Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Missouri Veterans Home – Cameron

Location: 1111 Euclid, Cameron, MO 64429

Onsite / Virtual: Onsite

Dates of Survey: 5/7/24 - 5/10/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 125

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from May 7, 2024 through May 10, 2024, at Missouri State Veterans Home – Cameron. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (e) (1) – (3) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when—	Based on observations, interviews, and record review, the facility failed to protect residents' right to personal privacy of medical treatment by communicating personal health information via a radio system in common and public areas for one (1) resident observed during the dining process from a total of 20 residents sampled (Resident #19). The findings include: On 5/8/24, the facility was asked for a policy and/or procedure governing the processes for ensuring the privacy of residents' protected health information. Administrative Nurse A explained that the facility did not have a policy for its radio system. The facility did produce a copy of its policy for the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The policy defined protected health information as "any individually identifiable health information." A review of Resident #19's medical record revealed an initial admission date of [DATE]. Resident #19's medical history included Type 2 Diabetes Mellitus.

(i) The resident is transferred to another health care institution; or (ii) Record release is required by law. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	A review of Resident #19's Physician Orders revealed an order, dated [DATE], for Insulin Aspart 10 units to be injected subcutaneously before meals for a diagnosis of Diabetes. A review of Resident #19's Care Plan revealed a problem area which indicated Resident #19 was a diabetic, required blood sugar monitoring, and received insulin. On 5/8/24, at 12:00 p.m., an observation of the lunch meal was conducted in the [LOCATION]. There were nine (9) residents sitting at dining tables in the immediate area. During the observation, Certified Nurse Aide A was wearing a portable radio. A conversation regarding Resident #19's protected health information was overhead on the radio in the [LOCATION]. An employee identified Resident #19 over the radio by using their room number and asked Certified Nurse Aide A how much lunch Resident #19 had eaten, and stated, "[Their] blood sugar was 125 and [they are] supposed to get 10 units of insulin." Certified Nurse Aide A responded via the radio to state, "[They] ate 75%." On 5/9/24, at 10:00 a.m., an interview was conducted with Administrative Nurse A regarding the facility's practices for ensuring resident privacy of protected health information. Administrative Nurse A explained that radio traffic should be kept to a bare minimum, and confirmed that protected health information should not be communicated via radio and should only be communicated in person or over the phone.
§ 51.70 (f) (1) – (2) Grievances. A resident has the right to— (1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observations, interviews, record review, and policy review, the facility failed to have an effective grievance process that allowed residents to voice concerns, without discrimination or reprisal, related to treatment received and not received, and failed to provide a prompt effort to resolve grievances (Resident #1 and Resident #28). The findings include: Review of the facility's Employee Policies Handbook policy titled, "h. Veteran Grievance/Complaints," dated 1/5/24, revealed: "1) [Administrative Staff A] shall ensure that Veteran rights are respected and assure that all informal methods of addressing problems or concerns relating to any aspect of Veteran care are exhausted in a timely and efficient manner…3) [Consultant Staff A] or their designee is responsible for receiving, processing and tracking all Veteran grievances." Review of the Veterans Association (Resident Council) Meeting Minutes, dated [DATE], revealed: "Resident Rights & [and] Responsibilities" were discussed by a resident. The text written

	was: "You have the right to exercise your rights as a resident and citizen of the United States without interference, coercion, discrimination, or reprisal." Resident Rights number seven (7) revealed that residents were to: "Seek out and use appropriate channels (e.g., Veterans Council, Care Plan Meeting, and Grievance Procedures) for recommending changes, pursuing problems, or resolving concerns," and Veterans were: "advised to contact appropriate leadership for issues/concerns." Review of Resident #28's medical record revealed the resident was admitted on [DATE], with a diagnosis of Multiple Sclerosis with Quadriplegia. The most recent Brief Interview for Mental Status, dated [DATE], revealed a score of 15, which indicated the resident was cognitively intact. Review of Resident #28's Plan of Care, updated [DATE], revealed the resident was involved in activities to enhance their physical, mental, social, and spiritual well-being. In an interview with Resident #1, on 5/8/24, at 1:15 p.m., they stated: "We are told to voice our grievances in Veterans Council. The [consultant staff] member is our mediator." An interview with Resident #28, on 5/9/24, at 1:47 p.m., revealed they had never filed a grievance with the facility. They stated no form of education of the grievance process had been provided to them. They stated there had been several times in the last seven (7) years where they would have filed a grievance had they been aware of a grievance process. The resident stated they felt that they were not welcome in the facility, and that some of the staff had told the residents not to report anything to the Administrative staff, but to contact the line staff by way of social media through instant messaging. They identified there had been a time when the activities staff told them reporting anything to the Administration would get them fired. They stated that residents fear if they report anything to the Administration, they would "kick me out of the facility." They stated the residents were told to follow the chain of command, related to management on each unit, or take any concerns to Resident Council and not to Administration. Resident #28 confirmed that, through conversations with other residents, they were afraid of reprisal if they reported anything to the Administration. An interview, on 5/9/24, at 2:30 p.m., with Consultant Staff B revealed they were not aware of any grievances voiced in Resident Council. They stated they attended the Resident Council meetings monthly. A joint interview, on 5/10/24, at 9:48 a.m., with Consultant Staff C and Administrative Staff A revealed they were not

