

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Thief River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Eastwood Drive Thief River Falls, MN 56701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075</p> <p>Based on observation, interview and document review, the facility failed to ensure an assessment was completed for an electric scooter to increase mobility for 1 of 1 residents (R57) reviewed for accomadation of needs.</p> <p>Findings include:</p> <p>R57's significant change Minimum Data Set (MDS) dated [DATE], identified R57 was cognitively intact, was independent with bed mobility, no functional limitation in range of motion of upper or lower extremities, and used a walker and wheelchair for mobility. R57 participated in physical and occupational therapy during the assessment period.</p> <p>R57's care plan revised on 11/14/24, identified R57 was independent with bed mobility, required assistance of one staff and gait belt to transfer between surfaces, and required stand-by assistance while walking with a walker. The plan failed to identify use of an electric scooter.</p> <p>On 1/13/25 at 6:20 p.m., R57 stated she had an electric scooter at home and talked to staff about it. R57's son brought the scooter to the facility; however, R57 stated she had not received any follow-up from staff. R57 stated she received therapy every day and had not had any discussion or assessments related to use of the scooter.</p> <p>R57's care conference notes from 11/27/24 were reviewed; however, the notes did not identify any discussion regarding the electric scooter use.</p> <p>R57's medical record lacked any assessment or referral for the use of the electric scooter.</p> <p>On 1/16/25 at 9:13 a.m., social services (SS)-A stated R57's electric scooter was in the building by the front entrance and was under the impression R57 was assessed by occupational therapy but was not strong enough to drive the scooter independently. SS-A stated she was uncertain what R57 had been told regarding using the scooter.</p> <p>On 1/16/25 at 12:13 p.m., physical therapy assistant (PTA)-A stated therapy had not received a referral to assess R57 for use of the electric scooter.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245252
		If continuation sheet Page 1 of 21

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/25 at 12:13 p.m., SS-A provided an undated and untitled document with R57's name and written notes that identified scooter eval. - key in top drawer. SS-A stated the document was notes she made to herself, although she failed to pass the information onto nursing staff.</p> <p>A policy regarding following up on resident's requests was requested but not provided.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to update the care plan with a new transfer status for 1 of 2 residents (R32) reviewed for falls; and the facility failed to update the care plan with a new turning and repositioning schedule for 1 of 2 residents (R8) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R32's significant change Minimum Data Set (MDS) dated [DATE], identified R32 had severe cognitive impairment. R32 was dependent on staff for toileting transfer.</p> <p>R32's History and Physical dated 1/7/25, identified R32 was seen for a left intertrochanteric hip fracture following a fall in the nursing home. R32 was to be admitted to the hospital for orthopedic surgery.</p> <p>R32's care plan dated 1/14/25, identified R32 required assistance with activities of daily living (ADLs) and was weight bearing as tolerated. Staff were to assist R32 with assist of one and gait belt to transfer. R32 had a recent left hip fracture related to a fall with surgical intervention. Staff were directed to anticipate and meet needs, make sure call light was within reach and to respond promptly to all requests for assistance. R32 was able to be weight bear as tolerated with physical and occupational therapy evaluations ordered.</p> <p>During observation on 1/14/25, at 5:34 p.m. R32 was lying in bed with bed low to the floor and head of the bed elevated to sitting position. Nursing assistant (NA)-B sat at R32's bedside and stated they did not get R32 up to the toilet or commode or in her wheel chair because the Hoyer lift (full lift) transfers were too painful for R32.</p> <p>A joint interview was conducted with registered nurse consultant (RN)-I and director of nursing (DON) on 1/15/25, at 1:37 p.m. The DON stated after R32 fell on [DATE], she was non weight bearing and needed a Hoyer lift to transfer, as the family opted not to have surgical repair to R32's right hip. RN-I stated when a resident returned from the hospital, licensed staff completed a skilled progress note daily, bowel and bladder, fall, skin, and pain assessments were completed. Changes were then made to the resident's care plan and changes would go directly to the resident's Kardex where the aides could see what care needs and changes the resident had. Therapy was also seeing R32 and went by their recommendations as well for care plan items.</p> <p>When interviewed on 1/16/25, at 10:52 a.m. the DON stated therapy was seeing R32 since her hospital return and R32 was to be a Hoyer lift transfer. The DON had questioned several nursing assistants and they reported they were using a Hoyer lift when transferring R32; however, R32's care plan was not accurate and did not match her transfer status to reflect her needs. Updating the plan of care to accurately reflect what residents needed was an issue the DON had been aware of and was working on.</p> <p>40948</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's significant change MDS dated [DATE], identified severe cognitive impairment. R8 required substantial/maximal assistance with turning and repositioning and toileting. R8 was at risk for pressure ulcers, currently did not have any skin issues. Diagnoses included Alzheimer's disease and non-Alzheimer's dementia.</p> <p>R8's care plan dated 11/12/24, identified R8 should be repositioned every three hours as R8 had a potential for skin impairment.</p> <p>R8's progress note dated 1/6/25 identified a new skin issue located on the inside of R8's right buttock. The area was 1.5 centimeters (cm) x 1.5 cm with 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals.). Primary care provider notified. Tissue tolerance identified to turn every 2 hours.