STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	865 Mankato Avenue Winona, MN 55987

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview, and document review, the facility failed to comprehensively assess wounds including measurements weekly for 1 of 3 residents (R24) reviewed for pressure ulcers. Findings include: R24's facesheet printed 12/5/24, included diagnoses of severe dementia, difficulty in walking, and dysphagia (difficulty swallowing). R24's quarterly minimum data set (MDS), dated [DATE], identified R24 had severely impaired cognitive decision making skills, disorganized thinking and inattention constantly present. R24 required substantial to maximum assist with bed mobility and dependent on staff for wheelchair mobility. R24 did not have a pressure ulcer but was identified at risk of pressure ulcer development and had a pressure reducing device in wheelchair. R24's physician orders dated 10/15/24, included left heel wound: Cut to fit Aquacel Ag (sterile dressing to cover wounds that excrete fluids and includes antimicrobial) to the wound bed, cover with 4x4 Allevyn gentle border foam (water/bacteria-proof silicone adhesive dressing) and change every other day and as needed. R24's plan of care dated 9/12/24, included R24 has a potential for skin integrity impairment with goal indicating the skin will remain intact. Interventions included weekly skin assessment. Treat skin concerns per protocol as able. Update provider with issues or concerns. Monitor every 2 hours, turn and reposition schedule. The care plan did not include pressure reducing device for heels. During interview and observation on 12/2/24 at 3:25 p.m., R24 was sitting in her broda chair (provides comfort, support and mobility) with slippers on both feet. Prevalon boot (heel protector) was on the floor next to the television. The foot rest on left side of Broda chair was off and R24 had her left heel suspended with her foot resting on on her right foot. Family member (FM)-A stated she has had a heel ulcer for the last few months. FM-A stated he removes the prevalon boot because R24 likes to kick her feet around and he doesn't think it does any good even though staff tell me it does. FM-A added the wound is doing good now and healing but is still open. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 12/3/24 at 8:42 a.m., R24 was sitting in her chair in her room with FM-A present. Left foot rest on Broda chair remained off and R24 had her left foot resting on top of her right foot. R24 had slippers on both feet. Registered nurse (RN)-B entered room to complete wound care and observed FM-A remove old dressing. Scant serosanginous drainage was present on old dressing. FM-A stated the wound has always been dime size and it is even smaller now. RN-B measured wound at 7 x 9 millitimeters (mm) across and stated it is healing, no tunneling present or redness or signs of infection. RN-B when questioned about the wound type, and wound bed description stated I'm unsure what to call this wound at this time. RN-B indicated wound assessments and measurements are documented in the progress notes when done. RN-B was unsure how frequently this facility requires a comprehensive wound assessment to be done. R24's completed skin assessments included: 10/3/24: Generalized self-inflicted scratches. Otherwise skin intact 10/10/24: Light redness inner buttocks, skin tear right hand and fourth finger. No mention of heel issues A Wound Management Detail Report dated 10/14/24, by RN-A for R24 included unspecified left heel ulcer. Moderate amount of serosanguineous (clear thin liquid that oozes from wounds) drainage present with no tunneling. Tissue type is slough (dead tissue within the wound). Comments included newly discovered stage 3 (full thickness skin loss with damage to subcutaneous tissue) pressure ulcer to left heel with wound nurse assessment and recommendations for treatment. Podiatry appointment is scheduled for 10/24/24. A Podiatry Note dated 10/22/24, included R24 is being seen for pressure ulcer on the posterior, plantar lateral aspect of her left heel. History of this ulcer is not known. FM-A who is with R24 today stated she had some type of callused lesion over that area for quite some time however, there is no record of any open ulceration until 10/15/24. A padded heel boot was recommended to help offload pressure at the ulcer site. Silver alginate with an Allevyn dressing was applied and this has been changed frequently since then. The day after the wound care nurse visit, the patient's primary care provider thought there was some concern of infection at the wound and prescribed doxycycline (antibiotic) 100 mg twice a day for ten days. Assessment of wound included stage 2 (one that has progressed to affect both the top and bottom layers of the skin but not fatty tissue beneath) pressure ulcer measuring 0.5 x 0.4 cm which is an improvement from 1.0 x 0.8 cm when she was seen by wound care 1 week ago. The base of the ulcer is red and granular with about 2 mm of depth at the center tapering out to 1 mm and lesser on the edges. No active drainage or sign of infection at this time. There is no necrotic (dead) or devitalized tissue surrounding or over the wound. R24's wound evaluations from 10/25/24 to 12/4/24, included: 10/25/24: Scant serous drainage on bandage. Open area posterior 0.3 cm x 0.4 cm. Wound description not completed. 10/31/24: Pressure sore to left heel open to air. Pea sized open area, not red, calloused edges have softened. Depth 0.3 mm. Scant drainage, no edema. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/7/24: Pressure ulcer related to left heel not changed this shift, not measured, or assessed. Has been charted as improving. 11/8/24: 0.5 cm x 0.5 cm light serous drainage, 50% epithelial tissue and 50% non granulation tissue. Wound is improving. 11/18/24: No drainage from left inner heel scabbed area, is size of a pea. 11/23/2024: Left inner heel has a pea sized red shiny area, scab appears to have sloughed off. Treatment was completed with no indicators of pain. No signs of infection. Receives Aquacell AG and mepilex border with gauze wrapping. 11/27/24: Heel is open now, red and clean, appears 0.3 cm deep 1cm circular - no drainage or odor. 12/1/24: Stage 2 pressure ulcer to left heel. Minimal serosanguinous drainage. Wound is 1 cm x 0.8 cm. Comments: Stage 2 pressure injury to left heel appears to be healing well with current treatment. No surrounding pink discoloration, redness or warmth. Scant amount of drainage present. The wound assessments lacked consistent weekly measurements and comprehensive wound assessments including but not limited to wound bed description, drainage, and wound edges. During interview on 12/4/24 at 7:43 a.m., RN-D indicated wound care including assessments of the wound are required to be completed weekly. RN-D stated we do a brief note with all dressing changes. During interview 12/4/24 at 10:12 a.m., RN-A, also identified as covering nurse manager, upon review of wound documentation, confirmed wound measurements and comprehensive wound assessments were not completed weekly but should have been. During interview 12/5/24 at 1:19 p.m., the administrator indicated weekly wound measurements and wound assessment including secretions, wound base, tissue at wound bed should be documented per policy and procedure. Facility Skin Care policy dated 7/2023, included: When a skin ulcer or other wound is identified, an assessment of that specific wound will be completed and documented in the electronic medical record (EMR) by the nurse . The assessment will include: measurements of the pressure ulcer, other wound or bruising, condition of wound bed, condition of surrounding tissue and any other signs and symptoms of infection. Weekly skin assessment of the area will be added to the medication administration record.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observations, interview, and document review, the facility failed to complete a comprehensive, person-centered care plan, to promote fecal continence to the extent possible that is dignified, and per resident choice for 1 of 2 residents (R34) who were reviewed for bowel incontinence. Findings include: R34's minimum data set set (MDS) dated [DATE], indicated R34 had a Brief Interview for Mental Status (BIMS) score of 9, indicated moderate cognitive impairment. R34 required extensive assistance for mobility, transfers, and toileting. R34 had a diagnosis of diarrhea. R34 did not have an active bowel program to manage bowel continence. R34's care plan dated 10/9/2024 did not include bowel care interventions or a bowel management regimen. R34 required a two-wheeled walker, gait belt, and assist of one for transfers. R34's physician orders did not address bowel diagnosis and incontinence care and prevention. During observation on 12/2/24 1:57 p.m., R34 stated he has a full depends (disposable product used for incontinence), but nursing assistant (NA)-B is coming back to help him. R34 already had his light on. R34 stated he is uncomfortable, and stated he has crap in his depends. R34 yelled at surveyor go away cause if you can't change me then you are no help. Enhanced precaution at door (resident has catheter). No obvious smells in room. During observation on 12/02/24 2:03 p.m., R34 was yelling from his room sitting here with . [explicit language] in my pants, what are you going to do, everyone just walks out and leaves me . [female name] where are you? I need your help. Can you get me my walker? I need help. I want my walker to walk out. You aren't doing a . [explicit language] thing for me. Aren't you going to help me get clean? I have to have help. Gotta have help. Can you help me? R34 became angry, yelling can I have someone help me? During interview on 12/02/24 at 2:22 p.m., R34 stated he does not like sitting in own poop. He stated he would rather use the toilet, so he doesn't get stool all over himself. R34 stated he needs assistance getting to the toilet but once there, he could have a bowel movement without soiling himself. During interview on 12/03/24 at 10:25 a.m., NA-B stated she usually checks on R34 every 2 hours to see if his catheter needed emptying or if his brief was dirty. NA-B stated she does not offer the restroom periodically to prevent stool incontinence. NA-B stated R34 has a history of clostridium difficile (bacterial infection that can cause diarrhea and other intestinal conditions) and does have more episodes of stool incontinence than most other residents. NA-B stated R34 can be predictable; with his bowel movements mostly a short while after he eats. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/3/24 at 01:24 p.m., registered nurse (RN)-C stated R34 should be checked for safety every hour and his catheter should be checked every two hours. RN-C stated the NA's will also check his brief for signs of a bowel movement. RN-C stated R34 was not offered periodic restroom visits to prevent stool incontinence. RN-C stated approximately 30 to 45 minutes after R34 eats, he will likely experience a fecal blow-out or large fecal incontinence episode. RN-C stated a resident with this predictable bowel pattern should have a bowel care plan or bowel management program. RN-C stated R34 did not have a current or previous bowel care plan or bowel management program. RN-C stated R34 she had not written or entered a care plan for R34 because the staff know R34's bowel pattern after eating so they assist him with cleaning after his incontinent bowel movements. RN-C acknowledged R34 should have a bowel care plan so staff know to assist R34 to the bathroom after lunch before he has a blowout. During interview on 12/5/24 at 9:43 a.m., administrator stated the current practice is to use the facility standing orders and check and change every two hours until resident orders or care plans are developed after admission. If a resident experiences a change in bowel habit, new orders and a care plan are completed. Administrator stated a resident with a predictable bowel pattern such as R34, should have a bowel care plan or bowel management plan to optimize fecal continence. Administrator verified R34 does not have an active or previous bowel care plan or bowel management program. Administrator verified the facility had a policy to assess and manage fecal incontinence. Facility Toileting and Incontinence Care Standard Work policy dated 11/18/19 stated if the resident is continent, assist with the use of the toilet per frequency indicated in their care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure side rails were comprehensively assessed to determine if they were appropriate and safe, discuss risks and benefits, and obtain informed consent prior to use of bed rails for 3 of 3 residents (R1, R27, R38), who were observed to have assist bars raised on their beds. This had the potential to affect all 48 residents who utilized an assist bar(s) for mobility. Findings include: R1's facesheet printed on 12/5/24, included diagnoses of spastic cerebral palsy and osteoarthritis. R1's annual Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R1 was dependent upon staff for activities of daily living, including rolling from side to side in bed, transferring and toileting. R1 was not able to move from lying in bed to sitting on the edge of the bed. R1's care plan dated 4/12/23, indicated R1 required assistance of two staff and a Hoyer lift (mechanical lift device) for transfers. R1 used a manual wheelchair for mobility and did not walk. R1's care plan did not identify use of assist bars. R1's fall risk assessment dated [DATE], indicated R1 was a moderate fall risk. R1's electronic medical record lacked side rail assessment, documentation of informed consent and discussion of risks and benefits for use of bed rails. During an observation on 12/2/24 at 1:56 p.m., observed two cane shaped assist bars on R1's bed in the elevated position toward the top of R1's bed, near the location of her head/pillow as R1 laid in bed. R1 stated they had always been on her bed, and she had not had a problem with them. R27's facesheet printed on 12/5/24, included diagnoses of repeated falls and Parkinson's disease. R27's quarterly MDS dated [DATE], indicated moderately impaired cognition, could usually understand, and was understood. R27 was dependent on staff for most ADLs. R27 required substantial assistance to roll side to side in bed, and to move from lying in bed to sitting on the edge of the bed. R27's care plan dated 10/25/24, indicated R27 had falls related to cognitive impairment. Interventions included if tired, recommend doing pivot transfers to bed in the later evening. Care plan dated 11/15/24, indicated assist of two pivot transfer or EZ stand (mechanical assist device). Have R27 stand for a second to get bearings before taking a step. Remind him to push up using grab bars. A fall risk assessment dated [DATE], indicated R27 was a high fall risk. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's electronic medical record lacked side rail assessment, documentation of informed consent and discussion of risks and benefits for use of bed rails. During an observation on 12/3/24 at 5:02 p.m., one assist bar on R27's bed was observed in the upright position on the side of the bed away from the wall. The assist bar was positioned toward the head of the bed and the C shape of the assist bar was facing the head of the bed. R38's facesheet printed on 12/5/24, included diagnoses of dementia, carpel tunnel syndrome (numbness and tingling in fingers), and back pain. R38's quarterly MDS dated [DATE], indicated severe cognitive impairment. R38 could be understood and could usually understand. R38 was independent with mobility and used a wheelchair. R38's care plan dated 10/11/24, indicated she was a fall risk related to dementia diagnosis. R38's care plan did not identify use of assist bars. A fall risk assessment dated [DATE], indicated R38 was a high fall risk. R38's electronic medical record lacked side rail assessment, documentation of informed consent and discussion of risks and benefits for use of bed rails. During an observation on 12/3/24 at 5:02 p.m., both assist bars on R38's bed were observed in the upright position on either side of the bed. The bars were positioned toward the head of the bed and the C shape of the assist bars were facing the head of the bed. During a telephone interview on 12/3/24 at 12:54 p.m., manufacturer technician support (TS)-F, was asked for a service manual for the Hill-Rom assist bars. TS-F stated there used to be instructions online, but they were no longer available. TS-F had a physical copy in his files and took screen shots of the installation directions for the assist bar and provided them via phone text. TS-F stated their products were designed and tested in the