

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Mayo Clinic Health System - Lake City		STREET ADDRESS, CITY, STATE, ZIP CODE  500 West Grant Street Lake City, MN 55041	

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)
<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>49893</p> <p>Based on interview and observation the facility failed to ensure residents received mail timely on weekends. This has the potential to affect all residents in the facility who receive mail.</p> <p>Findings include:</p> <p>During interview on 6/11/2024 at 9:46 A.M., R7 stated she did not believe mail was delivered on Saturdays, mail was delivered by the activities staff. R1 stated she does not get mail often so she was unsure if mail was delivered Saturdays. R28 stated his mail was delivered to family.</p> <p>During an interview on 6/12/2024 at 11:00 A.M., the activities director (A-A) stated her department was responsible for delivering mail to the residents. Her staff occasionally worked on weekends, however, did not think mail was delivered to the facility on weekends. She verified with the receptionist mail was not delivered on weekends and was held for delivery until the following Monday.</p> <p>During interview on 6/13/2024 at 8:52 A.M., the receptionist stated mail was not delivered to the facility on weekends because there was no staff at the desk to receive it. The decision was made to hold mail to safeguard protected health information. The receptionist stated the facility got minimal mail on weekends because the facility utilizes email and facetime for communication with residents' families.</p> <p>During interview on 6/13/2024 at 10:58 A.M., the administrator stated mail was delivered to the attached hospital and placed in the mailroom. The activities staff sorted it in the mailroom and delivered it to the residents. The hospital stopped mail delivery on weekends however, the administrator would have to confirm the reason. It was not something initiated by the facility. At 11:27 a.m., the administrator stated mail was not delivered to the building on Saturday because the mail room was locked. The administrator stated no other arrangements had been attempted to deliver mail on weekends.</p> <p>A policy regarding resident mail delivery was requested but not received.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>48013</p> <p>Based on interview and document review, the facility failed to provide the required written Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) forms to 3 of 3 residents (R2, R162, R258) reviewed whose Medicare A coverage ended and then remained in the facility and/or discharged home.</p> <p>Findings include:</p> <p>R2</p> <p>R2's Centers for Medicare and Medicaid Services (CMS)-10123 (NOMNC) identified a last covered day (LCD) of 3/13/24. NOMNC indicated community support manager (CSM) called family member (FM)-A, who was also R2's power of attorney (POA), on 3/11/24 to notify that skilled services would be ending on 3/13/24 with financial liability being on 3/14/24. NOMNC lacked signature of FM-A acknowledging notification of services ending.</p> <p>R2's undated Census Records listing identified on 4/14/24, R2's payer source changed from Medicare Part A to Private Pay, and remained in the facility.</p> <p>R2's SNFABN lacked signature acknowledging that FM-A had received and understood the notice. SNFABN indicated beginning on 3/14/24, estimated cost of room and board was up to \$743.59 with additional fees for physical, occupational and/or speech therapy. SNFABN indicated under additional information to: See NOMNC - FM-A given options verbally on 3/11/24.</p> <p>During interview on 6/11/24 at 3:54 p.m. FM-A stated he vaguely remembered a phone call regarding this and had not received and/or signed either written notice.</p> <p>R162</p> <p>R162's NOMNC identified a last covered day of 4/22/24. NOMNC indicated CSM called FM-B, who was also R162's POA, on 4/19/24 to notify that skilled services would be ending on 4/22/24 with financial liability beginning on 4/23/24. NOMNC lacked signature of the power of attorney acknowledging notification of services ending.</p> <p>R162's undated Census Records listing identified on 4/23/24, R162's payer source changed from Medicare Part A to Private Pay, and remained in the facility.</p> <p>R162's SNFABN lacked signature acknowledging FM-B had received and understood notice. SNFABN indicated beginning on 4/23/24, estimated cost of room and board was up to \$743.59 with additional fees for physical, occupational and/or speech therapy. SNFABN indicated under additional information to: See NOMNC - POA did not want to appeal.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/11/24 at 4:00 p.m. FM-B stated he never received and/or signed either written notice. FM-B stated, on a different occasion, he received a piece of paper with a table on it which included different care levels and prices but did not know what care level R162 was.</p> <p>R258</p> <p>R258's NOMNC identified a last covered day of 4/24/24. NOMNC indicated CSM called FM-C on 4/22/24 to notify that skilled services would be ending on 4/24/24 with financial liability being on 4/25/24. NOMNC lacked signature of the FM-C acknowledging notification of services ending.