</p> <p>During an interview on 1/15/25 at 11:06 a.m. NA-G stated they were assigned to care for R8 today. NA-G stated R8's care plan was recently updated and R8 was supposed to be repositioned every two hours, because R8 had a new area of impaired skin integrity on the identified R8's buttocks. NA-G was not sure when the last time R8 was repositioned.</p> <p>During an interview on 1/15/25 at 3:00 p.m., RN-C stated R8 had developed a new area on her inner right buttocks and were doing dressing changes every three days and as needed. R8 was also to be repositioned every two hours to keep pressure off the wound. The updates with repositioning R8 had been communicated with nursing staff and the nursing assistants, but not updated on the care plan.</p> <p>The facility policy Person Centered Care Planning revised 4/20/23, identified the resident's baseline care plan would be developed based on admission orders, information available from the transferring provider and discussion with the resident and resident representative. Information would be included necessary to properly care for the resident, including immediate health and safety concerns to prevent decline or injury and activities of daily living (ADL)s.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948</p> <p>Based on observation, interview, and document review, the facility failed to provide timely assistance with toileting/incontinence care for 1 of 3 residents (R8) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.</p> <p>Findings include:</p> <p>R8's significant change Minimum Data Set (MDS) dated [DATE], identified R8 had severe cognitive impairment and was dependent on staff for her ADLs. R8 was incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia.</p> <p>R8's Bowel and Bladder Risk assessment dated [DATE], identified R8 was incontinent of bowel and bladder.</p> <p>R8's care plan dated 11/12/24, identified R8 required extensive assist of one for toileting and incontinence care every three hours and as needed.</p> <p>Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identified the following:</p> <ul style="list-style-type: none"> - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area. - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been toileted or offered toileting. - At 9:24 a.m. R8 was taken by an unidentified activity staff to an activity in the common area of the nursing home. R8 had not been toileted or offered toileting. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been toileted or offered toileting. - At 10:40 a.m. R8 remained in the common area and participated in a bible study that finished at 10:50 a.m. - At 11:00 a.m. R8 continued in her wheelchair and had not been toileted or offered toileting. <p>During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G was not sure when the last time R8 was toileted. NA-G then went to bring R8 to the bathroom.</p> <p>During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 11:04 a.m., NA-F stated staff reviewed the communication board or it would be passed on in report when a resident was to be assisted with toileting and/or have their brief checked. The facility recently updated their electronic charting system and staff could also see the care planned interventions in the Kardex . NA-F stated she had not worked with R8 and did not know when she needed to be checked.</p> <p>During an interview on 1/15/2 at 11:07 a.m., NA-G stated they were assigned care of R8. R8's care plan was recently updated and was supposed to be offered toileting and check and change every 2 hours because an area of impaired skin integrity was identified on her buttocks. NA-G was not sure of when the last time R8 was checked or offered toileting assistance. NA-G stated they usually checked her right after breakfast, but did not do it today and was unsure if it was done. The last time NA-G knew R8 was checked was when she got up this morning and NA-G brought R8 to the bathroom.</p> <p>During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 was to be checked and changed every 2 hours, which was changed from check and change every 3 hours due to a new area of impaired skin integrity. Residents who sat in soiled incontinent briefs had an increased chance of skin breakdown and should be checked and changed frequently.</p> <p>During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it was the expectation staff would have followed resident care plan related to check and change of incontinent briefs to ensure R8's care was done.</p> <p>The facility's Urinary Incontinence Program policy dated 4/6/15, identified each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview, and document review, the facility failed to identify a significant increase in weight with dependent edema in the lower extremities and conducted a comprehensive assessment and implement interventions for 1 of 1 residents (R55) reviewed for edema.</p> <p>Findings include:</p> <p>R55's admission Minimal Data Set (MDS) dated [DATE], identified R55 had intact cognition and required moderate to maximal assist with activities of daily living (ADLs). R55's admission weight was recorded as 203 pounds (lbs). Diagnoses included acute embolism and thrombosis of deep veins of superior vena cava, kidney failure, hypertension and pulmonary hypertension.</p> <p>R55's undated care plan identified R55 required assistance with ADL's and staff were directed to assist R55 with dressing, grooming, toileting, bed mobility and transfers. The plan of care failed to identify issues with intact skin, weight or edema.</p> <p>R55's medical record identified the following weights:</p> <ul style="list-style-type: none"> - 10/30/24, R55 weighted 203 lbs. - 11/26/24, R55 weighted 219 lbs. - 12/03/24, R55 weighted 231 lbs. (28 lb weight gain from admission, 13.79% gain) - 12/10/24, R55 weighted 229 lbs. - 12/17/24, R55 weighted 232 lbs. - 12/24/24, R55 weighted 231 lbs. - 1/14/25, R55 weighted 225 lbs(22 lb weight gain from admission, 10.84% gain) <p>R55's medical record lacked evidence the significant weight gains were assessed and interventions implemented.</p> <p>R55's progress note dated 12/23/24, identified family member (FM)-A requested a nurse to look at R55's left foot. FM-A requested the facility obtain an order for ace wrap to R55's left leg. A fax was sent to R55's primary provider to update on R55's skin and request ACE wrap for R55's left leg.</p> <p>On 1/13/25, at 5:53 p.m. R55 was observed seated in a wheelchair in his room. R55's legs were in a dependent position and feet were placed on the wheelchair foot rests. There was significant swelling in both of R55's lower extremities from his knees to his toes with greater swelling noted on his left leg.