	knowledgeable about the grievance process, and would have to check on it. Consultant Staff C stated they aware that Consultant Staff informed residents to voice their concerns to the Resident Council, to not file a grievance, and to utilize Consultant Staff B's personal social media to communicate their concerns, and Consultant Staff B would take care of the problem. Consultant Staff C and Administrative Staff A stated they were not aware of any ongoing education provided to the residents related to the grievance process. Administrative Staff A stated they knew residents were provided paperwork regarding grievances upon admission to the facility. They stated there was a sign on each unit that informed the residents to contact Consultant Staff D if they had grievances. They stated the facility had not received any grievances in the past two (2) years.
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and review of facility policy, the facility failed to ensure the dignity of one (1) of 20 sampled residents (Resident #21) for privacy, and four (4) of eight (8) residents observed for dining. The findings include: Review of the facility's employee handbook policy titled, "Surveillance of Veterans," dated January 5, 2024, revealed: "MVC employees are to respect the Veterans rights, to afford privacy in treatment and in caring for personal needs; to close room doors and knock before entering the room, except in the case of an emergency or unless medically contraindicated." Administrative Nurse A was unable to provide a facility policy to review procedures to follow for staff who assisted residents with dining. On 5/8/24, at 12:00 p.m., an observation of the lunch meal was conducted in the [LOCATION]. Resident #21 was observed sitting at a dining table with two (2) other residents. During a lunch observation, on 5/8/24, at 12:11 p.m., eight (8) residents were in the [LOCATION] of the [LOCATION]. Three (3) staff members, Certified Nurse Aide B, Certified Nurse Aide A, Certified Nurse Aide C, were standing while assisting four (4) of the residents with their meals. On 5/8/24, at approximately 12:30 p.m., Licensed Nurse A entered the [LOCATION] and loudly exclaimed to Resident #21: "I'm here to check your noggin!" Licensed Nurse A then proceeded to assess a small, bleeding area to Resident #21's forehead.

	An observation was made, on 5/8/24, at 1:32 p.m., during an interview with Resident #21, in their bedroom. During the interview, an unidentified staff member opened the door without knocking and stated they were doing a check, then quickly closed the door. Resident #21 then said, "See that happens, but it is better." This surveyor noted that this resident had a sign on their door that stated: "Please knock before entering and announce yourself. Please respect my privacy." Resident #21 noted that the idea for the sign came from a consultant staff member, and the sign had been in place for about a year. During an interview with Administrative Nurse A, on 5/9/24, at 9:50 a.m., they confirmed that wound assessments and care that were not emergencies should be carried out in a private area, and that Licensed Nurse A's statement to Resident #21 was inappropriate. An interview was conducted with Administrative Staff A, Administrative Nurse B, and Administrative Nurse A on 5/9/24, at 3:45 p.m. The staff was informed of the observations at dining and the lack of privacy provided. Staff nodded in agreement.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to revise the Plan of Care to reflect behaviors of removing oxygen for one (1) of one (1) resident reviewed for respiratory care from a total of 20 residents sampled (Resident #11). The findings include: A review of Resident #11's medical record revealed an admission date of [DATE]. Resident #11's medical history included Parkinson's Disease and Pneumonia. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], identified that Resident #11 was receiving oxygen therapy. On 5/7/24, at 10:40 a.m., an initial tour of the [LOCATION] was conducted. Resident #11 was observed sitting in their wheelchair in the [LOCATION] of the neighborhood. A portable oxygen cylinder was attached to the back of the resident's wheelchair. A nasal cannula was attached to the oxygen cylinder, but the resident was not wearing it. On 5/7/24, at 2:50 p.m., Resident #11 was observed attending a bingo activity in the [LOCATION]. A portable oxygen cylinder was attached to the back of the resident's wheelchair. A nasal cannula was attached to the oxygen cylinder, but the resident was not wearing it.