</p> <p>R258's undated Census Records listing identified on 4/25/23, R258 discharged from facility.</p> <p>During an interview on 6/11/24, at 4:12 p.m., CSM verified she was responsible to provide the Medicare NOMNC and the SNFABN notices within the nursing home. CSM stated she got the last covered day from therapy or resident's insurance. CSM then gave the resident/representative a two-day notice. CSM stated she gave the resident/representative a NOMNC with appeal information and asked if they would like to appeal. CSM stated if resident is planning to remain in the facility, she also gave the resident/representative the SNFABN. CSM stated these conversations occur over the phone and sometimes she asked if they would want a copy mailed to them. CSM stated she did not remember offering and/or giving written copies and/or obtain written signatures for R2, R162 and/or R258. CSM stated it was be important to provide written documentation to residents/representative as conversations can be forgotten and or misconstrued. CSM also stated it was important to have a signature to ensure the resident/representative understood the process and the financial liability they would be responsible for.</p> <p>The facility Medicare A Denial policy, dated 6/2019, indicted the facility must deliver a completed copy of the NOMNC to beneficiaries/enrollees of Medicare and Medicare Advantage plans receiving covered skilled services. The facility must ensure that the resident or resident representative signs and dated the NOMNC and when applicable the SNFABN to demonstrated that they received the notice and understand that the termination decision can be disputed.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49893</p> <p>Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 1 resident's reviewed for wandering.</p> <p>Findings include:</p> <p>R26's admission MDS dated [DATE], indicated severe cognitive impairment, physical and verbal behaviors with rejection of care. Wandering with no significant risk. Wanderguard in place.</p> <p>R26's quarterly MDS dated [DATE] indicated severe cognitive impairment, physical and verbal behaviors directed toward others. No documented wandering. Wanderguard in place.</p> <p>R26's provider orders included mirtazapine (medication for depression and sleep), buspirone (medication for anxiety).</p> <p>R26's diagnoses list included delusional disorders and dementia with anxiety.</p> <p>R26's elopement careplan indicated history of elopement at previous facility in addition to multiple attempts to exit current facility with increased wandering during episodes of delusional thoughts.</p> <p>Facility progress notes reviewed from 3/20/24 through 3/27/24 indicated on 3/22/24 R26 attempted to leave the facility multiple times, refused medications, and required redirection and 1:1 care.</p> <p>During interview on 06/13/24 10:12 a.m., MDS coordinator (RN)-C stated she used a reference sheet to confirm what assessments were due and the dates they were to be completed. The reference period used for assessments was 6 days prior to and including the assessment reference date (ARD). RN-C stated she referenced task documentation and progress notes made during reference period when completing MDS assessments. RN-C reviewed progress notes for reference period 3/20/24 through 3/27/24 and confirmed progress notes dated 3/22/24 indicated multiple attempts to exit the facility. RN-C stated she must have overlooked it. RN-C stated accurate MDS documentation would be important for careplanning and accuracy of Medicare payment.</p> <p>During interview on 6/13/24, director of nursing confirmed the importance of accurate MDS assessments for appropriate resident care. She confirmed inaccurate MDS assessment could also lead to inaccurate Medicare reimbursement.</p> <p>A facility policy titled MDS/Careplan Process dated 2/1/2024 indicated the purpose of a comprehensive assessment as identify the resident's care needs, develop a comprehensive plan of care for the resident, identify the resident's strengths, assist the resident to attain the highest practical level of mental and physical function and well-being.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</b></p> <p>Based on interview and document review, the facility failed to ensure medications were administered per physician's order for 1 of 1 resident (R40) reviewed for assessment prior to medication administration.</p> <p>Findings include:</p> <p>R40's admission Minimum Data Set (MDS) dated [DATE], identified R40 had intact cognition and required assistance with all activities of daily living (ADLs). R40's diagnoses included chronic combined systolic and diastolic heart failure (heart failure that occurs when the heart has trouble relaxing between beats), atrial fibrillation (abnormal electrical impulses suddenly start firing in the atria), heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), hypertension (pressure in your blood vessels that is too high), obstructive sleep apnea (intermittent airflow blockage during sleep) and chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems).</p> <p>During review of R40's electronic health record (EHR), signed physician's order indicated an order for Metoprolol Tartrate 150 mg (milligram) to be given by mouth one time a day for hypertension and to hold for heart rate less than 50 and systolic blood pressure less than 100. Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation of obtaining and monitoring blood pressure and pulse prior to administration of medication from 5/17/24 to present.</p> <p>During interview on 6/12/24 at 10:22 a.m., trained medication aide (TMA)-A stated R40 did not have special monitoring for medication administration. TMA-A checked signed physician's orders and confirmed that R40 should have blood pressure and pulse checked prior to administration of Metoprolol. It was important to check blood pressure and pulse as medication may not be able to be administration if blood pressure and/or pulse are below parameters.</p> <p>During interview on 6/12/24 at 4:10 p.m., registered nurse clinical manager (RN)-D stated staff had been checking resident's blood pressure occasionally but was not with every dose and not being checked per physician's orders. RN-D stated checking the blood pressure and pulse prior to administration of medication was important because it is a physician's order, and it should not be administered if blood pressure or pulse was low as R40 could get dizzy or blood pressure could decrease more. RN-D reviewed signed physician's orders and confirmed the blood pressure and/or pulse were not being obtained with every dose administered.</p> <p>During interview on 6/13/24 at 8:22 a.m., consultant pharmacist (CP) stated staff should have been obtaining R40's blood pressure and pulse prior to administration of Metoprolol to ensure that medication was able to be administered per physician's orders. CP stated he would expect them to be obtained and documented on the medication administration record (MAR). CP stated monitoring of blood pressure and pulse is important as R40 would be at risk of having too low of a blood pressure or too low of a pulse. CP reviewed R40's EHR and confirmed that there was no documentation of blood pressure and pulse prior to medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/13/24 at 8:33 a.m., director of nursing (DON) stated she expected provider's orders to be followed, including parameters of medication administration. DON confirmed R40's blood pressure and pulse should have been obtained prior to administration of the Metoprolol. DON stated following these parameters was important, so the blood pressure doesn't bottom out leading to the resident being transferred out of facility to the emergency room (ER) as it could be life threatening.</p> <p>A Medication Administration/Monitoring policy and procedure was requested but was not received.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</b></p> <p>Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to promote healing of pressure ulcer for 1 of 1 resident (R4) in accordance with the individualized care plan.</p> <p>Findings include:</p> <p>R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had moderately impaired cognition and required assistance with all activities of daily living (ADLs). R4's diagnoses included non-traumatic brain dysfunction (brain damage caused by internal factors), atrial fibrillation (abnormal heart rhythm), heart failure (syndrome cause by an impairment in the heart's ability to fill with and pump blood), renal insufficiency/failure (kidneys are functioning poorly), diabetes mellitus (disease that affect how the body uses blood sugar (glucose)), non-Alzheimer's dementia (loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual activities), seizure disorder or epilepsy (disorder of the nervous system that causes abnormal electrical activity in the brain), depression, pressure ulcer - stage 3 (full-thickness skin loss potentially extending into the subcutaneous tissue layer), muscle weakness, restlessness and agitation and major depressive disorder severe with psych symptoms.</p> <p>R4's pressure ulcer Care Area Assessment (CAA) dated 5/21/24, indicated R4 was at risk for the development of pressure ulcers.</p> <p>R4's care plan dated 5/20/24, identified R4 had a stage three pressure ulcer and was at risk for the development of pressure ulcers and directed to reposition R4 every two hours while in bed and/or wheelchair.</p> <p>During continuous observations on 6/11/24 from 9:42 a.m. to 12:57 p.m., R4 was observed to be seated in a Broda (reclining wheelchair with bilateral supportive cushions) chair. At 9:42 a.m., R4 was in the common area watching television with other residents. At 10:25 a.m., R4 remained in common area watching television. At 11:45 a.m., staff assisted R4 to the dining room for lunch. At 6/11/24 at 12:23 p.m., R4 was sitting in dining room eating independently. At 12:43 p.m., staff assisted R4 from the dining room to the common area where R4 remained in broda chair? and watched television. At 12:57 p.m., staff assisted R4 to her room to assist R4 with toileting (checking and changing) incontinence products and was assisted back seated in her wheelchair.