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25, at 3:22 p.m. R55 was observed seated in wheelchair in his room watching television. R55 was observed with his legs in a dependent position with feet resting on wheelchair footrests. R55 had significant swelling in both feet and lower legs bilaterally.</p> <p>On 1/15/25, at 9:30 a.m. registered nurse (RN)-B entered R55's room to check R55's feet. RN-B removed R55's socks, both lower extremities had significant swelling from knees to toes. RN-B wrapped R55's left lower leg and foot with ace wrap after covering both legs with a soft sleeve.</p> <p>On 1/15/25, at 9:45 a.m. FM-A stated the facility staff never made attempts to have R55 lie down in bed or elevate his legs. If FM-A chased down the staff and begged them, they would come in and assist him to lie down. R55 needed to lie down to help with the swelling in his legs. When R55 was at home for three weeks in October, he did not have any swelling in his legs at all, because he had remained in bed a majority of the time.</p> <p>On 1/15/25, at 9:47 a.m., RN-B stated the facility had notified the provider about R55's edema, but they never get any response. Staff try to ask R55 to lie down or sit in recliner but he frequently refuses. The facility did not schedule for R55 to elevate his feet or document when he refused their attempts. RN-B stated the facility was not monitoring R55's weights or edema on R55's treatment record. There was no one tasked to assess edema or look at resident weights. Further, if a large weight gain was noted from week to week, the facility should print off the weights and see if the provider wanted to address them. RN-B would check with the charge nurse to see if anyone had addressed R55's weight gain.</p> <p>During interview on 1/15/25, at 10:46 a.m. RN-B stated the facility had been requesting compression wraps for R55's left leg and his provider was faxed with that request on 12/23/24, however, the facility had never received a response back from R55's provider.</p> <p>During interview on 1/15/25, at 10: 26 a.m. RN-A stated the facility conducted weekly weight meetings which they discussed resident weight gain or losses and reviewed everything with dietary. RN-A did not document any notes related to the meetings, but they discussed resident weights, reviewed if they were felt to be accurate, if supplements were needed and such. RN-A knew R55's provider had been notified of his edema but the provider had not gotten back to them. No new interventions had been attempted to try to reduce R55's edema and RN-A had not reviewed R55's diet or spoken to him about the need to lie down or elevate his feet in the afternoons.</p> <p>During interview on 1/16/25, at 9:47 a.m. the director of nursing (DON) stated facility staff should be reviewing resident's weights when they documented them in the resident's medical record. R55 should have had orders for ACE wraps or compression hose. Residents with weight gain should be evaluated and staff should be assessing residents weights regularly.</p> <p>The facility policy Weight Monitoring Program dated 1/18/21, identified a medically significant weight gain was a weight gain of five or more pounds in one week which could indicate a change in health status. Weight data would be assessed, tracked, and entered into the residents medical record weekly. The attending practitioner would be contacted for any resident with a medically significant weight gain of five pounds or more.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948</p> <p>Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R8) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R8's significant change Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. R8 required substantial/maximal assistance with turning and repositioning and toileting. R8 was at risk for pressure ulcers, currently did not have any skin issues. Diagnoses included Alzheimer's disease and non-Alzheimer's dementia.</p> <p>R8's Braden Risk Assessment (a tool used to assess a patient's risk of developing pressure ulcers) dated 11/1/24, identified R8 was at moderate risk of developing a pressure ulcer.</p> <p>R8's care plan dated 11/12/24, identified R8 should be repositioned every three hours as R8 had a potential for skin impairment.</p> <p>R8's Tissue Tolerance-Repositioning Observation dated 1/6/25, identified after R8 was in sitting or lying in same position after two hours redness was observed in areas of pressure. It identified R8 was to be repositioned every two hours.</p> <p>R8's progress note dated 1/6/25 identified a new skin issue located on the inside of R8's right buttock. The area was 1.5 centimeters (cm) x 1.5 cm with 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals.). Primary care provider notified. Tissue tolerance identified to turn every 2 hours.</p> <p>Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identified the following</p> <ul style="list-style-type: none"> - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been repositioned or offered repositioning. - At 9:24 a.m. R8 was taken by unidentified activity staff to an activity in the common area of the nursing home. R8 remained seated in her wheelchair and had not been repositioned or offered repositioning. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been repositioned or offered repositioning. - At 10:40 a.m. R8 remained in the common area and participated a bible study that finished at 10:50 a.m. R8 had not been repositioned or offered to be repositioned. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 11:00 a.m. R8 remained in her wheelchair seated in the same position. R8 had not been repositioned or offered to be repositioned.</p> <p>During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G stated R8's care plan was recently updated and R8 was supposed to be repositioned every two hours, because R8 had a new area of impaired skin integrity on the identified R8's buttocks. NA-G was not sure when the last time R8 was repositioned. The aids usually repositioned R8 right after breakfast, but NA-G did not do it today and was unsure if it was done. The last time NA-G knew R8 was repositioned was when she got R8 up this morning. NA-G then went to bring R8 to the bathroom and reposition her.</p> <p>During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact.</p> <p>During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 had developed a new area on her inner right buttocks and were doing dressing changes every three days and as needed. R8 was also to be repositioned every two hours to keep pressure off the wound. The updates with repositioning R8 had been communicated with nursing staff and the nursing assistants. R8 should not have gone more than two hours without repositioning as her ulcer could worsen.</p> <p>During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it is the expectation staff followed the care plan related to resident with impaired skin integrity and/or pressure sores. Which included timely repositioning of R8.</p> <p>A policy for pressure ulcers was request, but not received.</p> <p>The facility's Tissue Tolerance Repositioning Observation policy dated 11/26/24, identified it was to establish and adjust individualized repositioning schedules based on skin assessments. To provide guidelines to staff on the ability of the resident's skin and its supporting structures to endure the effects of pressure without adverse effects.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Thief River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Eastwood Drive Thief River Falls, MN 56701	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review the facility failed to ensure a dependent resident was toileted per request for 1 of 2 residents (R32) reviewed for accidents. This resulted in actual harm for R32 who fell when self transferring to the toilet and fractured their hip.</p> <p>Findings include:</p> <p>R32's significant change Minimum Data Set (MDS) dated [DATE], identified R32 had severe cognitive impairment. R32 was dependent on staff for toileting transfer and required maximal assistance with toileting hygiene. R32 had no falls prior to admission, however had two or more falls, without injury, since admission. Diagnoses included dementia, kidney failure, diabetes and history of urinary tract infections (UTI).</p> <p>R32's History and Physical dated 1/7/25, identified R32 was being seen for a left intertrochanteric hip fracture following a fall in the nursing home. R32 was forgetful and tried to go to the bathroom on her own which caused her to fall. R32 was to be admitted to the hospital for orthopedic surgery.</p> <p>A Nursing Home Incident Report-Investigative Summary dated 1/10/25, identified activities aide (AA)-C observed R32 wheeling out of the facility dining room and asked R32 where she was going. R32 stated she needed to use the bathroom. AA-C reported to nursing assistant (NA)-AA and NA-BB who stated R32 had been toileted thirty minutes prior to going to the dining room and was reminded that she had just gone to the bathroom. AA-C asked R32 if she had just been to the bathroom and R32 shrugged and stated she was full up. AA-C told R32 to stay in the dining room and wait for someone to assist her to the bathroom. AA-C notified NA-AA and NA-BB, R32 was adamant she needed to use the bathroom and was trying to leave the dining room. Neither NA-AA or NA-BB knew when R32 had left the dining room as they continued to pass trays in the dining room. R32 was found on the floor, in the public bathroom at 5:20 p.m., complained of severe pain to her left hip and transferred to the emergency room at 5:30 p.m.</p> <p>R32's care plan dated 12/4/24, identified a risk for falls and injury related to cognitive deficit with a goal to be free from falls and injury. Interventions included call don't fall sign in room, call light in reach and encourage to call for assistance, appropriate footwear, bed in low position with fall mats and non skid strips next to bed. R32 required assistance with activities of daily living (ADLs) and was dependent on staff to transfer. Staff were directed to anticipate and meet needs, ensure call light was within reach and to respond promptly to all requests for assistance. Staff were directed to provide extensive assist of one to two for toileting. R32 was frequently incontinent of bladder and occasionally of bowel and staff were directed to assist with toileting on awakening, before and after all meals and every two hours.</p> <p>During telephone interview on 1/13/25, at 6:11 p.m. family member (FM)-A stated R32 did not have the patience to wait to go to the bathroom. When she had to go to the bathroom, she would not wait for staff to help her. R32 had already fallen in November trying to go to the bathroom herself. R32 could not remember to use the call light.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25, at 9:00 a.m. R32 was observed lying in bed with head of the bed elevated. The bed was in lowest position to the floor and a bedside mat was on the floor beside the bed. R32 was drowsy and difficult to arouse. Registered nurse (RN)-B entered room to administer medications. RN-B stated R32 had fallen in the public bathroom in the main entry area, had broken her hip and just returned from the hospital. The facility had put Velcro stop signs on the public bathroom doorways to prevent confused residents from entering the bathrooms to prevent future falls.</p> <p>R32's progress notes identified the following:</p> <ul style="list-style-type: none"> - 12/4/24, When staff went to offer toileting, R32 was found in the bathroom transferring herself off of the toilet. - 12/16/24, R32 was found on floor in bathroom, after having toileted herself. R32 was to be care planned to toilet before and after meals and as needed. - 12/29/24, Staff noted resident room door was shut. On entering room, R32 was found to have self transferred to the toilet. - 1/6/25, R32 was found in public bathroom in common entry area. R32 had been trying to use the bathroom, urine was on the floor and R32's pants and brief were down. R32 was admitted to the hospital with left hip fracture. <p>R32's current Urinary Continence Task flow sheet 1/11/25 to 1/15/25, identified the following:</p> <ul style="list-style-type: none"> - 1/11/25, R32 was incontinent of urine at 1:30 a.m., 5:30 a.m., and 7:58 p.m. and did not void when toileted at 10:37 a.m. - 1/12/25, R32 was incontinent of urine at 3:10 a.m., 10:20 a.m. and 9:44 p.m. -1/13/25, R32 was incontinent of urine at 2:38 a.m., 6:30 a.m., 2:30 p.m., 4:30 p.m., 6:15 p.m., and 8:15 p.m. -1/14/25, R32 was incontinent of urine at 3:26 a.m., 10:33 a.m. 3:49 p.m., 5:30 p.m., 7:15 p.m., 8:45 p.m. -1/15/25, R32 was incontinent of urine at 5:59 a.m., 1:59 p.m. and 4:11 p.m., 6:09 p.m., and 9:09 p.m. <p>The flow sheet lacked documentation that R32 had been checked and/or changed every 2 hours and before and after meals as directed on R32's care plan. The Urinary Continence Task Flow sheet for the day of the fall was requested and not received.