The five other residents were still present in the dining room. On October 15, 2024, at 4:30 p.m., CNS-A stated they would expect the employee to bring the resident to their room to complete the task in privacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		