STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Care Hastings Health and Rehabilitation	930 West 16th Street Hastings, MN 55033

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33925 Based on interview and document review, the facility failed to ensure the Office of Ombudsman for Long-Term Care (OOLTC) was notified in a timely manner of resident' hospitalization s (i.e., facility-initiated discharges) for 1 of 2 residents (R40) reviewed for hospitalization ; and 11 of 11 residents identified to have been hospitalized within the last month. Findings include: R40's Minimum Data Set (MDS) records, dated 12/12/23 to 3/23/24, were reviewed. This identified a total of four (4) discharge - return anticipated records were completed on 12/23/23, 1/12/24, 2/9/24, and 3/20/24, respectively, with each of these recording the discharge location as, 04. Short-Term General Hospital. On 4/8/24 at 3:07 p.m., R40 was interviewed with his family member (FM)-A present. FM-A explained R40 admitted to the care center in December 2023 and had been in and out of the hospital since then for various reasons. FM-A explained a hospitalization happened in February 2024, when R40 had a medication miscommunication and was too sedated as a result. R40's progress notes, dated 2/9/24 to 2/11/24, identified R40 developed tremors and increased weakness; and he was sent via ambulance to the hospital. R40's subsequent note, dated 2/11/24, identified R40 readmitted to the care center with dictation, . recurrent weakness secondary to be caused by increase in Lyrica [medication] dose . However, R40's medical record was reviewed and lacked evidence the OOLTC had been notified of any of these hospitalization s. During the recertification survey, from 4/8/24 to 4/11/24, evidence of such notification for R40 or any hospitalized residents' for the past months was requested. On 4/10/24, an email (dated 4/9/24) was left for the surveyors which was addressed to the regional OOLTC with dictation, Hello - attached you will find d/c's [discharges] from the past month, with a Admit/Discharge Report, dated 3/1/24 to 3/31/24, attached. This report identified a total of 11 residents, including R40, had been hospitalized in March 2024. (continued on next page)

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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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	An e-mail correspondence with the OOLTC, dated 4/10/24, identified the care center was supposed to be sending the monthly notices of hospitalization to the main office who then placed them into each respective Ombudsman' folder for review, however, there was no record of notices from the care center for an undetermined amount of time. The Ombudsman was unaware if they were receiving the notices or not depending on where the care center had potentially been sending them. When interviewed on 4/10/24 at 12:23 p.m., the administrator stated the medical records personnel was responsible to send the monthly listing of hospitalization s to the OOLTC, however, upon review they discovered it hasn't been done. As a result, they had just sent the listing (provided to the surveyors) for March to the OOLTC the day prior. The administrator stated the list was supposed to be done on a monthly basis and just got dropped at some point, so they would review and revise the process, if needed. The administrator stated it was important to update the OOLTC with hospitalization s to help ensure residents' get the help needed. A facility' policy on OOLTC notification was requested, however, none was received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 33925 Based on observation, interview and document review, the facility failed to ensure a dry-powder inhaler was administered in accordance with manufacturer instructions and current standards of care for 1 of 1 resident (R121) observed to receive inhalers during the survey. Findings include: A US National Institutes of Health (NIH) National Heart, Lung, and Blood Institute article titled, How to Use a Dry Powder Inhaler, dated 10/2021, identified such devices contained pre-set doses of medicine in a powder form. A section labeled, How To Use It, directed multiple steps to ensure the safe, accurate use of the medication including, 11. If your medicine is an inhaled corticosteroid, rinse your mouth with water and spit it out. Rinsing helps to prevent an infection [i.e., thrush] in the mouth. In addition, a Patient Information Breo Ellipta insert, dated 5/2023, identified Breo Ellipta combined two medications, including a corticosteroid, and was used to treat chronic obstructive pulmonary disease (COPD) and asthma. A section labeled, Instructions For Use, demonstrated how to use the device for oral inhalation along with corresponding photos. This included, Step 6. Rinse you mouth See Figure K . Rinse your mouth with water after you have used the inhaler and spit the water out. Do not [bolded] swallow the water. R121's Hospitalist Discharge Summary, dated 4/4/24, identified R121 was hospitalized with chronic respiratory failure and hypoxia due to aspiration pneumonia. A section was provided labeled, Discharge Medications, which outlined R121's medications for the care center. This included orders for, Breo Ellipta 100-25 mcg [micrograms]/dose inhalation powder . Inhale 1 puff by mouth once daily. R121's subsequent Nursing Admission, dated 4/4/24, identified R121 admitted to the care center on the same date. The completed evaluation identified R121 use oxygen on a continuous basis, and R121 did not wish to self-administer medications while at the care center. R121's MAR, dated 4/2024, identified R121's current medication orders, including the special instructions or directions, and spaces for staff to record their administration. This included an order which read, Breo Ellipta . 