	A review of Resident #11's Physician Orders revealed an order for routine oxygen at 2-4 liters per minute to maintain Resident #11's oxygen saturation above 90%. A review of Resident #11's Care Plan revealed a focus area for oxygen. The problem statement read: "I require use of continuous oxygen." Continued review of Resident #11's Care Plan revealed no focus areas for noncompliance related to their oxygen therapy. On 5/7/24, at 2:55 p.m., an interview was conducted with Certified Medication Aide A, who confirmed that Resident #11 was supposed to be wearing oxygen continuously. When asked whether Resident #11 had any behaviors, such as removing their oxygen cannula, Certified Medication Aide A stated, "Not that I can think of." On 5/9/24, at 9:50 a.m., an interview was conducted with Administrative Nurse A regarding Resident #11's order for oxygen. Administrative Nurse A confirmed Resident #11's current order for routine oxygen at 2-4 liters per minute. Administrative Nurse A added that Resident #11 "refuse[d] to wear oxygen sometimes." Administrative Nurse A then acknowledged that Resident #11's Plan of Care had not been revised to reflect that alleged behavior.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, clinical record review, and review of facility policy, the facility failed to ensure that residents received wound care in a manner that met professional standards of quality for three (3) of three (3) residents observed for wound care (Resident # 3, Resident #12, and Resident #20). The findings include: Review of the facility's policy titled, "Dressing Changes," dated 1/5/24, revealed: "To clean, cover, and protect the wound from the external environment, while reducing pain, decreasing the risk for infection, optimizing the healing process…15. Date and initial new dressing." 1. Review of Resident #3's clinical record revealed the resident was admitted into the facility on [DATE], with diagnoses of Chronic Atrial Fibrillation, Heart Failure, Hypertension, Peripheral Vascular Disease, Malignant Neoplasm, and Mild Cognitive Impairment. Review of Resident #3's Care Plan, dated [DATE], revealed that the resident had a history of a left ankle wound and a history of abrasions to the lower legs from a fall. The goal for this issue

	was for Resident #3 to have no skin issues over the next 90 days. Review of the facility's weekly skin meeting minutes, dated [DATE], for wound rounds completed on [DATE], revealed Resident #3 was seen by the Wound Care Plus Wound Team, and they examined the right lower leg with an open blister, known as an arterial ulcer. The treatment ordered for Resident #3 stated: "cleanse area with anti-microbial wound cleanser, apply Fibracol, cut to fit to wound cover with bordered gauze dressing and change daily" [sic]. An observation during wound care for Resident #3, on 5/8/24, at 10:18 a.m., revealed an old dressing was removed from the right lower leg. The dressing did not have a date, or initials, to indicate when it was originally placed and by whom. A review of Resident #12's medical record revealed an admission date of [DATE]. Resident #12's medical history included Malignant Neoplasm of Skin. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #12 required extensive to total assistance with Activities of Daily Living (ADLs). A review of Resident #12's Physician Orders revealed a treatment order, dated [DATE], for a malignant lesion to their right ear. On 5/7/24, at 10:40 a.m., an initial tour of the [LOCATION] was conducted. Resident #12 was observed sitting in their wheelchair in one (1) of the neighborhood's common areas. A dressing was noted to Resident #12's right ear. The dressing was undated. 2. Review of Resident #20's clinical record revealed the resident was admitted into the facility on [DATE], with diagnoses of Vascular Dementia, Heart Failure, Hypertension, Chronic Atrial Fibrillation, Peripheral Vascular Disease, Acquired absence of Right Leg Above the Knee. Review of Resident #20's Care Plan, dated [DATE], revealed that the resident had a history of arterial ulcers to the ankle, left top foot, and left second toe. The goal was to provide the resident with no skin issues for the next 90 days. Review of the facility's weekly skin meeting minutes noted that Resident #20 was seen on [DATE], and their left great toe wound was examined, which was diagnosed as an arterial ulcer. The treatment ordered for Resident #20 stated: "to cleanse area with antimicrobial cleanser, apply marathon skin prep to peri wound once a week on Thursday after bath, apply Santyl