orientation documented to ensure proper patient and user safety. The illustration provided via text was titled: Installation Instructions - Side rail, Assist Bar and Headrail Upgrade Kits dated 10/20/09. The instructions on page 175 indicated: point the cane (A) on the assist bar assembly (B) toward the foot end of the bed (see figure 1 on page 176). The figure on page 176 illustrated the assist bar positioned at the lower half of the bed frame, and the C of the assist bar facing the foot of the bed. The assist devices at the facility were installed on the beds in the opposite location and direction -- toward the head of the bed and the C facing the head of the bed. During an observation on 12/3/24 at 5:02 p.m., 48 of 57 residents had either one or two assist bars in the elevated position on their beds. The assist bars were installed closer to the head of the bed, at the level of the resident's pillow/head, and the C shape of the assist bars were facing the head of the beds rather than the foot of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hill-Rom brochure received via email from manufacturer representative (MR)-D on 12/4/2024 at 1:06 p.m., for the Resident(R) LTC Bed, dated 2015, indicated the bed was designed specifically for long-term care. Options were available including an optional assist bar. A picture on page two of the brochure showed side rails on either side of the bed toward the top end, and assist bars on either side of the bed toward the lower end. The assist bars were C shaped resembling a walking cane. The C was facing the foot of the bed in the picture. During a telephone interview on 12/4/24 at 11:27 a.m., MF-D was asked questions about installation of the assist bars, including the proper location and direction, and who installed them when purchased in 2017. MR-D stated he would check and call back. In addition, a photo of the assist bars on R118's bed was emailed to MR-D to illustrate current position and direction of assist bars at the facility. In an email dated 12/4/24 at 1:06 p.m., MR-D wrote: as you can see, the brochure (page 2) shows the assist bar pointing toward the foot of the bed. Also, on the cover page, you can see how they also fold down out of the way toward the foot section of the bed. I am able to confirm that an order was placed for 106 assist bars back in early June of 2017. That said, I cannot confirm if someone at the site or someone on the Hill-Rom team installed them. During an interview on 12/5/24 at 9:48 a.m., registered nurse (RN)-C, who was also a nurse manager, stated the facility did not conduct siderail assessments on residents who used a grab bar (assist bar), as they were not considered a siderail. RN-C stated residents were asked upon admission if they wanted to utilize a grab bar, but their preference was not documented. RN-C stated the facility did not do a safety risk assessment, address risk/benefits, obtain a consent, or add grab bars to the care plan because grab bars were not considered a side rail. In an email dated 12/5/24 at 11:56 a.m., MR-D wrote: in speaking internally, we do not recommend removing the upper side rails of the bed, and per our documentation, we only recommend the assist bars be used at the foot section of the bed as seen in the image in the brochure. (To clarify, the purchase proposal to the facility from Hill-Rom dated 5/19/17, included beds, assist bars and pendant controls - no side rails). During a telephone interview on 12/5/24 at 12:08 p.m., MR-D was asked if the assist bars were installed correctly based upon a photo emailed to him earlier (specifically the assist bars being positioned closer to the head of bed and C facing the head of the bed). MR-D stated it was not how we (Hill-Rom) built it or tested the bed but could not comment if the current configuration posed a safety risk to residents. MR-D stated it was the facility's bed and they could do what they wanted. MR-D stated the bed and assist bar purchase and installation was so long ago, he was not able to determine how the beds would have arrived at the facility -- with the assist bars attached, and/or if Hill-Rom personnel would have installed the assist bars on new and/or existing beds. On 12/5/24 at 1:14 p.m., the administrator was sent via email, the assist bar installation sketches received from TS-F on 12/3/24 at 1:10 p.m. which indicated the installation instruction illustrations came from a Hill-Rom document titled Installation Instructions - Siderail, Assist Bar and Headrail Upgrade Kits dated 10/20/09. The instructions on page 175 indicated: point the cane (A) on the assist bar assembly (B) toward the foot end of the bed (see figure 1 on page 176). The figure on page 176 illustrates the assist bar positioned at the lower half of the bed frame, and the C of the assist bar toward the foot of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 11:08 a.m., the administrator stated if a resident requested a grab bar, it would be added to the bed. The administrator stated she realized that a grab bar was considered a siderail and therefore the resident should be assessed for safety, risks and benefits, according to their policy. Facility policy Side Rail Use dated 1/2023, indicated typically, side rails were not used, however, if needed residents would be assessed for use on admission, prior to, or with any significant change. Before initiating use of any side rail, an assessment would be completed including consent form and discussion of risks and benefits. Risks and benefits were discussed, and the consent form given to the resident or the decision maker of the cognitively