Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Methodist Health Care Center	610 Summit Drive Fairmont, MN 56031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R264) reviewed who was observed to have medications at the bedside, had been appropriately assessed and deemed appropriate to self-administer medications. Findings include: R264's Admission Record printed 10/24/24, identified diagnoses including bloodstream infection, muscle spasm of the back, and lack of blood flow to the muscle. R264's entry tracking record Minimum Data Set (MDS) assessment dated [DATE], identified admitted [DATE], and admission from short-term general hospital stay. R264's care plan printed 10/24/24, identified R264 required extensive staff assistance for grooming, transfers, bed mobility, and dressing. Care plan further indicated R264 was at risk for ineffective coping related to health status with interventions of re-orientation, allow time to process, move slowly with cares and give simple explanations. R264's Order Summary Report printed 10/24/24, identified an order for miconazole nitrate external ointment (fungal cream) apply to fungal dermatitis topically two times a day for fungal dermatitis until healed and diclofenac sodium external gel (pain gel) apply to affected area topically four times a day. R264's record review did not include an assessment for self-administration of medication. During observation on 10/21/24 at 9:28 a.m., R264 was sleeping in her bed. Two prescription creams were observed within reach on bedside table. The creams were labeled as miconazole nitrate external ointment and diclofenac sodium external gel. During observation on 10/22/24 at 1:45 p.m., miconazole cream and diclofenac gel remained on the bedside table in R264's room. During interview on 10/22/24 at 4:41 p.m., licensed practical nurse (LPN)-B verified no assessment for self-medication administration had been completed for R264. LPN-B further stated the cream and gel should not have been in R264's room prior to there being an assessment completed for self-administration. LPN-B removed the cream and gel from R264's room. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/22/24 at 5:12 p.m., director of nursing (DON) stated she would expect an assessment completed for self-administration of medication prior to medications being left in R264's room. DON further stated an assessment should have been completed to ensure R264 was safe to have medications at bedside. The facility Self-Administration of Medication policy revised 12/28/22, indicated: The interdisciplinary team must ask the resident during assessment whether he/she wishes to self-administer drugs. The resident has the right to defer the responsibility to the facility. If a resident chooses to self-administer drugs, the interdisciplinary team must assess the resident's cognitive, physical, visual abilities to carry out this responsibility. A physician's order will be obtained and recorded in the chart. Order to include which specific medications can be kept at bedside. Place on resident care plan, review and revise as needed.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 44630 Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 7 of 7 residents (R3, R12, R19, R24, R32, R41, R49) who voiced concerns with mail delivery during resident council. This deficient practice had the potential to affect all 61 residents residing in the facility. Findings include: Resident Council was held on 10/23/24 at 11:00 a.m., R3, R12, R19, R24, R32, R41, R49 attended. R3, R12, R19, R24, R32, R41, R49 stated they did not receive mail on Saturdays and received the mail on Monday through Friday. R12 stated the mail was delivered to the post office and not to the facility. On 10/23/24 at 11:18 a.m., activity director (AD)-A confirmed resident mail was not delivered on Saturdays, and further stated activity staff delivered the mail to residents Monday through Friday. AD-A stated on Saturdays activity staff were not at the facility after 1:00 p.m., and the post office delivered the mail to the facility after 1:00 p.m., so therefore mail was not delivered to the residents. On 10/23/24 at 11:21 a.m., staffing coordinator (SC)-A stated the post office would deliver the mail to the facility on Saturdays, however the facility does not have a locked location for the post office to deliver the mail. SC-A stated mail delivery had been suspended on Saturdays and the mail was held at the post office on Saturday because the facility did not want packages and personal mail left unsecured in the entry of the facility. On 10/24/24 11:23 a.m., administrator stated she was not aware the facility did not have mail delivery on Saturdays. The administrator stated residents were expected to receive mail on Saturday if the post office delivered the mail. The facility Mail and Electronic Communication policy dated 5/17, indicated: Mail and packages will be delivered to the resident within 24 hours of delivery on premises or to the facility's post office box (including Saturday deliveries).