100-25 mcg/dose ., along with directions to administer one puff daily and a box labeled, Special Instructions, which read, Rinse mouth after use to reduce risk of thrush. The order had a listed start date, 04/04/2024 - Open Ended. On 4/9/24 at 8:05 a.m., a medication pass with licensed practical nurse (LPN)-A was observed. LPN-A removed R121's medications, including multiple inhalers, from the mobile cart in the hallway and prepared them for administration. Included in these, LPN-A removed a Breo Ellipta inhaler which outlined instructions to take 1 puff every day. LPN-A brought R121's inhalers, including the Breo Ellipta, and prepared oral medications to his room. R121 had oxygen in place via nasal cannula and was soft-spoken with conversation. LPN-A removed the inhaler from the package and asked R121 if he would like to prime the device or if LPN-A should aloud. LPN-A then primed the device and handed it to R121 who inhaled a dose from the inhaler. LPN-A then removed, primed and handed the second inhaler to R121 who inhaled a dose. When done, LPN-A replaced both inhalers back into their respective containers and said aloud, You got your call light. LPN-A removed their gloves, used hand sanitizer and left the room. There was no offer, attempt or direction to have R121 rinse his mouth after using the Breo Ellipta. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following, on 4/9/24 at 8:14 a.m., R121 was interviewed. R121 explained he admitted to the care center a few days prior from the hospital and had been on multiple inhalers for a long time. R121 was questioned about rinsing his mouth with water after using the Breo Ellipta and expressed, You're supposed to do things like that, but I don't [usually]. However, R121 stated the care center staff, so far, had never told or asked him to do that when they administer his Breo Ellipta. On 4/9/24 at 8:18 a.m., LPN-A was interviewed and verified they did not complete or offer R121 any rinse and spit after the inhaler use. LPN-A stated they didn't as the MAR (Medication Administration Record) didn't direct to do so and, typically, it would if such was needed adding aloud, I don't think I missed anything[?] LPN-A then reviewed R121's electronic MAR and expressed it actually did direct to rinse the mouth after use of the inhaler. LPN-A stated, I missed that. LPN-A expressed they would return to R121 and have him rinse and spit adding such was important to do so the medication didn't remain in the oral cavity. LPN-A added, It can be bad for the oral cavity if it sits in there. On 4/10/24 at 11:13 a.m., a telephone interview was attempted with the facility' consulting pharmacist, however, they were unavailable. As a result, a telephone interview was completed with pharmacist (P)-A who worked for the dispensing pharmacy. P-A verified Breo and Incruse were both a dry-powder inhaler, and they expressed a rinse and spit should be done after using the Breo Ellipta because it has a steroid in it, adding failure to do such would cause a chance for developing thrush. P-A explained if giving multiple inhalers, then the recommendation would be to give the Incruse, followed by Breo, and then rinsing the mouth to help avoid medication particles becoming entrapped in liquid in the mouth. On 4/10/24 at 12:15 p.m., the assistant director of nursing (ADON) was interviewed with the administrator present. ADON explained administration instructions, such as rinse and spit, were recorded in the orders and, as a result, the MAR for the nurse to see and follow. ADON stated they had visited with LPN-A about the administration observed (on 4/9/24) who verified they didn't offer or provide a rinse and spit after the inhaler. ADON stated they told LPN-A where to review those instructions in the MAR going forward. ADON stated a rinse and spit should be done to prevent thrush, and education will be completed with the nurses. A facility' Inhaler Use policy, dated 3/2024, identified guidelines for administration for oral inhaled medications. This outlined, After inhalation of corticosteroids such as . resident should rinse their mouth with water and spit it out.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided to reduce the risk of complication (i.e., infection, skin scratches) for 1 of 1 residents (R38) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R38's quarterly Minimum Data Set (MDS), dated [DATE], indicated R38 had moderate cognitive impairment with signs of delirium and no behaviors or rejection of care. MDS indicated R38 required maximal assistance to dependent on assistance for activities of daily living (ADLs) including personal hygiene. R38's care plan, printed 4/9/24, identified R38 is at risk for decline in ability to participate in grooming. The document directed, staff to provide extensive assist with grooming. The document lacked evidence of R38 refusing or having a history of refusing staff assistance with cares or personal hygiene. R38's Visual Body Inspection, dated 4/6/24, lacked documentation of R38 refusing staff to trim and clean her fingernails. Document does instruct to observe resident nails and provide nail care as indicated. R38's progress notes, dated 3/20/24 to 4/9/24, lacked documentation of R38 refusing or declining staff to trim or clean fingernails. The notes further lacked documentation of refusals of showers or assistance with cares. On 4/08/24, at 3:06 p.m., R38 was observed sitting in her room in her wheelchair. R38's fingernails were observed to be long with numerous nails to have jagged edges with dark colored debris underneath. R38 stated that I have asked for a clipper from the desk, but they won't give me one, adding that it would be nice if they would clip and clean her nails for her. R38 expressed that her nails are dirty. R38 stated she has an emery board to file them but that doesn't help with the jagged edges or the dirt underneath. During a subsequent observation made n 4/09/24, at 11:23 a.m., R38 was observed sitting in her wheelchair and preparing to go to lunch. R38's fingernails continued to be long with numerous nails to have jagged edges with dark colored debris underneath. During an additional subsequent observation made on 4/10/24 at 7:12 a.m., R38's fingernails continued to be long with numerous nails to have jagged edges with dark colored debris underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24, 7:17 a.m., licensed practical nurse (LPN)-B verified that they were currently working with R38 and familiar with R38. LPN-B stated that R38 requires a Hoyer lift (mechanical lift) for transfers, no longer ambulates and needs a lot of care. LPN-B indicated that R38 can perform some cares after staff set up items. LPN-B verified that nail care is done by staff, adding that R38 