impaired resident, that has been individually assessed by a licensed nurse whose assessment determines side rails as beneficial for the resident's use and are not classified as a restraint. Admission side rail assessment documentation was to include the side rail length; number of rails; which side of the bed the railing is to be up on; reason for being up; and any other comments that pertain to side rail use. The admission assessments were documented in electronic record (EMR) under the appropriate category pertaining to the intended use of the side rail. Ongoing documentation for side rail use was done in the EMR and should include the same information as the initial admission assessment. The care plan should reflect the use of side rails and their purpose to the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview, observation, and document review the facility failed to ensure proper food safety practices when food service workers (FSW-A and FSW-B) were observed not having hair secured, not properly disinfecting food thermometer, not recognizing need to reheat food when needed, and touching food with contaminated gloves. This practice had the potential to affect all 65 residents who received meals from 2 of 2 dining rooms observed. Findings include: During an observation and interview on 12/2/24 at 5:04 p.m., in the second-floor dining room, observed FSW-A standing behind the steam table preparing to plate food for the evening meal. FSW-A's hair which was long and curly, had not been fully secured in his hairnet -- all hair below the level of his ears was outside of the hairnet. FSW-A was asked not to proceed and to secure his hair. FSW-A stated he would try and left the dining room. FSW-A returned a few minutes later and his hair was still not fully secure. He tucked the rest of his hair into the hairnet, washed his hands and donned gloves. During an observation on 12/2/24 5:10 p.m., FSW-A touched his face with gloved hand, and opened the door to the thermal plate base warmer to remove more thermal bases. At 5:15 p.m., FSW-A handled French fries and chicken tenders with his contaminated gloved hands as he plated food for residents. FSW-A then handled multiple resident meal slips, opened, and closed equipment doors, and pushed up his eye glasses. At no time did FSW-A remove his gloves, wash his hands and re-glove. FSW-A stated he had been doing this job for over a year. At 5:20 p.m., FSW-A was observed cutting chicken tenders with a knife while holding the chicken with his contaminated gloved hand. FSW-A continued to handle meal slips, a pen, and rested both hands on the counter of steam table. At 5:28 p.m., FSW-A was again cutting chicken tenders while holding the chicken with his contaminated gloved hand. During this observation, he also latched a thermal cart, wrote on paper with a pen, and handled the food thermometer. At no time did FSW-A remove his gloves, wash his hands and re-glove. FSW-A was observed setting a food thermometer with the probe open and with visible food debris, on top of the steam table ledge. At 5:33 p.m., FSW-A wiped the thermometer probe with a paper towel and handed it to FSW-C who temped fruit with it. During an interview on 12/2/24 at 5:36 p.m., director of environment & risk management (DERM)-B with oversight over food and nutrition services, was in the dining room and was informed of observations. DERM-B stated food service workers were expected to have their hair fully covered in a hairnet when serving food. Further, DERM-B stated FSW were trained to wear gloves during meal services and were expected to remove gloves, wash hands and re-glove as they moved between tasks and before handling food. In addition, DERM-B stated staff were to place the probe of the food thermometer in a solution of food-safe QUAT (quaternary ammonium - a chemical sanitizer) to disinfect it between temping food. . (continued on next page)

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	245240	A. Building B. Wing	12/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/3/24 at 11:46 a.m., in the second-floor dining room, FSW-B stated he had been in his role for a week. FSW-B was standing behind the steam table waiting to plate food for residents and was observed wearing gloves. While waiting, FSW-B was observed talking on the phone, opening and closing the refrigerator, cupboard and cart doors, handling resident meal slips, putting on and taking off his eye glasses that were strapped around his neck, bending over and putting his gloved hands on his knees while looking at meal slips on the lower shelf of a cart. At 11:51 a.m., FSW-B temped pureed shrimp on the steam table and verbalized the temperature was 114 degrees F (Fahrenheit). When FSW-B did not take action, he was asked if that temperature was warm enough and he replied, yes. An unidentified dietary worker standing nearby said, no and she re-temped it, obtaining 116 degrees. The pureed shrimp was taken back to the kitchen. FSW-B stated the shrimp should have been 140 degrees or greater. At 11:55 a.m., a coworker whispered to FSW-B to put on new gloves, which he did, but did not wash his hands first. Again, FSW-B put on and took off his eye glasses multiple times, plated food, handled utensils, and filled cups with water from a dispenser. At 11:58 a.m., FSW-B removed and put on new gloves without washing his hands. At 12:03 p.m., FSW-B continued to plate food and continued to put on and take off his eye glasses, bend over and place hands on knees, and open and close the warmer. During an interview on 12/3/24 at 12:17 p.m., food & nutrition manager (FNM)-C who was in the dining room, stated new food service workers were trained for six shifts before they were on their own. It was the expectation workers wore gloves during meal services and to change gloves and wash hands before handling food directly. FNM-C also observed FSW-B touch face and eye glasses, then touch edges of a grilled cheese sandwich several times. FNM-C did not intervene. 