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 2 residents (R42) reviewed for elopement devices and 1 of 1 resident (R62) reviewed for hospitalization . Findings include: R42's Face Sheet, printed 10/24/24, included diagnoses of dementia and senile degeneration of the brain. R42's quarterly Minimum Data Set (MDS) dated [DATE], section P, P0200 under alarms, did not include a wander/elopement alarm. During observation and interview on 10/23/24 at 10:58 a.m., R42 was in her wheelchair propelling herself with her feet, and approached room [ROOM NUMBER] (empty room) and opened the closed door. R42 had a wanderguard (bracelet worn to prevent elopement) bracelet on her left lower leg. R42 closed the resident room door without entering and wheeled self towards the unit exit doors, with side of door open to hallway and other door closed. R42 made it to through the door when a staff member entering had R42 turn around and go back on the unit. During interview on 10/23/24 at 11:21 a.m., registered nurse (RN)-A, also identified as MDS coordinator stated R42 does have a wander guard alarm and after reviewing R42's 8/24/24 MDS confirmed the MDS was not accurate and will correct it. During interview on 10/23/24 at 11:34 a.m., the director of nursing (DON) indicated if someone has a wanderguard she would expect the MDS to reflect that. 50764 R62's discharge MDS assessment dated [DATE], indicated R62 was admitted on [DATE], had intact cognition, no behaviors, was independent with bed mobility, hygiene, transfers, and walking, diagnoses included: femur fracture and unspecified injury of the elbow or forearm. R62's discharge MDS further indicated a planned discharge with return not anticipated, and discharge to a short-term general hospital on 8/10/24. R62's facility document titled Discharge Summary dated 8/10/24, indicated discharge date of [DATE], and discharge location as son and daughter-in-law's home with transportation provided by family, all belongings and medications sent with R62 and family. During interview on 10/23/24 at 8:40 a.m., RN-A, also know as MDS coordinator, stated the discharge MDS was coded incorrectly in error and needed to be corrected. MDS coordinator further stated R62 discharged to son's home. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/23/24 at 11:05 a.m., DON stated she expected the MDS to be coded accurately to reflect accurate resident information. DON further stated the facility follows guidance of the Resident Assessment Instrument (RAI) manual and should have coded the MDS accordingly. Facility policy on MDS completion and accuracy was requested but not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to ensure a care plan was revised to address pressure ulcer risk and preventative measures for 1 of 2 residents (R31) reviewed for pressure ulcers (PU). Findings include: R31's face sheet printed 10/23/24, included diagnosis of Parkinson's disease (progressive movement disorder), lymphedema (swelling of the leg or arm), and body mass index 36.0 - 36.9 (normal is 25-30). R31's quarterly Minimum Data Set (MDS) dated [DATE], identified one stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) not present on admission. Cushion on chair, air mattress on bed. R31's physician orders dated 6/28/24 included apply rolled towel to left lower leg for left lateral malleolus (bony prominence on each side of the human ankle) pressure reduction every shift for left lateral malleolus pressure area stage III. Complete skin observation assessment every shift every Tuesday, dated 5/28/24. R31's most current care plan last revised 6/28/24, included pressure ulcer injury stage III to left lateral malleolus. Treatment in place. Interventions included; Assess, monitor and record wound healing weekly. Measure length, width and depth where possible. Assess and document wound perimeter, wound bed and healing progress. Report improvements and declines to practitioner. Daily skin inspection. Report abnormalities to the nurse. Inform the resident/family/caregivers of any new area of skin breakdown. Keep skin clean and dry. Use lotion on dry scaly skin. The care plan lacked individualized interventions including air mattress, repositioning, chair cushion and foot/heel protector. During interview and observation on 10/21/24 at 9:56 a.m., R31 was lying in bed, feet were resting directly on the bed and heel/foot protector was in the Broda (positioning for comfort) chair parked in the room. R31 had an air mattress present on his bed. R31's feet were both turned outwards and laying on the mattress with no rolled towel or foot/heel protectors present. R31 stated he has a sore he thinks on or close to his heel that gets a dressing put on every day. R31 indicated he did not have this PU prior to his admission and thinks it was awhile ago when it started. During observation and interview on 10/22/24 at 11:34 a.m., R31 was lying in his bed with feet both rotated outwards. Heel/foot protector was sitting on his Broda chair. R31 stated he hasn't had his heel/foot protector on for at least a few days. During observation on 10/22/24 at 6:05 p.m., R31 remains lying in his bed, both feet rotated outwards and heel/foot protector sitting in his Broda chair in his room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/23/24 at 8:36 a.m., R31 was lying in bed with feet both rotated