</p> <p>During interview on 6/12/24 at 8:34 a.m., nursing assistant (NA)-A stated R4 is unable to reposition herself in her wheelchair and needs staff to assist with repositioning. NA-A stated R4 was to receive assistance with repositioning every two to three hours per R4's care plan.</p> <p>During interview on 6/12/24, at 9:11 a.m., NA-F stated R4 should be laid down once in the morning after breakfast but R4 frequently refused to lay down. NA-F stated R4 was to receive assistance with repositioning every two hours when in wheelchair. NA-F stated R4 was not able to reposition herself in her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/12/24, at 10:22 a.m. trained medication aide (TMA)-A stated R4 was to receive assistance with laying down after meals but R4 frequently refused as she liked to be out with other residents watching television and attended activities regularly. TMA-A stated R4 was to receive assistance with repositioning every two hours in accordance with the care plan.</p> <p>During interview on 6/12/24, at 4:27 p.m., registered nurse clinical manger (RN)-D stated R4 liked to attend activities and watched television with other residents. RN-D stated R4 has a stage three pressure ulcer that has stalled (wound initially began to heal, but patient- or wound-related factors have prevented the wound from continuing to heal in an orderly and timely manner), provider was aware. RN-D stated R4 had the order to try and encourage R4 to lay down due to the pressure ulcer but R4 refused frequently. RN-D stated R4 was to receive assistance with repositioning every two to three hours if R4 refuses to lay down. RN-D stated repositioning R4 is important so her wound did not worsen as are result of not being repositioned.</p> <p>During interview on 6/13/24, at 8:49 a.m., the director of nursing (DON) stated the staff were to provide assistance with repositioning in accordance with the care plan. DON stated repositioning a resident with pressure ulcers was important, so the wound did not worsen.</p> <p>The Individualized Care Plan Policy dated 10/26/22, indicated the facility would develop a comprehensive care plan using the comprehensive assessments, will individualize the plan of care to accurately reflect resident's functional capacity and medical, nursing, psychosocial, activity and other identified needs.</p> <p>The Positioning the Resident Policy dated 11/2021, indicated the staff reposition identified residents to relieve pressure, prevent skin breakdown, pain, and promote proper body alignment.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41575</p> <p>Based on observation, interview and document review, the facility failed to investigate, review and analyze underlying causes of resident's anxiety and agitation for 1 of 1 resident (R24) who was reviewed for behaviors.</p> <p>Findings include:</p> <p>R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 had moderate cognitive impairment and diagnoses included dementia, repeated falls, malignant neoplasm of the prostate, weakness, hematuria and recent urinary tract infection. R24 required setup or clean up with personal hygiene and toileting and supervision or touch assist with ambulation. R24 had exhibited behaviors of physical, verbal and other behaviors one to three days during the observation period and wandered daily. R24's behaviors were identified as potentially harmful to himself or others.</p> <p>R24's care plan with review date 6/5/24, identified R24 was at risk for wandering and elopement as he had tried to exit the facility. R24 had impaired cognitive function due to diagnosis of dementia. Interventions included ask yes/no question, cue and reorient and supervise as needed, give verbal reminders, engage in purposeful activity, identify if there is a certain time of day wandering and elopement attempts occur, provide clear, simple directions, identify wandering/elopement de-escalation behaviors and wanderguard on left extremity.</p> <p>Progress notes identified the following:</p> <ul style="list-style-type: none"> <li>-On 5/15/24, interdisciplinary team (IDT) review note identified R24 had increased wandering, exit seeking, and aggression toward staff. R24 was moved to a different, quieter wing. Staff would continue to monitor his behavior.</li> <li>-On 5/19/24, R24 was wandering into other resident rooms, unsteady on his feet and hard to redirect.</li> <li>-On 5/22/24, R24 walked off the unit with another resident. Staff were able to redirect back to unit.</li> <li>-On 5/23/24, R24 was wandering halls and seeking exits. Interventions were somewhat effective.</li> <li>-On 5/24/24, R24 had attempted to disrobe in public areas. Interventions were ineffective.</li> <li>-On 5/25/24, R24 was wandering halls, verbally and physically aggressive with staff. R24 exited building and staff was able to redirect him back in to the building.</li> <li>-On 5/26/24, R24 was wandering halls and exit seeking. Nearly did get out of building before staff intervened.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 5/27/24, R24 was wandering the halls, attempting to go in to other resident rooms, and attempting to find exits to elope. Became combative with staff when attempted to assist him to the bathroom.</p> <p>-On 5/29/24, R24 was wandering halls and into others rooms. Attempting to exit out doors. Was difficult to redirect.