STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mille Lacs Health System	200 North Elm Street Onamia, MN 56359

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on observation, interview and document review, the facility failed to assess and monitor bruising for 1 of 1 residents (R9) reviewed for impaired skin integrity. Findings include: R9's annual Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition and diagnoses of dementia, benign paroxysmal vertigo (a sensation of spinning or moving), inflammatory arthritis (pain, swelling and warmth in the joints) and pruritus (itchy skin). R9's care plan dated 11/21/23, identified the potential for alteration in skin integrity and directed staff to complete skin audits with showers or baths weekly. During observation on 2/3/25 at 11:52 a.m., was seated in the memory care unit dayroom area and was noted to have what appeared to be a dark purple irregular shaped bruise on the top of her left hand between the thumb and index finger approximately five centimeters (CM) in diameter. When interviewed on 2/3/25 at 11:53 a.m., R9 stated she did not remember how she obtained the bruise, denied pain and denied deliberate harm by other residents and staff. R9 stated she bruised easily and could have bumped her hand on something but didn't remember. When interviewed on 2/4/25 at 6:14 p.m., R9 stated staff assist her with showers and believed she had received a shower that morning. R9's bathing and skin report task documentation dated 2/4/25 at 1:59 p.m., identified she received physical assist by one person on the bathing report and not applicable on her skin report. R9's bath checklist dated 2/4/25 at 9:45 a.m., identified she had a shower, and no skin issues were found. When interviewed on 2/5/24 at 8:01 a.m., registered nurse (RN)-B, stated the facility process for checking resident skin was done on each resident's bath or shower day. If skin issues were found, the staff member completing the bath or shower was to report to the charge nurse. The charge nurse would then assess the skin, measure or provide first aide, investigate cause and make appropriate notifications to the resident's provider, family and director of nursing (DON). (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/5/25 at 8:37 a.m., nursing assistant (NA)-A stated she thought the discoloration on R9's left hand was not new and not a bruise otherwise she would have reported it to the charge nurse. When interviewed on 2/5/25 at 9:36 a.m., clinical manager (CM)-A stated she had assisted R9 with a shower on 2/4/25 in the morning and did not notice any bruising on R9's left hand. CM-A stated she assisted R9 with washing and drying her back and feet and R9 was able to wash and dry the rest of her body independently with supervision. CM-A stated R9 had a habit of rubbing and scratching her own skin and this was the most logical explanation for the bruising. CM-A stated the facility process for checking resident skin was done on their bath or shower day. If a staff member noticed any impaired skin integrity, they were to report this to the charge nurse. The charge nurse should then assess the resident's skin and initiate any needed first aide and monitoring and make notifications to the provider and families. On 2/5/25 at 9:47 a.m., CM-A measured the discolored area on R9's left hand at 3.5 CM x 4.3 CM in diameter with light purple edges and dark purple covering the rest of the area and agreed it appeared to be a bruise. CM-A again stated she did not notice the bruise when providing R9 her shower the previous day and stated the facility impaired skin integrity process had now been initiated for R9 including notifications to her provider and family. On 2/5/25 at 10:36 a.m., the director of nursing stated her expectation was that staff report any skin impairment to the charge nurse immediately who should then assess, make notifications and monitor healing per facility policy and procedure. The DON acknowledged this process was missed for R9. The facility policy Skin injury (non-pressure) Prevention and Management dated1/9/25, identified all new skin injuries would be documented and would include a description of the injury with measurements, the potential or actual cause of the skin injury, the intervention or treatment implemented, and the resident representative notification of injury.