outwards, no leg wraps on and heel/foot protector in his Broda chair. R31 stated they haven't put his heel/foot protector on for a few days now. R31 stated you would think they would know by now it needs to be on there. During observation and interview on 10/23/24 at 8:53 a.m., registered nurse (RN)-B, also identified as wound care nurse entered R31's room and exposed R31's lower legs. R31 did not have heel/foot protector on or towel roll present for positioning. RN-B stated he should have a heel/foot protector on his left lower leg and foot. RN-B examined left lateral malleolus area and stated there should also be a dressing present on the PU area, which was not present. RN-B stated the malleolus pressure ulcer was discovered in June but has improved and is now healed and the dressing is more to protect the area along with the heel/foot protector. RN-B stated they had tried repositioning to try to keep the left lateral malleolus off the bed, but it was too painful for R31. R31 confirmed this and stated he just couldn't take the pain of his leg being rotated on the positioning devices. RN-B placed the heel/foot protector on R31's foot after examination and then informed the nurse it needed to have dressing placed on. A Wound Evaluation dated 6/28/24 at 10:29 a.m., indicated new stage III pressure ulcer with 60% granulation and 50% slough. Treatment included foam dressing with additional care to include heel suspension/protection device, moisture control. Wound evaluations were completed weekly with measurements and assessments with wound showing gradual improvement. A wound evaluation dated 10/22/24 at 3:15 p.m., included pressure stage 3 ulcer on left lateral malleolus, 3 months old was resolved. Wound has been closed for last three assessments. Will discontinue weekly wound assessments but continue with heel protector positioning with pillow indefinitely due to outward turn of leg. Continue with foam dressing as long as remains red. Skin assessments were not completed daily per plan of care. The following skin assessments were completed: 4/29/24: Open areas to right and left legs. Mepilex (absorbent foam dressing) treatment. 5/13/24: Open area to right lower leg. Left lower leg area is scabbed over. 7/2/24: Left ankle outer with pressure and right lateral leg with healing blister. Notes included left malleolus area is pressure. Dressing changed and being followed by wound care for measurements. Boot and rolled towel initiated. 8/2/24: Left lower malleolus pressure wound, see wound care notes. 8/20/24: Wound to bilateral lower extremity and received treatment and assessed by wound nurse today. 9/3/24: Right buttock red raised areas, right shin old scab. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1/24: Shower today. Barrier cream applied to buttocks. No new alteration to skin integrity. Healing wounds assessed by wound care today of right leg and left malleolus. Review of interventions and tasks for October, heel protector to left foot at all times was listed as an intervention but lacked any documentation. On interview 10/23/24 at 9:41 a.m., licensed practical nurse (LPN)-A indicated the nursing assistants (NA) are responsible for putting the heel protectors on R31. LPN-A indicated he does wear the heel/foot protector boot, but refuses to get out of bed or have his feet repositioned. LPN-A indicated they do weekly skin assessments on all residents generally on bath day. On interview 10/23/24 at 9:49 a.m., NA-A indicated she only works on the unit once a week and ensures R31 has his heel/foot boot on at all times. NA-A is unsure if they document the boot but she thought so. On interview 10/23/24 at 9:56 a.m., NA-B indicated R31 has his heel/foot protector is on most of the time but does sometimes refuse. NA-B added R31 refuses to reposition or get into his Broda chair. NA-B indicated she doesn't believe there is a place to document the boot when on or off or if he refuses. On interview 10/23/24 at 10:01 a.m., the director of nursing (DON) indicated weekly skin assessments are completed on all residents. The DON confirmed there is no documentation on the heel/foot boot for September or October. The DON after investigation stated the heel/foot boot protector was just added to the task list today, which is why there was no documentation present. The DON confirmed skin assessments were not completed daily and the heel/foot protector should be on at all times and should have been part of the care plan and the tasks for documentation. The DON confirmed the care plan should reflect the preventative measures being taken to prevent skin breakdown and was generic and not specific to R31's interventions. The facility Body/Skin Audit policy dated 4/2018, included: -Care plan for skin will be reviewed and revised. The facility Skin Safety Protocol, Pressure Ulcer Prevention policy reviewed 4/30/14, included pressure ulcer prevention is to be provided for all residents at risk of pressure ulcer development and for those individuals who have a pressure ulcer. There may be some medical or personal conditions that may impeded interventions from this protocol being implemented. Individualize the interventions as appropriate for these patients.