</p> <p>During interview on 1/14/25, at 2:44 p.m. NA-A stated he thought R32 felt the need to urinate frequently was related to her up and down blood sugars. Staff toileted R32 every two hours. R32 was hoier lift transfer and could not bear weight, but would still try to get up on her own and toilet herself as R32 had no patience. NA-A was not working when R32 had fractured her hip, but he could see R32 getting up and to toilet herself as R32 had been so confused.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 1/15/24, at 7:50 a.m. NA-CC stated she would toilet R32 before and after meals and every two hours but R32 was one that would ask to go to the bathroom ten minutes after just being taken. R32 was continent of bladder prior to her fall with fracture and may have been nervous about having accidents. R32 was very anxious and when R32 felt the urge to go she would have to go right then and nothing would stop her. R32 liked to be in her room and if tried to have her out by the nurses station, she would just wheel away.</p> <p>When interviewed on 1/15/25, at 8:09 a.m. NA-C stated R32 was a handful. NA-C would leave R32's room door open, and continuously walk around the wing to keep an eye on her. If NA-C noticed R32 was getting slightly restless, she would immediately take her to the bathroom. R32 was continent prior to her fall and could have been nervous of having an accident in her pants. NA-C just checked on R32 all the time and took her to the bathroom.</p> <p>During joint interview with nurse consultant registered nurse (RN)-I and the director of nursing (DON) on 1/15/25, at 1:37 p.m. The DON stated she was present when R32 had her last fall and so had questioned all the staff involved immediately following the incident. NA-AA and NA-BB had been busy passing plates and getting supper going when R32 requested to go to the bathroom. The aides told R32 she had just been on the toilet and could hold on a little bit. AA-A notified the both NA-AA and NA-BB R32 needed to use the bathroom. The DON stated staff should have assisted R32 to the bathroom when she asked for help. The DON immediately educated the aides regarding providing assistance to residents and following resident's care plan.</p> <p>When interviewed on 1/16/25, at 9:37 a.m. the DON stated flow sheets for R32's turn and repositioning and toileting did not indicate R32 was checked or changed every two hours. Urinary Continence Task flow sheet was requested prior to her hospital return on 1/10/25, however, no flow sheets were available prior to her hospital return on 1/10/25, as the facility had started tracking when she returned from the hospital. The DON stated there had been no audits or documentation to ensure staff were following R32's care planned interventions, specifically toileting every two hours, and R32 had been falling regarding toileting.</p> <p>The facility Fall Prevention and Management dated 6/5/23, identified a fall analysis would be completed if a resident had two or more falls to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. If identified as a high fall risk, a comprehensive assessment would be completed. The assessment would identify resident's history of falls, activity level, visual impairment, balance and gait, elimination status and diagnoses and medications, and other contributing factors related to fall. Assessment data would be analyzed with a summary completed identifying interventions to mitigate the resident's fall risk. All interventions identified through the assessment/review process would be documented in the resident's care plan using person centered language.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview and document review, the facility failed to ensure food was served at warm, palatable temperatures for 5 of 5 residents (R30, R4, R32, R11,R18) who received meal trays out of temperature range.</p> <p>Findings include:</p> <p>R30's significant change MDS dated [DATE], identified R30 had intact cognition and was independent with eating.</p> <p>On 1/14/25, at 2:00 p.m. R30 stated he ate his meals in his room and the meal trays served were almost always cold. R30 stated this occurred with all the meals served in his room and it did not matter if was breakfast, lunch or supper.</p> <p>On 1/14/25, at 4:56 p.m. the supper meal services were observed on the Blueberry unit where several residents were seated in the dining area waiting for the supper meal. Residents were served a meal of hot dogs and tater tots in the dining room. The supper trays were on an open metal cart with three shelves. Each tray was covered with a dish cover over the plate of food. At 5:18 p.m. nursing assistant (NA)-O began delivering supper trays to the residents in their rooms. At 5:19 p.m. NA-O delivered a supper tray to R30's room. At 5:20 p.m. NA-O delivered a supper tray to R4's room. At 5:20 p.m. NA-O delivered a supper tray to R32's room. At 5:21 p.m. NA-O delivered a supper tray to R11's room. At 5:23 p.m. NA-O delivered a supper tray to R18's room. At 5:25 p.m. a test tray was removed from the resident cart and cook (CK)-A tested the hotdog and tater tots for temperature. The hot dog measured 99.5 degrees, and the tater tots measured 94 degrees. CK-A stated the food was cold and should temp around 145 degrees.</p> <p>On 1/14/25, at 5:40 p.m. CK-A stated the food had been hot when leaving the kitchen area and he thought the problem with the food cooling off so quickly was the dietary aide had not allowed the steam table to warm up adequately prior to meal service. The dietary aide had also not been trained on using the plate warmer function of the steamer table and that may have contributed to the cold food as well.</p> <p>When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated the food temperatures at supper service was not acceptable and should have been warmer. The cold food did not taste very palatable and was unappetizing.</p> <p>During interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated she observed food service at the facility in the past and could recall the facility used an open tray cart, which could contribute to the food cooling off quickly. Food was not safe if the temperature was dropped below 135 degrees and cold food was just not palatable.