51578 During interview and observation on 12/03/2024 at 11:30 a.m., food service worker (FSW)-D did not follow proper procedure when sanitizing the dietary thermometer in between temping foods for the residents in the main dining room on the first floor of the facility. FSW-D was observed not to use a alcohol wipe on the thermometer when cleaning it in between checking food temps. FSW-D was observed using a sanitizer bucket full of QUAT (quaternary ammonium - a chemical sanitizer). This sanitizer is food safe, however the thermometer was not wiped with alcohol after the use of the quat sanitizer. During observation on 12/04/2024 at 12:26 p.m., on the second floor dining room FSW-B was checking temps of food that would later be returned to the kitchen and possibly used for other meals. FSW-B was observed taking the thermometer out of a sanitizer bucket and then took the thermometer and rubbed the thermometer on the bottom of pants to help dry off the thermometer and then temped the gravy behind the steamer. During interview on 12/4/2024 at 12:32 p.m., FSW-B was asked about the process for temping foods and the steps for cleaning the thermometer to temp the food prior to returning it back to the kitchen for later use. FSW-B stated when they are done with the lunch meal they verify which foods will be returning to the kitchen or maybe kept for further use. FSW-B explained the process for temping the foods and the use of the thermometer in the following steps 1) clean the sanitizer in either a red bucket that is next to the food on the counter or 2) use the sterilizer container each time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When specifically asked about the cleaning of the thermometer, FSW-B stated that the red bucket that was used was the same as the small container of QUAT and can be used to sanitize all surfaces and items that need to be properly cleaned to prevent food born illness. This container looked like a small salt and pepper shaker and was used on both of the dining rooms observations. The tip of the thermometer was submerged in the sanitizer container prior to temping the foods During the interview, FSW-B was aware that the thermometer was wiped on his pants and explained it was an accident. When asked, FSW-B explained that the rationale, stated because the food was not going to all be used so perhaps it was out of instinct. FSW-B verified that the normal process was to either use the red bucket full of sanitizer or the small container of QUAT. FSW-B stated they temp the food prior to sending what is left back to the kitchen for further use. During an interview on 12/4/2024 at 1:22 p.m., Director of Environment & Risk Management Services (DERM)-B verified that they have a specific process for cleaning the thermometer after each time for temping the foods. While at Kitchenette #2 on the second floor verification of the difference between the red bucket of sanitizer and the small container of sanitizer. DERM-B stated that there is the same sanitizer in the red bucket as the small container of QUAT. When asked about the process for cleaning the thermometer DERM-B explained the process for temping foods was to place it in the small QUAT container and then wipe it down with an alcohol wipe prior to temping foods and in between. The DERM-B explained that the sanitizer in the bucket was the same as the small red container however this was to be used when cleaning down the area behind the steamer and not the thermometer during temping foods. During an interview on 12/4/24 at 2:48 p.m., DERM-B reiterated the following: -- Hair nets: hair must be secure/covered for anyone behind steam table. When staff report to work, everyone goes to kitchen first to wash hands and put on hairnet. DERM-B stated there was not a mirror in this area for staff to visibly determine if their hair was fully covered. --Hand hygiene and glove use: DERM-B stated it was the expectation that dietary staff wore gloves when working the steam table and dishing up food, adding they had been doing that for [AGE] years and believed it to be best practice. DERM-B stated it was the expectation staff stayed behind steam table and if they went outside of it, to remove gloves and wash hands. --DERM-B stated it was FSW-B fifth day on the job. Day one of orientation included organization-wide training, day two included handbook, expectations, and safe food handling videos, then partnering with staff for four to six shifts and with a manager observing during meal service. Due to survey observations, DERM-B stated FSW-B had been removed from the schedule for additional training. --Regarding FSW-A holding chicken tenders with contaminated gloves, DERM-B stated that was unacceptable. --Regarding disinfecting the food thermometer probe, DERM-B stated staff were supposed to wipe the probe with an alcohol wipe to remove debris between temping foods. When not in use, DERM-B stated the thermometer probe could rest in the QUAT solution. DERM-B was unaware staff were not wiping the probe with an alcohol wipe. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Regarding pureed shrimp temping at only 114 degrees and FSW-B not taking action on his own, DERM-B stated that was something FSW-B should have known and that there were appropriate temperature references in the food temperature log. DERM-B provided a documented titled Hazard Analysis Critical Control Point Food Safety System, dated 2019. In an email dated 12/5/24, DERM-B indicated the document was not used for training or orientation, however the topics covered in the plan were in the Safe Food Handler training videos that new employees watched on the second day of employment and before they did any food service in the department. The document included the following: --Hair restraints (hairnets, hats, or caps) must cover the hair sufficiently to prevent hair from falling onto food or food equipment and to minimize hand contact with hair. --Disposable gloves must be used when handling ready-to-eat foods (foods that require no further processing and cooking/heating). Gloves must be changed before starting another job and when they are torn, dirty or contaminated. Hands must be washed before putting on gloves. --Thermometer stems must be washed, rinsed, and sanitized. Three sanitizing methods were approved: Sanitizing solution with immersion time of one minute. Hot water method (185 F or above) immersion time of three seconds, or alcohol swabs (antibacterial probe wipes containing 70% isopropyl alcohol). FSW-A's training checklist titled Food and Nutrition Services New Hire Checklist indicated FSW-A completed Food Handler Training Videos, parts 1-5 on 6/13/23, and FSW-B the same on 11/26/24. During an interview on 12/5/24 at 1:22 p.m., the administrator who had been informed of dietary findings by DERM-B, stated she expected staff to be fully trained and follow food service policies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 3 of 3 residents (R27,R24,R58) reviewed for wounds, and proper donning and doffing of personal protective equipment (PPE) was completed per standard guidelines for 2 of 3 residents (R20,R27). Findings include: R20's facesheet printed on 12/5/24, included diagnosis of chronic foot ulcer. R20's quarterly MDS assessment dated [DATE], indicated R20 was cognitively intact; was usually understood and could understand. R20 was dependent on staff for most activities of daily living (ADL), and had a stage 2 pressure ulcer on her foot. R20's care plan dated 10/4/24, indicated impaired skin integrity related to left foot pressure ulcer and enhanced barrier precautions were in place. During an observation on 12/2/24 at 2:38 p.m., in hallways on the north and south units on second floor, PPE carts and doffing receptacles (metal stands with blue garbage bags) were observed lining the hallways outside multiple resident rooms. On the doorframe of these rooms were laminated signs indicating the residents were in EBP. The signs did not provide guidance as to where staff should doff - inside or outside of the resident's room. During an observation on 12/3/24 at 9:44 a.m., outside R20's room was a three shelf PPE cart, doffing receptacle and a CDC (Center for Disease Control) sign on the door frame indicating R20 was in EBP. Observed nursing assistant (NA)-A don PPE consisting of gloves and a yellow reusable gown and entered R20's room. During an observation on 12/3/24 at 10:04 am, NA-A exited R20's room, removed PPE and placed it in the doffing receptacle. NA-A stated sometimes the doffing receptacle was located inside the resident's room, and sometimes it was outside the resident's room. NA-A thought staff were supposed to doff inside the resident's room, but since the receptacle was on the outside of the room, that's where she doffed. During an observation on 12/4/24 at 7:26 a.m., doffing receptacles were still outside resident rooms on the north and south units on second floor. An undated documented titled Enhanced Barrier Precautions in Nursing Homes Algorithm located on a bulletin board on second floor identified for staff training, indicated: position trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room. 40614 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R27's facesheet, printed 12/5/24, included diagnoses of Parkinson's disease (movement disorder), chronic myeloid leukemia (blood cancer that starts in the blood forming cells of the bone marrow), and gastrostomy status (external opening into the stomach). R27's quarterly minimum data set (MDS) assessment dated [DATE], identified R27 had moderately impaired cognition and received tube feedings for more than 50% of nutritional needs. On observation 12/3/24 11:35 a.m., R27 had a sign outside of his room indicating enhanced barrier precautions (EBP) and to gown and glove to provide cares. Upon entry into the room, registered nurse (RN)-B was present in R27's room and was flushing R27's gastric tube (GT). RN-B did not have a gown on but was wearing gloves. RN-B upon exit of the room indicated she is not aware of the exact procedure at facility but was aware of the sign on the door for enhanced barrier protection for R27. RN-B stated I wore gloves and that is what I did. A linen hamper for nondisposable gowns was located outside of R27's room. On observation and interview 2/3/24 11:38 a.m., nursing assistant (NA)-C and NA-D gowned and gloved and assisted R27 from his recliner to his wheelchair. NA-C and NA-D took R27 in his wheelchair to the doorway and removed gloves and disposed in trash in the room. NA-C and NA-D exited the room and took off non-disposable gowns and discarded in the laundry hamper outside of R27's room. NA-C stated she is not sure why the laundry hamper was outside of the door, but since it was, they wore the gowns into the hallway to discard