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 20794 Based of observation, interview and document review, the facility failed to ensure physician prescribed medications are reviewed and monitored, for interactions between other prescribed medications, for 1 of 12 residents (R9) in the resident sample reviewed. Findings include: R9's annual Minimum Data Set (MDS) assessment of 11/11/24, identified R9 had brief interview for mental status (BIMS) score of 9, classified as moderate cognitive impairment. R9's medical diagnoses included unspecified dementia - unspecified severity without behavioral disturbance, psychotic disturbances, mood disturbance, anxiety, major depression, Gasto-esophageal reflux disease (GERD) without esophagitis and hyperuricemia (increased uric acid levels) without signs of inflammatory arthritis or tophaceous disease (monosodium urate crystals build up in the body). In review of R9's physician orders, the following medications were noted to have been ordered: Allopurinol 50 milligrams (mg) - give 1 tablet every day for hyperuricemia Diltiazem HCL 15 mg - give 1 tab three times a day for hypertension Carafate 1 gram (gm) - give 1 tablet by mouth two times a day for Gastric reflux melt 1 tablet in scant amount of water prior to administering to make a slurry. In review of R9's History and Physical (dated 10/20/23) documented R9 has the diagnosis of: Hyperuricemia, documenting: [R9] generalized aching could be hyperuricemia exacerbated by dehydration or if she has worsening chronic kidney disease. Likely, her generalized aching could be polymyaligia rheumatic, autoimmune disorder, fibromyalgia. We will evaluate these with laboratory testing. She stopped allopurinol. During medication observation on 2/4/25 at 6:16 p.m., trained medication assistant (TMA)-A began setting up R9's 7:00 p.m. medications, placing resident's allopurinol 50 mg tablet and diltiazem 15 mg tab in a medication cup. Then pouring a small amount of water in a plastic medication cup, TMA-A placed the Carafate 1 gm tablet into the water, stirring until dissolved. TMA-A then approached R9 and resident drank the Carafate slurry, then took the other two medications with a glass of plain water. When asked about the other medications being given with the dose of Carafate, TMA-A stated she would have to ask a nurse, while she doesn't know medication interactions. TMA-A assumed when the medications are scheduled on the electronic medication record, that is when they are to be given. In review of the pharmaceutical reference site, Drugs.com, the reference indicted the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Using sucralfate [Carafate] together with allopurinol may decrease the effects of allopurinol. Allopurinol should be administered at least 3 hours before or after sucralfate. If your doctor does prescribe these medications together, you may need a dose adjustment or special test to safely use both medications. In review of R9's lab testing the following was noted: Uric Acid Levels: 1/1/14 - 6.4 milligrams / deciliter (mg/dl) (rang for Females: 2.4 - 8.0 mg/dl) 3/19/24 - 5.3 mg/dl 12/30/24 - 5.4 mg/dl 1/7/25 - 4.7 mg/dl During telephone interview on 2/5/25 at 8:40 a.m., pharmacy consultant (PharmD) stated any medication should be separated from the Carafate by 3 hours, so not to bind to and prevent absorption of any medication, according to the reference materials her organization utilized. PharmD stated this must have been missed in review of R9's medications. During telephone interview on 2/5/25 at 8:56 a.m., primary physician (MD)-A stated according to her references, Carafate should be given 2 hours before or 2 hours after all medication and/or meals. MD-A stated Carafate can affect the absorption of other medications, and with R9 taking water with her other medications, potentially washed the Carafate coating to the espohagus that the Carafate was ment for. During interview on 2/5/25 at 9:17 a.m., registered nurse / care manager (CM)-A stated she knew Carafate should be given 1 hour before or after meals, but was not aware of the medication interaction with R9's other medications. In an interview on 2/5/25 an 10:37 a.m., the director or nursing (DON) stated they were unaware of this concern and they are currently looking to see if there are any other residents were receiving Carafate and had it scheduled in this manner. In review of the facility's policy, entitled: Documentation and Communication of Consultant Pharmacist (last reviewed 03/08/2022) indicated the following: PURPOSE: The facility supports pharmacy services that promote quality care including drug regimen review (DRR). DRR is defined as the systematic evaluation of drug therapy viewed within the context of resident-specific data. The consultant pharmacist reviews the drug regimen of each resident at least monthly and more frequently if deemed necessary. Irregularities are reported to the director of nursing, RN Care Coordinators, the attending physician, and the medical director for irregularities to be addressed by the attending physician. PROCEDURE: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. The facility assures that the consultant pharmacist has access to residents and the residents' medical records; the provider pharmacy's resident medication profiles, if requested; the facility's records of medication receipt and disposition; medication storage areas; and controlled substances records and supplies. Section 1. - ix. The administration schedule is appropriate for the resident, considering side effects and compatibility with other medications and diet.