	ointment nickel thick to wound bed, skin prep to peri wound cover with bordered gauze dressing, change daily and prn [as needed]." An observation during wound care for Resident #20, on 5/8/24, at 10:30 a.m., revealed that the resident had no secured dressing over their left great toe or their left second toe, only gauze placed in between the toes. The gauze had no date or initials to indicate when it was originally placed and by whom. In an interview with Licensed Nurse B on 5/8/24, at 10:32 a.m., when asked if the old dressing for Resident #3 and Resident #20 should be initialed and dated, they stated, "You are right, it should be."
§ 51.120 Quality of care. Each resident must receive, and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record review, the facility failed to establish an effective communication process between the nursing home and the dialysis facility by: 1) Failing to ensure dialysis communication forms were completed and reviewed, and 2) Failing to ensure orders from the dialysis center were transcribed to the resident's Physician Orders for one (1) of one (1) residents reviewed for dialysis from a total of 20 residents sampled (Resident #13). The findings include: According to Drugs.com (https://www.drugs.com/cg/fluid-restriction.html): "A fluid restriction means that you need to limit the amount of liquid you have each day. Fluid restriction is needed if your body is holding water. This is called fluid retention. Fluid retention can cause health problems, such as tissue and blood vessel damage, long-term swelling, and stress on the heart." A review of Resident #13's medical record revealed an admission date of [DATE]. Resident #13's medical history included End Stage Renal Disease, for which they received dialysis services. The facility utilized paper "Dialysis Communication Forms" for communication of health information between the nursing facility and the dialysis center. Review of a Dialysis Communication Form, dated [DATE], revealed no vital signs, pain assessment, or dialysis access assessment upon return to the facility. Additionally, a handwritten order was noted on the side of the form which directed facility staff to place Resident #13 on a 32-ounce fluid restriction.

	A review of Resident 13's facility Physician Orders revealed no order for a fluid restriction. A review of Resident #13's Care Plan revealed that there were no interventions for fluid restriction. A review of Resident #13's nursing progress notes revealed no entries regarding the initiation of a fluid restriction. On 5/9/24, at 1:40 p.m., an interview was conducted with Licensed Nurse C regarding Resident #13's dialysis services. Regarding the dialysis communication forms, Licensed Nurse C stated they were not aware of the order to place Resident #13 on a fluid restriction. Licensed Nurse C explained that the staff nurse was responsible for receiving the dialysis communication forms upon the resident's return, completing the bottom of the form, noting and transcribing any new orders, and filing the form for medical records to upload into the system. Licensed Nurse C added, "I don't usually look at them because they are handled by the nurse." When asked to review the [DATE] dialysis communication form, Licensed Nurse C reviewed the form and stated, "Oh, there it is. Please put the patient on a 32-ounce fluid restriction." Licensed Nurse C then reviewed the dialysis communication form dated [DATE], and acknowledged that the form had not been completed by the dialysis center. Licensed Nurse C explained that if the forms were sent back to the facility without being completed by the dialysis center, the nurse was responsible for calling to obtain the information and stated, "it doesn't look like that was done in this case."
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to administer oxygen therapy in accordance with Physician Orders and the Plan of Care for one (1) of one (1) resident reviewed for respiratory care from a total of 20 residents sampled (Resident #11). The findings include: A review of Resident #11's medical record revealed an admission date of [DATE]. Resident #11's medical history included Parkinson's Disease and Pneumonia. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], identified that Resident #11 was receiving oxygen therapy. On 5/7/24, at 10:40 a.m., an initial tour of the [LOCATION] was conducted. Resident #11 was observed sitting in their wheelchair in the [LOCATION] area of the neighborhood. A portable oxygen cylinder was attached to the back of the resident's wheelchair. A nasal cannula was attached to the oxygen cylinder, but the resident was not wearing it.