</p> <p>The facility policy General Food Preparation and Handling dated 10/23, identified all meats were to be heated to a safe minimum internal temperature. Staff were to refer to the charts Minimum Cooking Food Temperatures and Holding Times and Suggested Food Cooking Temperatures and Holding Times, which identified hot holding temperature of 135 degrees.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41575</p> <p>Based on observation, interview and document review, the facility failed to ensure the final rinse on the dishwasher reached 180 degrees Fahrenheit (F) to sanitize dishes. This had the potential to affect 61 of 62 residents who consumed food from the main production kitchen.</p> <p>Findings include:</p> <p>On 1/13/25, at 11:58 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall with several hard plastic racks on the conveyor belt in front of machine. DA-A loaded several plate covers onto a hard plastic rack and placed them into the dishwasher. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash and on the gauge next to the 150 F degrees there was black marker identifying the temperature. A second gauge was labeled rinse, and the black marker was marked at 180 F next to the gauge. DA-A identified the temperatures were the minimum required for the dishwasher to reach when monitoring the temperatures. DA-A ran the rack with plate covers through the dishwasher machine three times. On the first run, the rinse temperature registered 160 F., on the second run the rinse temperature registered 172 F, and on the third run, the rinse temperature registered 180 F just after the dish tray exited the dishwasher and the cycle was completed. DA-A stated the third tray had not reached the rinse temperature of 180 when in the dishwasher.</p> <p>The Dishwashing Machine Temp Sheet for the month of January 2025, identified from January 25 through January 29, 2025, the dishwasher rinse temperature was recorded between 150 degrees and 160 degrees for the am shift/meal.</p> <p>The Dishwashing Machine Temp Sheet for the month of December 2024, identified 12 of 49 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals.</p> <p>During interview on 1/13/25, at 12:00 p.m. cook (CK)-B stated the dishwasher repair person had told dietary staff to shut off and drain the washer every shift to help it to reach adequate temperatures and she was not sure that was being done. The dishes would not be rinsed properly if the rinse temperature did not reach the required 180 degrees. When it was identified the dishwasher was not reaching adequate temperatures, staff were to call the dishwasher repair person. Staff were to keep running the dishes through the dishwasher until it reached the adequate rinsing temperature to ensure the dishes were sanitized and she would let maintenance know they were having problems with the dishwasher.</p> <p>During interview on 1/13/25, at 12:32 p.m. maintenance (MAINT)-A observed the dishwasher cycle with rinse temperature at 160 degrees. MAINT-A stated he had never been notified the dishwasher was not working properly. He did not work on the dishwasher but would call the repair person to come.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A joint interview was completed with DA-A and CK-B on 1/13/25, at 12:40 p.m. CK-B stated they never manually sanitized dishes in the sink. CK-B could only remember hand washing dishes one time when the dishwasher was being replaced. CK-B stated currently the dishwasher was not working properly if the rinse did not reach 180 degrees. DA-A stated maybe they should be hand washing the dishes to sanitize them.</p> <p>During a second tour of the kitchen on 1/13/25, at 1:05 p.m. DA-A was observed hand washing cooking equipment, pots and utensils in a sink with soapy water. DA-A put the hand washed equipment into a hard plastic rack and ran three racks of hand washed pots, equipment and utensils through the dishwasher. The dishwasher rinse gauge registered 175 degrees. DA-A stated she ran the dishes through the dishwasher after hand washing them in order to sanitize the dishes. DA-A stated the dishes were not getting properly sanitized since the rinse temperature did not reach 180 degrees, but she did not know what else she could do. At 1:24 p.m. DA-A completed washing all the lunch dishes through the dishwasher and the rinse temperature reached 180 degrees and greater. DA-A stated it was just the first few trays that were run through that the rinse was below 180 degrees. DA-A was watching all the trays going through now to make sure the rinse reached 180 degrees or more.</p> <p>During interview on 1/14/25, at 10:30 a.m. MAINT-A stated the dishwasher repair person checked the dishwasher, and it was working properly. The repair person indicated the surface temperature needed to be 160 degrees and was reaching 168 degrees. The staff needed to run a holding thermometer or test strip or plate through the machine to get the most accurate readings.</p> <p>During observation of dishwasher on 1/14/25, at 4:29 p.m. DA-B ran a rack of plastic glasses through the dishwasher. The rinse temperature registered 160 degrees. DA-B stated she always ran resident glasses through two times. DA-B ran the glasses through the dishwasher a second time. The rinse temperature registered 178 degrees. DA-B stated she did not know where to locate or how to run a thermometer or temperature plate through the dishwasher, as she had never been taught. DA-B stated she only looked at the front gauges to record the dishwasher temperatures and had never been told or taught to do it any other way.</p> <p>During interview on 1/14/25, at 5:35 p.m. MAINT-A stated the dishwasher took a while to heat up to the 180 degree rinse. MAINT-A was not aware the dietary staff were not trained on how to check dishwasher temperatures other than to read the front gauges. The dishwasher repair technician who checked the machine earlier that day had not trained the dietary staff on alternative methods to check dishwasher temperatures.</p> <p>During interview on 1/15/25, at 1:11 p.m. CK-A stated he thought he had figured out the problem with the facility's dishwasher. The dishwasher took a while to heat up to the required 180-degree rinse temperature. CK-A instructed all the dietary staff to run a tray through the dishwasher several times until the rinse temperature reached 180 degrees before washing any dishes with the dishwasher. Staff had not been getting the dishwasher up to the required temperature before washing dishes. The staff would just run the dishes through right away in order to get done for the day quickly. The staff have been instructed now to get the dishwasher up to required temperature prior to starting to wash any dishes.