</p> <p>-On 5/31/24, R24 was wandering and agitated with redirection.</p> <p>-On 6/1/24, R24 was wandering and urinated on the floor in another resident's room. R24 became agitated when staff tried to assist him to change his wet pants. Staff walked away to allow R24 to calm down. R24 exited out of the building. Staff responded to door alarm, had significant difficulty getting R24 to return to the building. A nurse from a different wing came to assist and was able to get R24 to return to the building.</p> <p>-On 6/3/24, R24 was seen by provider related to psychotropic medication review.</p> <p>-On 6/4/24, order received to increase mirtazapine (an antidepressant).</p> <p>-On 6/5/24, R24 was wandering halls and attempting to exit building. Unable to distract and re-direct. Requested assistance from other nursing staff.</p> <p>-On 6/6/24, R24 was wandering halls and into others rooms, searching for an exit. Interventions ineffective.</p> <p>-On 6/8/24, R24 wandering halls and going into others rooms. Interventions ineffective.</p> <p>-On 6/9/24, R24 had water and urine all over floor in bathroom. Refusing to allow staff to change his soiled clothes. Interventions ineffective.</p> <p>During observation on 6/10/24, at 4:30 p.m. R24 was seen wandering the halls. Staff attempted prompts for him to sit down and rest. R24 walked away from them and refused to sit down.</p> <p>During continuous observation on 6/11/24, at 10:15 a.m. to 12:00 p.m. R24 was observed wandering the halls and attempted to enter other resident rooms. R24 stated he had to go to the bathroom, however, when assisted to the toilet at 10:30 a.m., was unable to void. R24 continued to pace the halls and refused staff attempts to redirect. At 10:35 a.m. R24 was wandering and stated he had to go to the bathroom. When brought to the bathroom, immediately turned around and stated he did not have to go. At 11:35 a.m. R24 exited the unit doors into another hallway. Nursing assistant (NA)-A noted he had exited the unit and went out to redirect him back into the unit. R24 was resistive to redirection. NA-B approached to assist and they were able to get R24 to return to the unit.</p> <p>During observations on 6/11/24, at 1:45 p.m. through 4:00 p.m. R24 continued to pace the halls with unsteady gait and agitated manner. Staff attempted to intervene with diversional activity and one to one, however, were unsuccessful.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Mayo Clinic Health System - Lake City		STREET ADDRESS, CITY, STATE, ZIP CODE  500 West Grant Street Lake City, MN 55041	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview with registered nurse (RN)-D and RN-E on 6/11/24, at 4:00 p.m. RN-E stated the staff were doing one to one with R24 and trying more redirection. They were trying to find activities and music he would enjoy or offered food or drink. They had put a wanderguard on R24 to address his wandering and exit seeking behaviors. The staff document a lot of behavior notes, but as far as assessments, the provider had seen R24 twice to address his medications. The providers could do assessments and address a resident behaviors. They discussed resident behaviors during their weekly IDT meetings but she was not sure if it was documented in the resident chart as social services would be the one to document that. An analysis of behaviors would be important to see if there was a cause such as infection, and to treat it and maybe improve the behaviors. When they put in for an acute provider visit they communicated the resident behaviors with the provider and then it would be up to the provider to address the behaviors and order tests if they wanted them. RN-E had not been made aware R24 would ask for the bathroom and then refuse to go and the behavior could possibly be related to R24's diagnosis of untreated prostate cancer. RN-D stated she was only able to find the one IDT note on 5/15/24 and the two provider notes related to medications.</p> <p>R24's medical record reviewed 5/15/24 through 6/11/24, lacked review and analysis of R24's behaviors to try to determine underlying causes or triggers.</p> <p>During joint interview on 6/12/24, at 4:40 p.m. with the director of nursing (DON) and clinical operations manager (CO)-D, CO-D stated she was not sure if the facility had behavior meetings but resident behaviors were addressed in IDT weekly meetings and daily stand up meetings. It would be the IDT team to look at the bigger picture of resident behaviors. It would be important to really have a look at what the resident was doing and what was preceding the behavior. She had not found an overall review of resident behaviors.</p> <p>The facility policy Mood and Behavior/Behavioral Health dated 10/5/22, identified the facility would assess and develop individualized behavioral care plan interventions for individuals with dementia. Mood and behavior would be reviewed by the IDT team on a quarterly basis or more often as needed to determine trends and effectiveness of care plan interventions.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49893</p> <p>Based on interview and record review the facility failed to follow up on provider orders for 1 of 1 (R26) residents reviewed for dementia care.