has a nail file but staff is responsible to clean and cut nails. LPN-B stated she is unaware if R38 refuses nail care and if R38 does then it would be documented in a progress note. LPN-B stated that nail care is done weekly on bath/shower days and as needed. LPN-B observed R38 fingernails and stated, there is some debris underneath her fingernails that could be cleaned. On 4/10/24, at 7:25 a.m., LPN-C verified that they are familiar with R38 and have worked with her frequently. LPN-C stated that they are unaware of R38 refusing cares, more specifically nail care. LPN-C stated that I have clipped her nails in the past and she has never refused. LPN-C indicated that if a resident refuses nail care it should be documented in a progress note. LPN-C stated that nail care is done weekly on bath/shower days and as needed. On 4/10/24, at 7:31 a.m., nursing assistant (NA)-A verified they are familiar with R38 and work with her frequently. NA-A verified that R38 does not have a history of refusing cares. NA-A stated they don't typically give her showers as that is done on the afternoon shift. NA-A observed R38's fingernails and stated they are little dirty inside and could be cleaned. She likes them longer. On 4/10/24, at 12:52 p.m., registered nurse (RN)-B verified that they are familiar with R38. RN-B stated that the expectation would be that nail care is done weekly on bath days and as needed. RN-B stated if a resident refused nail care, it would be documented in a progress note. RN-B stated, to my knowledge, [R38] does not routinely refuse nail care, at times she might say she wants to do it herself. RN-B verified this would be documented in a progress note. During interview on 4/11/24, at 10:50 a.m., administrator stated that nail care is important for infection control, hygiene, and dignity. Administrator verified that nail care is offered on bath days and as needed for all residents. A facility policy titled Nail Care, review date of 3/27/24, was provided. The document indicated that nails will be maintained in a clean and neat manner to support resident dignity and to avoid problems associated with rough, cracked, overly long, or broken nails.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure activities of interest were offered or provided to enhance quality of life for 1 of 1 resident (R19) reviewed who resided on the short-term stay (i.e., TCU) unit. Findings include: R19's admission Minimum Data Set (MDS), dated [DATE], identified R19 had moderate cognitive impairment, demonstrated no delusional thinking, and required moderate/partial assistance to complete most mobility-based activities of daily living (ADLs). Further, under the section labeled, F0500. Interview for Activity Preferences, identified it was, Very Important, for R19 to do things with groups of people and their favorite activities while at the care center. On 4/8/24 at 2:13 p.m., R19 was observed seated in a recliner chair in her room with the television on. R19 was interviewed about her quality of life while at the care center including what, if any, activities she attended. R19 stated she [didn't] really know if she had ever been invited or attended activities while at the care center, but expressed she would like to, if offered. R19 stated her activities of choice would include anything with games including with other residents but nobody at the care center, to her recall, had ever asked about it. R19 reiterated she'd like to attend activities if they had some adding, I think that would be fun. R19's initial Therapeutic Activities Observation, dated 3/19/24, identified R19 admitted to the care center on 3/15/24, and had a planned stay of less than three months. The assessment outlined various questions to be completed by staff including, With consideration to the anticipated length of stay, what is the resident's level of interest in pursuing leisure/activities? This was answered with, Minimal interest due to anticipated length of stay. The evaluation continued and outlined R19 was Lutheran and attended services, along with checkmarks placed next to her preferred program style including large groups, small groups, religious activities, and other (i.e., pet visits, social events). A section labeled, Describe resident's current interests ., was listed which outlined, Knitting, cookinf [sic], social events, cooking, along with social events, coffee, and getting to know others being listed as important for life enjoyment and a meaningful daily routine. The evaluation outlined, Initiate care plan. R19's activities care plan, last revised 3/15/24, identified R19 was able to independently structure her own leisure time and listed a goal, Resident will be content with leisure routine during stay. The care plan listed two approaches to help R19 meet this goal which read, Inform of group activities of interest, Provide leisure materials as requested. R19's progress notes, dated 3/15/24 to 4/10/24, were reviewed and identified the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/24, a therapeutic recreation (TR) note identified R19 admitted to the transitional care unit for rehabilitation. The note outlined, In leisure time resident enjoys reading, knitting, sewing baking, crocheting plus spending time with friends and family . goals for upcoming 90 days are to pursue independent leisure activities of interest. Staff will monitor and provide any independent leisure materials needed. A subsequent note, dated 3/15/24, identified TR staff met with R19 and informed her of the activities department. R19 was provided an activity calendar and a brief explanation of the types of activities available and how they can be attended. R19 requested a book to read and was provided with several feel good books. On 3/16/24 and 3/30/24, respectively, R19 was visited by the onsite chaplain. However, there were no other recorded notes by TR to demonstrate what, if any, activities had been offered, attended, provided or refused by R19 during her admission to the TCU. When interviewed on 4/9/24 at 12:41 p.m., nursing assistant (NA)-B stated they had worked with R19 before and described her as needing help with transfers and having some forgetfulness. NA-B stated R19 was involved with therapy and, of late, had been coming out of her room for meals more often with staff