	A review of Resident #11's Physician Orders revealed an order for routine oxygen at 2-4 liters per minute to maintain Resident #11's oxygen saturation above 90%. A review of Resident #11's Care Plan revealed a focus area for oxygen. The problem statement read: "I require use of continuous oxygen." Continued review of Resident #11's Care Plan revealed no focus areas for noncompliance related to their oxygen therapy. An additional observation of Resident #11 was made on 5/7/24, at 2:50 p.m., Resident #11 was observed attending a bingo activity in the [LOCATION]. A portable oxygen cylinder was attached to the back of the resident's wheelchair. A nasal cannula was attached to the oxygen cylinder, but the resident was not wearing it. On 5/7/24, at 2:55 p.m., an interview was conducted with Certified Medication Aide A, who confirmed that Resident #11 was supposed to be wearing oxygen continuously. When asked whether Resident #11 had any behaviors such as removing their oxygen cannula, Certified Medication Aide A stated, "Not that I can think of." On 5/9/24, at 9:50 a.m., an interview was conducted with Administrative Nurse A regarding Resident #11's order for oxygen. Administrative Nurse A confirmed Resident #11's current order for routine oxygen at 2-4 liters per minute. Administrative Nurse A added that Resident #11 "refuse[d] to wear oxygen sometimes." Administrative Nurse A then acknowledged that Resident #11's Plan of Care had not been revised to reflect that alleged behavior.
§ 51.140 Dietary services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observations and interviews, the facility failed to provide a well-balanced diet that meets daily nutrition needs by failing to offer and provide dessert to residents requiring assistance with meals. This deficient practice affected eight (8) of nine (9) residents observed for lunch on 5/8/24. The findings include: On 5/8/24, at 11:45 a.m., a lunch menu was observed at the entrance to the [LOCATION]. The lunch menu included baked spaghetti, steamed broccoli, garlic bread, and daffodil cake. On 5/8/24, at 12:00 p.m., an observation of the lunch meal was conducted in the [LOCATION]. There were nine (9) residents sitting at dining tables in the immediate area. Each of the nine (9) residents were served lunch. Eight (8) of the nine (9) residents did not have a dessert served with their lunch tray. After eating lunch, eight (8) of the residents were assisted back

	to their neighborhoods by Certified Nurse Aide B and Certified Nurse Aide A. These eight (8) residents were not offered or provided with dessert. On 5/8/24, at 12:50 p.m., an interview was conducted with Certified Nurse Aide A regarding the facility's practices for ensuring each resident was offered dessert in accordance with the facility's meal menu. When asked whether staff offer the residents desserts, Certified Nurse Aide A stated, "Sometimes," and immediately walked away. On 5/8/24, at 12:55 p.m., an interview was conducted with Resident #11. When asked whether they had been offered dessert, Resident #11 stated, "No." On 5/8/24, at 12:58 p.m., an interview was conducted with Resident #22. When asked whether they were going to receive dessert, Resident #22 stated, "Not that I know of." When asked whether they would like dessert, Resident #22 stated, "Sure, yes! I'll take some chocolate ice cream or whatever they have back there." On 5/9/24, at 11:35 a.m., an interview was conducted with Dietary Staff A regarding the facility's practices for ensuring residents received dessert with their meals in accordance with the facility's established menu. Dietary Staff A explained that the residents requiring assistance with dining were served meals by the nursing staff, and residents that did not require assistance with meals were served by dietary staff. Dietary Staff A went on to explain that it "was up to nursing staff" to make sure residents requiring assistance with dining received meal items in accordance with the menu.
§ 51.190 Infection control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observations and interviews, the facility failed to ensure hand hygiene was performed at appropriate intervals during observation of the lunch meal on 5/8/24. This deficient practice affected three (3) of nine (9) residents observed during the lunch meal (Resident #4, Resident #11, and Resident #21). The findings include: On 5/8/24, at 12:00 p.m., an observation of the lunch meal was conducted in the [LOCATION]. There were nine (9) residents sitting at dining tables in the immediate area. Certified Nurse Aide A was assisting residents with eating lunch who were seated at two (2) separate dining tables. Certified Nurse Aide A applied a pair of gloves and initially sat with Resident #21, who required total assistance with their meal.

	After assisting Resident #21 with three (3) bites of food, Certified Nurse Aide A moved to Resident #4, who also required assistance with their meal. While wearing the same pair of gloves they had previously used to assist Resident #21, Certified Nurse Aide A began assisting Resident #4. Certified Nurse Aide A then moved to Resident #11, who also required assistance with their meal. While wearing the same pair of gloves they had previously used to assist Resident #21 and Resident #4, Certified Nurse Aide A began assisting Resident #11 with their meal. On 5/8/24, at 12:50 p.m., an interview was conducted with Certified Nurse Aide A regarding the facility's practices for hand hygiene. Certified Nurse Aide A acknowledged the failed opportunities for hand hygiene, and confirmed that hand hygiene and glove changes should have been performed between each provision of care.