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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 skin and/or consistently implement interventions to prevent the development of new pressure ulcers for 2 of 2 residents (R31, R48) who were reviewed for pressure ulcers. Findings include: R31's Face Sheet printed 10/23/24, included diagnoses of Parkinson's disease (progressive movement disorder), lymphedema (swelling of the leg or arm), and body mass index 36.0 - 36.9 (normal is 25-30). R31's quarterly minimum data set (MDS) dated [DATE], identified R31 was cognition was intact, needed substantial to moderate assistance for all activities of daily living except was able to eat independently. Further, the MDS indicated R31 was at risk for pressure ulcer (PU) development, currently had a stage III pressure ulcer ((Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) not present on admission and had pressure reducing devices for bed and chair. R31's physician orders dated 6/28/24, included apply rolled towel to left lower leg for left lateral malleolus (bony prominence on each side of the human ankle) pressure reduction every shift for left lateral malleolus pressure area stage III. Complete skin observation assessment every shift every Tuesday, dated 5/28/24. R31's plan of care dated 6/28/24, included R31 has alternation in or potential for break in skin integrity. Interventions included; a pressure ulcer injury stage III present to left lateral malleolus. Treatment in place. Additional interventions included assess, monitor and record wound healing weekly. Measure length, width and depth where possible. Assess and document wound perimeter, wound bed and healing progress. Report improvements and declines to practitioner. Daily skin inspection. Report abnormalities to the nurse. Enhanced barrier precautions due to open wound. Inform the resident/family/caregivers of any new area of skin breakdown. Keep skin clean and dry and use lotion on dry scaly skin. During interview and observation on 10/21/24 at 9:56 a.m., R31 was laying in bed, feet were resting directly on the bed and heel/foot protector was in the Broda (positioning for comfort) chair parked in the room. R31 had an air mattress present on his bed. R31's feet were both turned outwards and laying on the mattress with no rolled towel or foot/heel protectors present. R31 stated he has a sore he thinks, on or close to his heel that gets a dressing put on every day. R31 indicated he did not have this PU prior to his admission and thinks it was awhile ago when it started. During observation and interview on 10/22/24 at 11:34 a.m., R31 was lying in bed with both feet rotated outwards. Heel/foot protector was sitting on his Broda chair. R31 stated he hasn't had his heel/foot protector on for at least a few days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 10/22/24 at 6:05 p.m., R31 remains lying in his bed, both feet rotated outwards and heel/foot protector sitting in his Broda chair in his room. During observation and interview on 10/23/24 at 8:36 a.m., R31 was lying in bed with feet both rotated outwards, no leg wraps on and heel/foot protector in his Broda chair. R31 stated they haven't put his heel/foot protector on for a few days now. R31 stated you would think they would know by now it needs to be on there. During observation and interview on 10/23/24 at 8:53 a.m., registered nurse (RN)-B, also identified as wound care nurse entered R31's room and exposed R31's lower legs. R31 did not have heel/foot protector on and no wraps present. RN-B stated he should have a heel/foot protector on his left lower leg and foot. RN-B examined left lateral malleolus area and stated there should also be a dressing present on the PU area, which was not present. RN-B stated the malleolus pressure ulcer was discovered in June but has improved and is now healed and the dressing is more to protect the area along with the heel/foot protector. RN-B stated they had tried repositioning to try to keep the left lateral malleolus off the bed, but it was too painful for R31. R31 confirmed this and stated he just couldn't take the pain of his leg being rotated on the positioning devices. Upon examination of R31's left lateral malleolus, RN-B stated the area on and around the left malleolus is red, but no open areas present. RN-B placed the heel/foot protector on R31's foot after examination and then informed the nurse it needed to have dressing placed on. RN-B confirmed skin assessments should be completed weekly by a nurse. Review of R31's task list for October, included heel protector to left foot at all times but lacked any documentation of completion. R31's Wound Evaluation dated 6/28/24 at 10:29 a.m., indicated new stage III pressure ulcer with 60% granulation and 50% slough. Treatment included foam dressing with additional care to include heel suspension/protection device, moisture control. Wound evaluations were completed weekly with measurements and assessments with wound showing gradual improvement. Dates included 6/28/24, 7/5/24, 7/10/24, 7/17/24, 7/23/24, 7/30/24, 8/6/24, 8/13/24, 8/20/24, 8/27/24, 9/3/24, 9/10/24, 9/17/24, 9/24/24, 10/1/24, 10/8/24, 10/15/24. A wound evaluation dated 10/22/24 at 3:15 p.m., included pressure stage III ulcer on left lateral malleolus, 3 months old was resolved. Wound has been closed for last three assessments. Will discontinue weekly wound assessments but continue with heel protector positioning with pillow indefinitely due to outward turn of leg. Continue with foam dressing as long as remains red. Skin assessments were not completed weekly per facility order and protocol. Below were skin assessments completed: 4/29/24: Open areas to right and left legs. Mepilex (absorbent foam dressing) treatment. 