encouragement. NA-B stated R19 had multiple visitors throughout the week and enjoyed her television adding, [R19] likes to relax. NA-B stated TCU residents are allowed to go upstairs to the long-term care unit for activities but there wasn't much, if any, group-based activities done on the TCU adding, There's not too much down here [on TCU], per se. On 4/10/24 at 9:07 a.m., the activities coordinator (AC)-A was interviewed. AC-A explained they had attempted to include R19 a few times with activities but she either had family present or, on one occasion, voiced feeling nauseated and unable to attend. AC-A stated activities participation was tracked using electronic point-of-care (POC) charting and provided such for review. R19's POC History Report, printed 4/10/24, identified a category which read, Activities, and included all shifts. However, the provided documentation only listed two (2) activities had been attended, both on 4/9/24, with no other recorded charting or evidence R19 had been offered, provided, attended or refused any activities prior (i.e., 3/15/24 to 4/8/24) on either unit despite being assessed as enjoying social events and getting to know others. In addition, the medical record lacked evidence R19 had ever been re-evaluated to ensure the program placed upon admission remained in accordance with her wishes or needs. AC-A verified the charting lacked refusals, attempts or completed activities and stated they had not been tracking those but would moving forward. AC-A stated they did round on the TCU unit and try to invite residents' to the various happenings but, again, verified these were not charted. AC-A stated they felt R19 enjoyed spending time more in her room and, when questioned on what, if any, one-to-one (1:1) activities had been attempted or offered in place then, AC-A stated their colleague typically does those but, again, they had not been charted. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 10:54 a.m., the administrator was interviewed and stated the activities director had resigned a few weeks prior. The administrator explained they had visited with AC-A and reviewed R19's medical record which supported R19 had been educated on activities in the building and provided a calendar of them upon admission. The administrator stated they discussed R19 with AC-A (after the surveyor discussion) and AC-A was going to check with R19 to see if more books could be provided on her topics of interest adding, I [administrator] don't know her that well. The administrator stated R19 had more weakness and illness when she first admitted but within the last few weeks now had been doing much better and coming out of her room more often adding, She's now feeling better and completely different person. When asked if R19 had been re-evaluated for her activities-involvement, in the setting of feeling better and coming out of her room more often now, the administrator explained there had been discussion of it, as a whole, in the morning clinical meetings but it wasn't specific to activities. The administrator reviewed R19's charted activity involvement and verified activities, including attempts and refusals, should be documented so, as a result, they were going to work with AC-A to implement a spreadsheet similar to the one used on the LTC unit. The administrator stated charting should be done as, That is your proof [offered]. A facility policy on activities was requested, however, none was provided.

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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** 49034 Based on observation, interview, and document review the facility failed to ensure the correct application of a neck brace to minimize the risk of spinal misalignment and corresponding adverse effects for 1 of 1 residents (R34) reviewed for neck brace application. Findings include: The undated Maimi J Instructions for Use, indicate the Miami J collar (neck brace) is used to provide immobilization to the cervical spine (bones or vertebrae in the neck) and indicates proper sizing is critical for achieving comfort and immobilization. The manufacturer guidelines indicate collar application must be secure to ensure proper fit, maintain alignment, and prevent the chin from slipping inside the collar. The guideline indicated if the patient can slip his/her chin inside the collar, it is [a] clear indication that it is not snug enough. R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated R34 had moderately impaired cognition and was diagnosed with fractures of the vertebrae in the neck and heart failure. R34 required maximal assistance with oral hygiene, bathing, and bed mobility. R34's Physician Order Report dated 2/10/23, indicated R34 must wear a neck brace at all times, and it must fit properly. R34 ' s care plan dated 2/3/24, indicated R34 disliked the neck brace but neurology had indicated R34 must wear it at all times. R34's neurology note dated 8/8/23, indicated R34 had chosen not to have surgery to treat his spinal fracture and instead was fitted for a Miami J collar. The note indicated R34 was wearing his cervical collar but [the] chin is tucked down in the collar along with his clothing. R34's provider note dated 3/18/24, indicated R34 was using a Miami J collar and expected to wear the Maimi J collar indefinitely. The note indicated R34 was wearing the collar on assessment, and it appeared well fitted but the chin was tucked into the collar. R34's medical record was reviewed and lacked indication R34 had refused proper collar application and if so risk versus benefit education had been provided to the resident and representative. During an observation on 4/8/24 at 1:19 p.m., R34 was observed sitting in his wheelchair in his room wearing a Miami J collar. R34's chin and bottom lip were tucked into the collar and were not visible. The collar had two padded plastic parts, a front part that fit under the chin and a back part that fit behind the neck. The two parts were held together by two blue Velcro strips. On the left side of the collar, there was an approximate 1. 