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated if dietary staff were not running dishes through a properly working dishwasher, they ran the risk of the dishes not being sanitized properly. The DON would expect the dietary staff to try to problem solve and find out the reason the dishwasher was not reaching the required temperature and to reach to the dietary manager or maintenance when equipment was not working properly.</p> <p>During telephone interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated running dishes through the dishwasher at low rinse temperatures meant the dishes were not being sanitized, which was not appropriate. DODS stated it was an area staff would need training on.</p> <p>The facility policy Cleaning Dishes/Dish Machine dated 4/20/22, identified the facility used a high temperature dishwasher which used heat for sanitization. Minimum wash temperatures were 150 degrees and minimum rinse temperature was 180 degrees. If minimum temperatures were not obtained, staff were to utilize sanitation process and indicate on the temperature log the corrective action used to ensure dishes were sanitized.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075</p> <p>Based on observation, interview and document review, the facility failed to expand COVID-19 testing/ and or contact tracing of staff and residents on other units after residents tested positive for COVID19 per Centers for Disease Control (CDC) guidelines. In addition, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 3 residents (R53) reviewed for activities of daily living (ADLs). This had the potential to affect all 60 residents residing in the facility.</p> <p>Findings include:</p> <p>COVID-19 Testing:</p> <p>The current CDC guidance on COVID-19 in the Nursing Home dated June 2024 included : Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.</p> <p>On 1/13/25 at 1:25 p.m., R10 stated she was waiting for her shower because the NA that was supposed to help her was pulled to the other unit (Evergreen) to work.</p> <p>On 1/15/25 at 2:37 p.m., maintenance worker-A stated there was a potential that housekeeping staff would be pulled to work from one unit to the other during the same shift.</p> <p>Review of the facility covid outbreak document dated 1/7/25, identified the following:</p> <ul style="list-style-type: none"> - NA-E worked the night shift (10:00 p.m. - 6:30 a.m.) on 1/6/25 and evening shift on 1/7/25 on Evergreen unit. Throughout the evening on 1/7/25, NA-E developed symptoms (not listed) and at 9:00 p.m. tested positive for COVID-19. NA-E immediately left the facility. The morning of 1/8/25, infection surveillance and tracking was initiated. The document identified NA-E had high risk contact with all 29 residents on Evergreen Unit and 16 staff (RN-C, RN-G, RN-H, LPN-C, TMA-A, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y, NA-Z, Hsk-C, Scheduler) that worked in the facility. - On 1/8/25, 4 residents (R3, R17, R36 and R43) tested positive for COVID-19 and were immediately placed on droplet precautions and were quarantined to their rooms. R3's symptoms included cough, congestion and sore throat. R17's symptoms included cough and congestion. R36 and R43 were asymptomatic. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Thief River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Eastwood Drive Thief River Falls, MN 56701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- On 1/10/25, all residents on Evergreen unit were tested for day 3 outbreak testing. One additional resident, R46, tested positive for COVID-19. R46 had symptoms including cough and runny nose and was immediately placed on droplet precautions and quarantined to the room. The previously identified high risk staff all tested negative for COVID-19.</p> <p>- On 1/12/25, all residents on Evergreen unit and previously identified high risk staff were tested and were negative for COVID-19.</p> <p>The facility staff schedules identified 19 staff, including 11 nursing staff (RN-B, RN-E, RN-F, LPN-A, LPN-B, NA-B, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-O, NA-P, NA-Q), 5 dietary aides (DA-A, DA-B, DA-C, DA-D), 2 activity aides (AA-A, AA-B) and 1 housekeeping staff (HSK-A), worked on 1/8/25, and were not tested for COVID-19. The schedules did not identify if staff were pulled to the other unit during their shift.</p> <p>During joint interview on 1/15/25 at 1:02 p.m., registered nurse (RN)-C and RN-D identified the on 1/7/25, nursing assistant (NA)-E was working the evening shift (2:00 p.m.-10:30 p.m.). Throughout the shift NA-E developed body aches and congestion. At 9:00 p.m., NA-E tested positive for COVID-19 and was immediately sent home by the nurse. The morning of 1/8/25, RN-C and RN-D were notified of NA-E's positive COVID-19 result and started employee contact tracing. All high risk staff identified through, contact tracing, and all residents on Evergreen unit were tested for COVID-19. Of those tested, zero staff tested positive; however, four residents tested positive. The positive residents were immediately placed in droplet precautions and a mass text was sent to inform all other employees of the positive cases.</p> <p>- The facility continued to test the originally identified high risk staff and all residents on Evergreen unit on day 3 (1/10/25), day 5 (1/12/25), day 7 (1/14/25) and planned to test on 1/17/25. The facility failed to expand the contact tracing, to include staff/residents exposed to the positive residents; or complete broad-based testing of all staff and residents after continued positive cases of COVID-19 were identified. Staff continued to worked in close proximity with residents and other staff from both units throughout their workday. The facility tried to keep staff, (including nursing, dietary, and housekeeping staff) on one unit or the other during their shift, although there was a potential for staff to be pulled from one unit to the other during, as well as residents from either unit to co-mingle during times including meals and activities. The facility failed to complete additional employee contact tracing and failed to consider broad-based testing for all staff and residents even after the facility continued to have positive COVID-19 test results.