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE], indicated R26 had a BIMs (test to assess cognitive impairment) score of 04 indicating severe cognitive impairment. No functional limitation in range of motion, history of falls, received antidepressants, antianxiety, and antipsychotic medication.</p> <p>R26's physician orders included mirtazapine (medication for depression that helps with sleep) and buspirone (medication used to treat anxiety).</p> <p>R26's diagnoses list included delusional disorders and dementia with anxiety.</p> <p>R26's elopement careplan, revised [DATE], indicated R26 was at risk for elopement due to dementia. R26 had a history of attempting to leave previous facility and wandering might increase with delusional thoughts, had wanderguard in place and, has history of going into other residents' rooms. It further indicated R26 has attempted to exit the facility. A mood/behavior careplan, revised [DATE], indicated R26 had a history of refusing care and scratching/hitting out at staff and had a history of delusional statements.</p> <p>R26's progress notes dated [DATE] through [DATE] indicated several incidents of behaviors that include verbal aggressiveness and threats, and elopement attempts. On [DATE] the provider wrote an order for psychological and psychiatric consult. Progress notes dated [DATE] through [DATE] continued to show behavioral episodes that include verbal aggression and elopement attempts, however did not indicate an increase in behavior. The progress notes lacked documentation a psychiatric consult appointment was made.</p> <p>During interview on [DATE] at 4:37 p.m., registered nurse (RN)-B confirmed R29's diagnoses of delusions, anxiety, and dementia. She stated R29 was forgetful and spoke of her deceased husband often. R29 had a wanderguard on due to attempts to leave the facility. R29 requested staff call 911. RN-B stated they had the hospital security staff member speak to R29 which was effective in reassuring R29. R29 has successfully exited the facility however was redirected back inside without issue.</p> <p>During interview on [DATE] at 10:53 a.m., nursing assistant (NA)-M stated R29 was independent with ambulation and has been more confused lately. R29 has been fixated on family and wandered back and forth from room to tv common area. NA-M stated R29 has successfully eloped from the facility however staff was able to redirect her.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on [DATE] 03:42 p.m., nurse managers (RN)-D and RN-E stated R29 looked for her deceased husband and children a lot. R29 had increased behaviors after family visits. R29 required a lot of redirection. R29's elopement attempts were either related to looking for her family or fear something horrible is happening. Staff have been instructed to be mindful of what is on the television (TV) in R29's room because R29 had trouble thinking TV was reality. R29's providers have made changes to medications including Seroquel (antipsychotic) and mirtazapine (antidepressant that aids in sleep). R29 was also taking buspirone (medication for anxiety) three times a day. They have also requested testing and labs to rule out medical issues. A psychiatric consult was ordered on [DATE] by the provider. When asked when R29's psychiatric appointment was, RN-D stated, Does she see psych? I don't know. Both RN-D and RN-E were unable to confirm date of psychiatric appointment. RN-D printed provider order for psychiatric appointment stating she would confirm with the unit secretary.</p> <p>During interview on [DATE] 08:59 a.m., the unit secretary (HUC) stated she was responsible for transcribing provider orders in the electronic record. When she completed transcribing, she pulled a specific tab on the resident's physical chart for the nurse to verify and, if necessary, clarify orders. The HUC recalled calling the provider in April to make the psychiatric appointment, however did not document making the call. She stated she was told by the clinic she could not make the appointment because the order was in review or something. She did not recall the specific reason she could not make the appointment. She confirmed no follow up phone call was made until RN-D asked her about the appointment on [DATE]. The HUC stated she called on [DATE] and was told the in-house psychiatrist would no longer be available and a referral to an outside psychiatric provider would have to be made. The HUC stated she should have sent an email to the ordering provider in April informing them an appointment could not be made and confirmed she should have followed up with the provider.</p> <p>During interview on [DATE] the director of nursing stated she would expect staff to follow-up on provider orders. This is important for the proper healthcare of the resident.</p> <p>A policy for provider orders was requested and not received.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</b></p> <p>Based on observation, interview and document review, the facility failed to ensure proper hand hygiene was completed when assisting with therapy for 1 of 2 residents (R38) whose therapy care was observed. In addition, the facility failed to ensure soiled and potentially contaminated laundry was sorted in a manner to reduce the risk of cross contamination and subsequent infection spread. These findings had the potential to affect all 58 residents who utilized laundry services.