5-inch vertical gap between the front and back parts of the collar where the neck was observed. The Velcro strip on the left side of the collar was secured halfway across the bottom strip. There were no noted markings indicating how far/tightly this strip should have been pulled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/9/24 at 11:05 a.m., R34 was observed sitting in his wheelchair in his room wearing a Miami J collar. R34's chin and bottom lip were tucked into the collar and were not visible. The Velcro strip on the left side of the collar was again secured halfway across the bottom strip leaving a gap between the front and back plastic parts of the collar. During an interview on 4/9/24 at 12:54 p.m., licensed practical nurse (LPN)-D stated he was the nurse in charge of R34's care and had assisted with neck brace application in the past. LPN-D stated he did not have any physical indications that he relied on when applying the brace to ensure correct application but instead relied on reported resident comfort levels. During an interview on 4/9/24 at 1:50 p.m., the director of nursing (DON) stated R34 was last seen by the neurology providers in 8/23 and they had not received a call reporting the collar was ill-fitted or incorrectly applied so she thought it was applied correctly. The DON stated if R34's collar was being misapplied or was ill-fitted, she would have expected a re-consultation of occupational therapy to assess for fit and re-educate nursing staff on the correct application of the device, but this had not happened for over a year. The DON stated she was unaware of R34 refusing to wear the collar correctly although he did tend to tuck his chin into the collar. The DON stated she would review the record and cofirmed that the resident had not refused to wear the collar correctly and if so, a risk versus benefit had been completed with the resident and his representative as she was not immediately seeing that this had occured. During an observation and interview on 4/9/24 at 2:08 p.m., R34 was observed sitting in his wheelchair in his room wearing a Miami J collar. R34's chin and bottom lip were unable to be observed as it was tucked into the collar. The Velcro strip on the left side of the collar was secured halfway across the bottom strip leaving a gap between the front and back plastic parts of the collar. The DON stated that she had never put on or taken off the collar so she was unsure what factors the nursing staff used to ensure that the collar fit properly. During an interview on 4/10/24 at 8:09 a.m., occupational therapist (OT)-A stated R34's Miami J Collar should not have been loose enough so R34 could so easily tuck his chin into it, and it was likely nursing staff needed re-education on correct application as it had been over a year since he had done that with them. OT-A stated he would assess R34 ' s collar later in the day and it should have markings on the Velcro to assist nursing in knowing how far to pull the Velcro strips. OT-A stated correct application of this brace was important for R34 ' s safety and correct spinal alignment. During an interview on 4/10/24 at 11:48 a.m., R34 ' s family member (FM)-B stated he took R34 to his neurology appointments, and the last time R34 was seen by them was last fall. FM-B stated the neurology team had noted R34 would tuck his chin into the collar which he was not supposed to do, so they had recommended to him that the brace be applied tighter. FM-B stated he was unsure if this was something the nursing staff had been doing. FM-B stated that he was not aware of R34 refusing to wear the brace or refusing to wear the brace in a tighter manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/10/24 at 12:52 p.m., R34 was observed sitting in his wheelchair with his chin resting on top of the brace with both lips visible. OT-A stated he had just reassessed and adjusted R34 ' s neck brace and it had been too loose. The top strip of Velcro on the left side of R34 ' s neck brace was now observed to almost completely cover the bottom strip of Velcro and the back plastic part of the collar was now overlapping the front piece. The OT-A stated he was going to mark the correct placement of the Velcro and see if he could find/create written instructions for nursing staff to follow when applying the brace as that had not been in place previously. A policy/procedure regarding neck brace application was requested and not received.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49034 Based on observation, interview, and document review, the facility failed to ensure the required nurse staffing information was posted daily and updated with each shift. This had the potential to affect all 58 residents residing in the facility and/or visitors who may wish to view the information. Findings include: During an observation and document review on 4/8/24 at 12:26 p.m., the nursing staff posting was observed in a hallway off the main lobby near the entrance. The posting was dated 4/5/24, with a resident population of 61, and the first shift starting at 6:30 a.m. During an interview on 4/10/24 at 8:55 a.m., the staffing coordinator (SC) stated she went on vacation recently, and registered nurse (RN)-B, the long-term care nurse manager, oversaw updating the staff posting on the weekdays when she was gone, and it must have been missed 4/8/24. The SC stated before she left the facility, each Friday, she would fill out the staff postings for the weekend and the morning charge nurse was supposed to discard the previous day's posting to display the current one when they arrived. The SC stated RN-C was the charge nurse this weekend and it must have been forgotten. The SC stated if the staffing levels or the census changed, she would update the weekend numbers when she arrived on Monday. During an interview on 4/10/24 at 9:56 a.m., RN-C stated that she worked at the facility every other weekend and was the day charge nurse the previous weekend. RN-C stated the SC normally managed the staff posting but wasn't sure who posted it on the weekend. During an interview on 4/10/24 at 12:21 p.m., the assistant director of nursing (ADON) stated that the SC oversaw the staff posting and would be a better resource for information regarding this. The facility Posting of Staffing Hours policy dated 10/20/23, indicated a staff posting containing the census, the current date, the name of the facility, and the total actual number of hours worked by nursing staff in each category, would be displayed daily by 9 a.m. The