</p> <p>On 1/16/25 at 10:33 a.m., RN-C stated she was monitoring the residents on Blueberry unit for symptoms of COVID-19 by reviewing their progress notes and receiving verbal report from nursing staff. She had not tested the residents on Blueberry because she thought symptom monitoring was sufficient. Additional staff were not tested because staff were monitoring their own symptoms. In addition, RN-C stated there was a potential for staff, including nursing, housekeeping, activities and dietary staff, to work on both units during the same shift, as well as residents from either unit to come into contact with each other during facility activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/16/25 at 10:53 a.m., the director of nursing (DON) stated the facility dropped the ball on testing staff and residents for COVID-19. Once there were additional cases of COVID-19 they should have tested the entire facility because staff work back/forth on both units and there was a risk that the staff were exposed and worked with other residents and/or staff when they had not been tested . The DON stated the risk of not testing appropriately is the risk of spreading the illness to other residents, staff or visitors.</p> <p>The facility Coronavirus Prevention, Screening, and Identification policy reviewed/revised 10//11/23, included the following: The facility will assess and identify the potential staff risk. Low risk includes when there is no direct exposure to a COVID-19 infected person. Contact risk is identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. The facility will communicate the risk level and recommendations to staff. Care center wide testing includes: if the care center becomes aware of a COVID-19 positive case among staff who have worked within the past 2 days and/or residents, an assessment to determine exposure will begin immediately. Residents and staff with close contact with someone with COVID-19 will begin testing 24 hours after exposure. If unable to determine close exposure to the COVID-19 positive individual broad testing of all staff and residents (regardless of vaccination status) will occur.</p> <p>The facility Suspected (or Confirmed) Coronavirus (COVID-9) Outbreak policy reviewed/revised 7/25/23, identified the purpose was to provide guidance for care center staff on handling suspected or confirmed Cornona virus (COVID-19) disease. During an outbreak of COVID-19 disease the facility would begin testing all exposed staff and residents immediately day one, (two days after exposure) day three, and day five after exposure, and 5-7 days after testing until 14 days of no further positive results.</p> <p>41575</p> <p>Enhanced Barrier Precautions:</p> <p>R53's quarterly Minimum Data Set (MDS) dated [DATE], identified R53 had severely impaired cognition and was dependent on staff for all activities of daily living (ADLs). R53 was incontinent of bowel and had an indwelling catheter and a feeding tube. Diagnosis included spastic quadriplegic cerebral palsy.</p> <p>On 1/14/25, at 8:55 a.m. a personal protective equipment (PPE) cart was observed in the hall beside R53's room door. The PPE cart's drawers contained disposable hospital gowns, disposable gloves and masks. A sign was posted above the cart which identified enhanced barrier precautions were required when providing high contact care with resident residing in the room. The poster identified when and what staff were required to don prior to entering the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation on 1/14/25, at 9:02 a.m. nursing assistant (NA)-Q entered R53's room to assist her with her morning care. NA-Q was wearing a surgical mask and put on gloves. NA-Q removed R53's brief and washed up R53's peri area with disposable wipes. NA-Q turned R53 away and then rolled her back toward her, leaning over R53 to perform the peri care. NA-Q changed her gloves after performing incontinence care and rolled R53 from side to side to secure the clean brief. R53's body would lean against NA-Q uniform at times, when rolling R53 toward her. NA-B entered the room wearing a face mask, gloves and disposable gown. NA-B and NA-Q placed a Hoyer (full lift) lift sheet underneath R53's body, again rolling her from side to side and at times leaning into NA-Q's uniform. Both aides utilized the Hoyer lift to transfer R53 into her wheelchair and secured her catheter bag to the side of the wheelchair and adjusted R53's feeding tube lines to ensure placement was appropriate.</p> <p>When interviewed on 1/14/25, at 9:14 a.m. NA-Q stated she wore a disposable gown in the [NAME] when she got R53 dressed. It was especially important to wear a gown and gloves when working with R53's indwelling catheter. NA-Q had not worn a gown when assisting with incontinent peri care, as she was just getting the resident up in her wheelchair and not emptying her catheter or anything like that. R53 had touched NA-Q's uniform when she was assisting her, and NA-Q had provided bowel incontinent peri care without a gown on. NA-Q should have worn a gown before assisting R53 with personal care.</p> <p>During interview on 1/14/25, at 9:18 a.m. NA-B stated staff were suppose to a wear gown and gloves with any residents who had a catheter or open wounds. Staff were to wear the PPE whenever providing care to those type of residents; however, were not required to wear the PPE when just passing water or going in room to speak with them.</p> <p>During joint interview with infection preventionist registered nurse (RN)-C and RN-D on 1/16/25, at 10:15 a. m. RN-C stated R53 was on enhanced barrier precautions and staff should wear the appropriate PPE of gown, mask and gloves to perform peri care. Staff were educated on the use of PPE with enhanced barrier precautions (EBP) in April 2024, and were to wear PPE whenever providing care, transfers, or toileting. The resident's that required EBP had PPE carts outside of their room doors and EBP posters on their doors to direct staff.</p> <p>The facility policy Enhanced Barrier Precautions dated 8/20/24, identified EBP were to be used when providing high contact care to residents who were colonized or infected with a multi-drug-resistant organism. EBP would also be used for residents with chronic wounds and/or indwelling medical devices. EBP was to be employed when performing high contact resident care activities such as dressing, bathing, changing linen, transferring, hygiene care, toileting, peri care, emptying catheter bag, wound care, indwelling medical device care and therapy treatment.</p> <p>The CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.</p>		