</p> <p>Findings include:</p> <p>R38's admission Minimum Data Set (MDS) dated [DATE], identified R38 had intact cognition and diagnoses included fracture of left humerus and femur and enterocolitis due to clostridium difficile (C-Diff). R38 required moderate assist with grooming and hygiene, was dependent with transfers and frequently incontinent of bowel.</p> <p>R38's progress note dated 6/12/24, 1:25 p.m. identified R38 continued to have loose, watery stools due to C-Diff infection.</p> <p>On 6/11/24, at 11:00 a.m. R38 was observed sitting in his wheelchair in the physical therapy room. Physical therapist (PT)-A donned disposable gloves and wheeled R38 onto the parallel bars ramp and locked his wheelchair brakes. On assisting R38 to a standing position, R38's clean, dry, incontinence brief slid down his legs onto the parallel bars ramp. PT-A reached down and pulled R38's brief back on and tightened the tape to secure more snugly. PT-A continued to wear the same gloves and assisted R38 to ambulate a few steps, then to sit in wheelchair for a brief rest. Still wearing the same gloves, PT-A assisted R38 to stand and ambulate a few steps two more times, once snugging R38's brief again to prevent it from falling off. After completion of the exercise, PT-A, still wearing the same contaminated gloves wheeled R38 off the ramp toward the exit door. Still wearing the same contaminated gloves, PT-A opened the bleach wipe container and pulled out a wipe. PT-A used the wipe to wipe down the parallel bars and discarded the wipe in the garbage. PT-A then discarded her gloves in the garbage. PT-A opened the therapy window blinds and then washed her hands with soap and water. PT-A wheeled R38 back to his room, entering the resident's room without putting on personal protective equipment (PPE) of gown or gloves. PT-A situated R38's wheelchair in front of his television and pushed his bedside table in front of him, handed R38 his remote control, after turning on his television. PT-A used alcohol based hand rub on exiting the room, however, did not wash her hands with soap and water. R38's door was clearly labeled for staff to utilize contact precautions of gown and gloves prior to entering his room and a cart with appropriate PPE was placed next to the entrance to R38's room. A sign to remind staff to wash hands with soap and water was visible on R38's bathroom door.</p> <p>During interview on 6/11/24, at 11:45 a.m. PT-A stated she had been told C. Diff was very contagious. If she were to work with R38 in his room, such as transferring him, she would need to put on an isolation gown and gloves and to wash hands with soap and water afterward. When working with R38 in the therapy room, she had been instructed to just wear gloves and to wipe any equipment used with bleach wipes and wash hands after therapy. PT-A stated she had pulled R38's brief up with her gloved hands when the brief slid off him and did not wash her hands and re-glove afterwards. PT-A stated she could see how her gloves could have been potentially contaminated, but she had washed her hands after working with R38.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/11/24, at 4:15 p.m. infection preventionist, registered nurse (RN)-A stated R38 was on contact precautions for C-Diff and staff were to gown and glove when entering R38's room, even if not providing direct care. As long as R38 washed his hands beforehand, he was not restricted to his room. The facility did not require therapy to wear an isolation gown when working with R38 in the therapy room as long as they gloved and wiped equipment used with bleach wipes. If PT-A had needed to pull up R38's brief during his therapy session, she should have removed her gloves and washed her hands and then re-gloved before continuing therapy. PT-A should have also gowned and gloved when she entered R38's room and washed her hands as soon as possible when she left the room. Both incidents were a breach in infection control and potential for spread of infection.</p> <p>During interview with the director of nursing (DON) and clinical operations manager (CO)-D on 6/12/24, at 5:00 p.m., the DON stated staff not changing their gloves after touching potentially contaminated items would be an infection control issue. It was important to follow all infection control practices and guidance to prevent the spread of infection.</p> <p>The facility's policy Clostridiodes Difficile Infection Prevention and Control and treatment of Residents dated 11/1/23, indicated all residents with suspected C-Diff infection would be placed on contact precautions. Gloves and gown would be worn prior to entering resident's room and removed prior to exiting room. Hand hygiene would be performed before putting on gloves, after removing gloves and any time hands were visibly soiled. Therapists, technicians, and all other personnel would follow contact precautions, wear appropriate personal protective equipment (PPE) and perform hand hygiene accordingly.