policy indicated that updates would be made to the posting for each shift as needed throughout the day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49339 Based on observation, and interview, the facility failed to ensure appropriate infection control measures were followed related to ensuring clean personal was transported intrafacility in a method that ensured cleanliness and protected the clean laundry . This had the potential to affect all 41 residents on the long-term care floor (LTC) along with an unspecified number of residents whose laundry is done by the facility in the transitional care unit (TCU). Findings include: On 4/8/24 at 2:06 p.m., a four-tiered metal open and uncovered laundry cart with personal clothing items was observed to be on 2nd floor uncovered. Along the top rack, personal items (short sleeve shirts, sweatshirt, etc.) hanging from hangers were hung from the metal bars along the sides and on the shelves were folded personal items (pants, etc.). On 4/08/2024, at 2:13 p.m., laundry aide (L)-A verified that they were delivering resident's personal laundry to their rooms. L-A verified this is the cart that is used to deliver all resident laundry on the second floor and a similar cart is used for the TCU. L-A verified that the cart is a metal four-tiered open cart. L-A stated that all the resident names are along the top of the cart and that is where the items that require hangers are hung (in correlation to their names). L-A verified that shelves are used for resident items that go in their drawers. L-A verified that cart is not covered. L-A stated the laundry cart for downstairs is smaller as we don't do everyone's laundry downstairs, like we do up here, as it is a temporary stay. L-A was not able to identify how many residents' laundry on the TCU was being done currently as it always is changing. On 4/10/24, 8:14 a.m., during a laundry tour both laundry carts for LTC and TCU were observed. Neither laundry carts had covers or a means to protect the clean laundry from dust or soil attached to them. The laundry cart used to deliver the personal items for TCU was similar to the cart used for LTC, just smaller in size. The carts used for linens were covered with attached plastic covers. L-A stated, the only reason I can think of why they aren't covered is because we put items on the top level. L-A verified, the linen carts are covered, and the personal laundry carts are not covered. L-A was unsure the reason to cover the laundry carts. During interview on 4/10/24, at 8:29 a.m., director of environmental services (ES)-A verified that they oversee laundry services and had worked in the facility for many years. ES-A verified that personal laundry carts are not being covered. ES-A verified that they are aware the personal item carts are to be covered during transport as they got notified about a month and a half to two months ago and stated, it doesn't make sense to me. ES-A verified the facility has not been covering the personal laundry carts when delivering items to residents' rooms and this is something we need to fix. During interview on 4/11/24, at 10:52 a.m., administrator verified it is important that any clean linen is covered for infection control purposes. Administrator added that education was provided to the team that carts that have clean linen must be covered at all times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Sorting Clean Linen, with a review date of 3/23/23 was provided. Document indicated that clean linen shall be dried, folded and sotred in enclosed, clean, designated locations.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and record review, the facility failed to implement their antibiotic stewardship program, to include proper testing, to reduce unnecessary antibiotic use to ensure good clinical outcomes and to reduce potential drug resistance for 1 of 2 residents (R4) reviewed for antibiotic stewardship who received 2 antibiotics without proper testing. Findings include: The Centers for Disease Control and Prevention (CDC) identifies antibiotic stewardship as the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients. Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance. An article by the National Institute of Medicine, titled Antimicrobial Stewardship - Can We Afford to do Without it?, dated 1/20/2015, stated the risk of prescribing and using inappropriate antibiotics leads to not only poor clinical outcomes but an increase in the risk of antibiotic resistant bacteria. R4's quarterly Minimum Data Set (MDS), dated [DATE], indicated R4 was cognitively intact and was independent with most ADLs but required partial to moderate staff assistance with bathing and toileting. R4's progress notes, dated 3/20/24 - 4/11/24, indicated R4 had ongoing complaints of dysuria (painful urination) and frequent urination from 3/20/24 to 4/9/24 despite being treated by two different antibiotics. The progress notes documented the following; -On 3/20/24, R4 had complaints of a burning sensation and urgency when urinating. R4's nurse practitioner (NP) was notified who ordered a urinalysis (a urinalysis, or UA, is a test of your urine. It's used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes. A urinalysis involves checking the appearance, concentration and content of urine.) with a conditional urine culture (a urine culture, or UC, test can identify what bacteria or yeast is causing a urinary tract infection (UTI). If bacteria multiply, an antibiotic sensitivity test can identify the antibiotic most likely to kill those particular bacteria.) -On 3/21/24 R4's UA results were received which indicated R4 had a urinary tract infection (UTI) and R4 received an order to start Macrobid (an antibacterial drug used to treat urinary tract and bladder infections caused by Escherichia coli or Staphyloccocus saprophyticus strains of bacteria that are sensitive to this drug) 100 mg twice a day for five days. R4 had continued complaints or a burning sensation with urination. -On 3/22/24 R4's UC results came back indicating mixed flora and was unable to determine what bacteria was causing R4's UTI. On-call providers stated since R4 was already on an antibiotic there was no further treatment. R4 continued to have complaints of dysuria and frequent urination. -On 3/23/24 R4 continued to have complaints of dysuria and frequent urination. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/24/24 R4 continued to have complaints of dysuria, frequent urination and increased weakness and stated she didn't think the antibiotic was working. The on-call provider was notified. -On 3/26/24 R4 completed her course of Macrobid, did not complain of dysuria but reported continued weakness and spent most of the day sleeping. -On 3/28/24 R4 had continued complaints of painful and burning urination, stating that she was treated with an antibiotic called Augmentin in the past. On-call providers were notified. A visual assessment of R4's peri-area/urethra opening for skin breakdown was done and noted no external abnormalities that could lead to burning with urination. Due to R4's continued symptoms of burning with urination and urinary frequency, R4 was stated on Keflex (an antibiotic utilized in the treatment of urinary tract infections caused by Staphylococcus aureus or Proteus mirabilis) 500 mg twice a day. -On 3/30/24 R4 continued to have burning with urination. -On 3/31/24 R4 received her last does of Keflex. R4 requested to speak with the provider as she was still having UTI symptoms. An order was received from the NP to extend the Keflex an additional two days. -On 4/3/24 R4 continued to have complaints of dysuria and frequency with urination. The NP ordered a second UA/UC. -On 4/4/24 R4's UA results came back with abnormal results indicating a UTI. The NP was updated and no new orders were given at this time. -On 4/8/24 R4's UC results came back and R4 began a third treatment for her UTI, Cefuroxime Axetil (used for the treatment of urinary tract infection particularly when due to beta-lactamase producing bacteria) 250 mg twice a day for 5 days. -On 4/9/24 R4 stated she was finally starting to feel better. -On 4/10/24 R4 stated she slept better and was not up as frequently to use the bathroom. -On 4/11/24 R4 had no complaints of UTI symptoms, stating she was feeling like herself again. R4's Order History, printed 4/11/24, indicated R4 had 2 scheduled antibiotic time outs (Antibiotic time-outs are formal reassessments of prescribed antibiotics. A time-out provides a structured opportunity to review a residents antibiotic therapy 36 to 72 hours into the regime)on 3/22/24 and 4/9/24, lacking an order for an antibiotic time out for the Keflex prescribed on 3/28/24. During an interview on 4/8/24, R4 stated she had a UTI and had been sick for weeks stating the facility had given her a couple different antibiotics but they were not working. R4 stated she was urinating a lot and it was painful, stating she felt very weak and had not been able to get out of bed in the past few weeks since becoming so sick. R4 stated she normally enjoyed going to activities and eating in the dining room however she was too weak to get out of bed because of her UTI and staff were bringing food to her in bed. R4 stated she was still bringing herself to the bathroom but that her legs felt like rubber. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 10:45 a.m., registered nurse and nurse manager (RN)-B stated she was aware R4 had been complaining of abdominal pain and dysuria. RN-B stated when a resident had complaints of dysuria or frequent urination, they would treat based on what the provider recommends, whether that be obtaining a UA/UC, pushing fluids, or just continuing to monitor. RN-B stated typically they would wait for the urine culture results to start an antibiotic, but not always, if a resident's symptoms were severe. RN-B stated it was not their typical practice to start antibiotics without a UA/UC which would determine what antibiotic will work based on what flora is present in a resident's urine. RN-B stated not knowing if the correct antibiotic will work can delay treatment. RN-B stated R4's nurse practitioner was aware that R4 was started on Keflex without a UA/UC and was still complaining of UTI symptoms (dysuria and frequent urinations) and had instructed staff to continue the antibiotic despite this until a visit was made to R4. During an interview on 4/10/24 at 11:56 a.m., the infection preventionist (IP) stated their process was to generally follow what the providers were recommending for treating a UTI but they would usually wait until the urine culture is received back to ensure they are treating the right bug stating it was best to not give antibiotics [NAME]-nilly as this could lead to super bugs. The IP further stated she was was surprised when the Keflex was extended as it was not working, further stating that starting the Keflex without a UA/UC was against their Antibiotic Stewardhip protocol and could delay proper treatment for R4. The IP stated their protocol was to always follow antibiotic stewardship. A facility policy titled Antibiotic Stewardship , reviewed 3/28/24, stated it was the facility's process to, monitor compliance with prescribing expectations and clinical practice guidelines relevant to antibiotic stewardship.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding pneumonia for 4 of 5 residents (R4, R32, R34, R44) over [AGE] years old whose vaccinations histories were reviewed. Findings include: 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. R4's face sheet, dated 4/10/24, indicated she was [AGE] years old and resided in long-term care. The face sheet indicated diagnoses which included type 2 diabetes mellitus. R4's facility immunization record and MIIC (Minnesota Immunization Report) report, both dated 4/10/24, indicated she received the received PPSV23 on 10/20/1999, and again on 3/29/2006 followed by the PCV13 on 9/21/15. R4's facility immunization record lacked evidence that R4 was offered or received education regarding PCV20 vaccine. The electronic medical record (EMR) lacked evidence of shared clinical decision making with the physician regarding the PCV20. The EMR lacked evidence R4 was offered or received PCV20. R32's face sheet, dated 4/10/24, indicated she was [AGE] years old and resided in long-term care. The face sheet indicated diagnoses included emphysema (condition in which the air sacs of the lungs are damaged and enlarged causing breathing issues), and chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe). R32's facility immunization record and MIIC (Minnesota