them. R24's facesheet printed 12/5/24, included diagnoses of severe dementia, difficulty in walking, and dysphagia (difficulty swallowing). R24's quarterly MDS assessment dated [DATE], identified R24 had severely impaired cognitive decision making skills, disorganized thinking and inattention constantly present. R24 required substantial to maximum assist with bed mobility and is dependent on staff for wheelchair mobility. R24 did not have a pressure ulcer but was identified at risk of pressure ulcer development. On observation and interview 12/3/24 at 8:42 a.m., no sign was present on R24's door indicating EBP. R24's family member (FM)-A indicated R24 has had a pressure ulcer on the heel of her foot for the past few months. A Wound management Detail Report dated 10/14/24, by RN-A included unspecified left heel ulcer. Comments included newly discovered Stage 3 pressure ulcer (pressure causes a wound into the skin's fatty layer) to left heel with wound nurse assessment and recommendations for treatment. On observation and interview 12/3/24 8:42 a.m., RN-B did not gown, but gloved and completed wound care on R24's left heel. Wound measurements included 7 millimeter (mm) x 9 mm open area. RN-B indicated she is not sure what to call the wound at this time but it is still open but healing. R24's room did not have an EBP sign at the door or PPE present. R58's facesheet printed 12/4/24, included diagnoses of heart failure, dementia, and lupus erythematosus (audtoimmune system attacks the body's tissues and cells). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R58's readmission MDS assessment dated [DATE], included moderately impaired cognition with delirium symptoms of inattention and disorganized thinking that fluctuates. R58 has 2 unstageable pressure ulcers (wound bed covered with slough/eschar {dead tissue}and can't be properly staged) present at the time of reentry. On observation 12/2/24 at 5:49 p.m., R58 was asleep in his bed. There was no sign present for EBP outside of the room or PPE equipment present. On observation and interview 12/4/24 at 1:22 p.m., R58 was asleep in his bed. No EBP sign was present outside of R58's room and no PPE present. RN-E completed wound care on both R58's heels wearing gloves but no gown. RN-E identified both wounds as pressure ulcers and open wounds but was unsure what stage they were presently. On interview 12/4/24 at 11:46 a.m., RN-A, also identified as infection preventionist, indicated doffing (removal of PPE) should occur in the residents room prior to exiting. RN-A indicated she was not aware the disposal hampers were outside of the rooms and stated they should be inside of the room by the door. RN-A stated she is unsure how contracted staff are trained on the facilities infection prevention policies, but would assume they are trained on EBP and hand hygiene prior to working at the facility. RN-A indicated R58 is on EBP precautions due to pressure ulcers, but upon arrival at R58's room indicated there was no sign or indication he was on EBP. RN-A indicated she is not sure what happened and why the EBP sign and equipment was removed from his room. RN-A confirmed R58 and R24 should both be on EBP due to open wound pressure ulcers. RN-A indicated EBP should be used for any wound stage 2 (one that has progressed to affect both the top and bottom layers of the skin) or higher. During interview on 12/5/24 at 1:19 p.m., the administrator, confirmed staff should doff PPE prior to exiting the room, before reaching the hallway. The administrator also confirmed anyone with an open wound should be in EBP precautions. Facility training slide deck titled Infection Control dated 8/7/24, and which according to RN-A was used for staff training, indicated PPE would be doffed before exiting the resident's room. Facility Infection Control policy dated 4/2024, indicated: A. A sign that indicates the type of precautions required will be placed outside each infectious room. B. Clean PPE needs to be applied when entering. C. Dirty PPE needs to be removed and discarded prior to exiting the room. D. PPE DON/DOFF instructions will be placed outside and inside each isolation room. E. Random audits of PPE use and placement will be conducted by the Infection Control Nurse or designee. A summary of these audits will be included in the monthly Infection Control review. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Infection Control policy dated 4/2024, included Multi-drug resistant organisms (MDRO) may require enhanced barrier precautions to align with nationally accepted standards. EBP's (generally gown and gloves) are recommended for certain residents during specific high-contact/high -risk activities conditions associated with MDRO transmission: Residents with indwelling medical devices regardless of colonization or infection (urinary catheter's, intravenous lines, feeding tube); Residents with open wound (does not include short lasting wounds such as small skin tears requiring a simple dressing such as a band-aid) ; High risk activities include device care or use, and wound care with any skin opening requiring a dressing. A. A sign that indicates the type of precautions required will be placed outside each infectious room. B. Clean PPE needs to be applied when entering. C. Dirty PPE needs to be removed and discarded prior to exiting the room. D. PPE DON/DOFF instructions will be placed outside and inside each isolation room. E. Random audits of PPE use and placement will be conducted by the Infection Control Nurse or designee. A summary of these audits will be included in the monthly Infection Control review.