</p> <p>Laundry</p> <p>On 6/13/24, at 8:45 a.m. a laundry tour was completed with housekeeper (HSK)-A. HSK-A stated laundry staff picked up filled, dirty laundry carts from the nursing floor, covered them with a drape and brought the carts to the laundry room. Laundry staff weighed each dirty laundry cart, put gloves on and opened each bag into the cart and put the loose, soiled resident laundry into the washer until the washer was full. With facility laundry, the soiled laundry bags were put in to the large open yellow bins to be picked up by the laundry company that was used to wash the facility laundry, such as personal protective gowns, sheets, towels, and other linens. Loose facility laundry, towels and isolation gowns were visible in the open yellow storage carts with several isolation gowns hanging out over the carts opening. HSK-A stated the laundry was suppose to be bagged but they also frequently found it loose in the bins. After handling the soiled laundry, she removed her gloves and washed her hands. The laundry staff did not wear a gown for sorting laundry, despite having to lift the dirty laundry bags and the loose soiled laundry, including isolation gowns from the floor cart to either the yellow storage cart or into the washers. HSK-A always put disposable gloves on but had never been instructed to wear a disposable gown to complete the sorting process. HSK-A had never observed anyone to gown while sorting soiled laundry and did not think gowns were kept in the area for that purpose. There were no gowns observed in the area for staff to use to sort the laundry. The facility did have a resident with active C-Diff and that resident's laundry was not handled any differently. Laundry got alot of isolation gowns because of all the residents on enhanced barrier precautions as well as the resident with C-Diff and there was no way to tell what resident room the gowns had been used in.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/13/24, at 10:00 a.m. the infection preventionist, registered nurse (RN)-A stated housekeeping staff should be wearing an isolation gown to sort all laundry due to the potential to contaminate their uniforms or other clean laundry. She planned to discuss the issue with the laundry supervisor when he returned to work.</p> <p>The facility policy Linen Handling to Prevent and Control Infection Transmission, dated 4/25/24, directed laundry staff to wear gloves and gowns when handling contaminated laundry.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48013</p> <p>Based on interview and document review, the facility failed to ensure 1 of 5 residents (R40) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s).</p> <p>Findings include:</p> <p>A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old.</p> <p>R40's face sheet, dated 6/12/24, indicated she was [AGE] years old. The immunization record, dated 6/13/24, indicated she received a PPSV23 on 8/8/2012 followed by the PCV13 on 11/17/2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R40 was offered or received PCV20.</p> <p>During interview with infection preventionist (IP), on 6/12/2024 at 2:24 p.m., the IP indicated immunizations are reviewed upon admission. IP stated that the admission nurse reviewed immunization record and eligible immunizations with resident upon admission and would let IP know if resident wanted any vaccines/immunizations. IP stated she was not sure why the PCV20 was not addressed with R40 on admission but that she read a progress note dated 5/17/24 which stated R40 did not want any further COVID vaccines and that all other vaccines were completed per Minnesota Immunization Information Connection (MICC). IP verified R40's pneumococcal immunizations as listed above and that R40 had not been offered or provided education on the PCV20. IP verified there had been no shared clinical decision making with the provider regarding pneumococcal immunizations for R40. IP stated it was important to ensure residents are offered all available vaccinations to prevent the risk of developing symptoms to lead to acute illness.</p> <p>During interview on 6/12/24 at 3:26 p.m., R40 stated she was not aware that there was a third pneumonia vaccine available. R40 confirmed that facility did not address or offer PCV20 to her at the time of admission or since admission and that R40 was interested in receiving the PCV20 vaccine.</p> <p>During interview on 6/12/24 at 4:33 p.m., registered nurse clinical manager (RN)-D stated when a resident admits to the facility, the admission nurse reviewed the resident's immunization record on MICC. If resident is eligible for a vaccine/immunization, the admission nurse would address it with the resident/representative to see if they would be interested in receiving vaccine/immunizations. RN-D stated if it stated the vaccine series was completed on MICC, then those were not discussed with resident. RN-D confirmed that R40 was not asked if she would be interesting in receiving PCV20.</p> <p>The Resident Pneumococcal Vaccine policy, dated 11/1/23 indicated each resident would be offered a pneumococcal vaccine if the resident has not previously received it according to CDC guidelines and under the discretion of the patient/resident's physician for frequency.</p>		