Immunization Report) report, both dated 4/10/24, indicated she received the received PPSV23 on 7/19/2007, the Prevnar 7 (PCV7) on 7/19/2007 followed by the PCV13 on 9/16/15. R32's facility immunization record lacked evidence that R32 was offered or received education regarding PCV20 vaccine. The electronic medical record (EMR) lacked evidence of shared clinical decision making with the physician for PCV20. The EMR lacked evidence R32 was offered or received PCV20. R34's face sheet, dated 4/10/24, indicated he was [AGE] years old and resided in long-term care. The document indicated diagnoses included hypertension (high blood pressure), acute respiratory distress (condition in which fluid collects in the lungs' air sacs, depriving organs of oxygen), and unspecified diastolic (congestive) heart failure (happens when the heart muscles do not relax properly between beats). R34's facility immunization record and MIIC (Minnesota Immunization Report) report, both dated 4/10/24, indicated he received the received PCV13 on 10/22/15, the PPSV23 and PCV13 on 9/15/16, followed by the PPSV23 on 9/12/17. R34's facility immunization record lacked evidence that R34 was offered or received education regarding PCV20 vaccine. The electronic medical record (EMR) lacked evidence of shared clinical decision making with the physician for PCV20. The EMR lacked evidence R34 was offered or received PCV20. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44's face sheet, dated 4/10/24, indicated he was [AGE] years old and resided in long-term care. The document indicated diagnoses included hypertension, unspecified atrial fibrillation (abnormal heart rhythm), and chronic kidney disease (kidneys no filtering waste properly). R44's facility immunization record and MIIC (Minnesota Immunization Report) report, both dated 4/10/24, indicated he received the received PPSV23 on 3/13/2011, followed by the PCV13 on 3/13/15. R44's facility immunization record lacked evidence that R44 was offered or received education regarding PCV20 vaccine. The electronic medical record (EMR) lacked evidence of shared clinical decision making with the physician for PCV20. The EMR lacked evidence R32 was offered or received PCV20. A TCU admission packet was provided on 4/10/24 to surveyor. The admission packet includes three separate pages of information on RSV, COVID, and pneumococcal vaccines that provided to TCU residents. The document prompts a conversation regarding each immunization. The document is signed by provider with a note under additional comments, advise pt. discuss with PCP. During interview on 4/10/24, at 10:43 a.m., infection preventionist (IP)-A verified she was the infection preventionist. IP verified it falls in her responsibility to ensure residents are up to date on all immunizations. She stated that immunizations are verified through MIIC (Minnesota Immunization Information Connection). IP-A indicated she used the current Centers for Disease Control and Prevention (CDC) recommendations for immunization guidelines and verified using the table from CDC from March 2023 for pneumococcal vaccines. IP stated that TCU residents are not given COVID, RSV (respiratory syncytial virus), or pneumococcal vaccines as the provider feels they are too sick while they are here to receive it. IP stated that LTC residents are offered the COVID, flu, tetanus and pneumococcal (PPSV23 or PCV13) vaccines. On 4/10/24, at 12:15 p.m., IP-A verified after she reviewed the EMR, R4, R32, R34, and R44's pneumococcal immunizations as listed above. On 4/10/24, at 1:23 p.m., IP-A verified that R4, R32, R34, and R44 where not offered the PCV20. IP-A stated no residents have been offered the PCV20 in the facility. IP-A verified that when checking the pneumococcal immunizations that she was verifying the completion of the series (PPSV23 and PCV13) and the facility was not doing any shared clinical decision making for the PCV20. IP-A verified that no education or conversations have been had with not only the residents listed above but any residents in the long-term care. IP-A stated that any TCU residents are referred to the primary care provider to obtain the pneumococcal immunizations as the provider overseeing their care (while in TCU), won't give orders for the immunizations as it is felt they are to sick while they are there. IP-A verified the documents listed above in the admission packet for TCU residents. IP-A stated the LTC admission packet is different and does not include these documents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Care Hastings Health and Rehabilitation	930 West 16th Street Hastings, MN 55033

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24, at 10:12 a.m., IP-A reviewed immunization consent forms with surveyor. IP-A stated they administer COVID vaccines the beginning of April and obtained consent to do this. The same form is used for all immunization consents, titled Immunization Consent. IP-A stated in the short description, she puts in what immunization is being discussed; for example, covid vaccine. IP-A stated that if all the radio buttons are not answered on the form, it cannot be locked and signed. IP-A verified that the consents signed for the covid vaccine (described in the short description), the only vaccine that was discussed was the covid vaccine. IP-A verified that for the pneumococcal vaccine section of the form, she marked on the radio-button no-I do not wish to receive the pneumococcal vaccinations that are recommended according to the CDC/ACIP and no discussion about the pneumococcal vaccine was had. IP-A verified the Immunization Consent forms for R4, R32, R34, and R44 did not indicate there was a discussion or education provided about PCV20 despite the radio-button having indicated it had been refused. During interview on 4/11/24, at 10:52 a.m., administrator verified that immunizations are given upon admission, and she referred to infection preventionist and director of nursing for their expertise. A facility policy titled Pneumococcal Vaccine with a review date of 7/24/23 was provided. Policy indicated to offer our residents immunization again pneumococcal disease in accordance with current CDC or state guidelines and recommendations. The document included the CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023.