5/13/24: Open area to right lower leg. Left lower leg area is scabbed over. 7/2/24: Left ankle outer with pressure and right lateral leg with healing blister. Notes included left malleolus area is pressure. Dressing changed and being followed by wound care for measurements. Boot and rolled towel initiated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/2/24: Left lower malleolus pressure wound, see wound care notes. 8/20/24: Wound to bilateral lower extremity and received treatment and assessed by wound nurse today. 9/3/24: Right buttock red raised areas, right shin old scab. 10/1/24: Shower today. Barrier cream applied to buttocks. No new alteration to skin integrity. Healing wounds assessed by wound care today of right leg and left malleolus. On interview 10/23/24 at 9:41 a.m., licensed practical nurse (LPN)-A indicated the nursing assistants (NA) are responsible for putting the heel protectors on R31. LPN-A indicated R31 does wear the heel/foot protector boot, but refuses to get out of bed or have his feet repositioned. LPN-A indicated they do weekly skin assessments on all residents generally on bath day. On interview 10/23/24 at 9:49 a.m., NA-A indicated she only works on the unit once a week and ensures R31 has his heel/foot boot on at all times. On interview 10/23/24 at 9:56 a.m., NA-B indicated R31 has his heel/foot protectors on most of the time but does sometimes refuse them. NA-B added R31 refuses to reposition or get into his Broda chair. NA-B indicate she doesn't believe there is a place to document the boot when on or off. On interview 10/23/24 at 10:01 a.m., the director of nursing (DON) indicated weekly skin assessments are completed on all residents. After review of documentation, the DON indicated R31's were not done weekly and went from mid May until July without being completed/documented. The DON confirmed there was no documentation on the heel/foot boot for September or October. The DON after investigation stated the heel/foot boot protector was just added to the task list today, which is why there was no documentation present. The DON confirmed skin assessments were not completed monthly and the heel/foot protector should be on at all times and should have been part of the care plan and the tasks for documentation. 50764 R48's face sheet printed 10/24/24, indicated diagnoses of type two diabetes mellitus with foot ulcer, chronic kidney disease, heart failure, and fracture of the tibia (lower leg bone). R48's quarterly MDS assessment dated [DATE], indicated R48 had intact cognition, no rejection of care, used a walker and wheelchair, required partial assistance with dressing, footwear, and hygiene, and was independent with transfers. MDS further indicated R48 was at risk for pressure ulcer development, currently had a stage III pressure ulcer not present on admission, and had pressure reducing devices for chair and bed, nutrition interventions for skin, and required pressure ulcer care, application of medications and dressings to feet. R48's physician's order dated 10/7/24, indicated an order for weekly wound assessment by wound care coordinator. Wound orders included treatment for left foot wound of cleansing wound by moistening gauze and laying over wound for five minutes, pat dry, cover wound with foam adhesive dressing, evening shift, every three days and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Methodist Health Care Center	610 Summit Drive Fairmont, MN 56031

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R48's care plan printed 10/24/24, indicated R48 had an alteration in or potential for break in skin integrity with interventions listed as assess, monitor, and record wound healing weekly. Measure length, width, and depth where possible. Assess and document wound perimeter, wound bed, and healing progress. Report improvements and declines to practitioner. Further interventions included daily skin inspections, keep skin clean and dry. During observation and interview on 10/21/24 at 2:43 p.m., R48 was seated in wheelchair with no sock on left foot. A foam adhesive bandage was observed adhered to the top of R48's left foot. R48 stated she was unsure what the bandage was for and thought her wound was healed. During interview on 10/22/24 at 4:39 p.m., LPN-B stated the pressure ulcer started from R48's shoe being too tight. LPN-B further stated the wound was healed and the bandage on R48's left foot was for protection to the area. During interview on 10/22/24 at 5:37 p.m., RN-B also identified as the wound care nurse stated she thought R48's left foot pressure ulcer was healed in September and was unsure why a treatment was still ordered. RN-B stated R48's left foot pressure ulcer developed 3/5/24, was stage III at the time of discovery, and that weekly skin audits should have been completed consistently prior to discovery of R48's wound. RN-B further stated wound measurements and assessments should be completed weekly to prevent worsening of wounds. Review of R48's weekly skin audits for one month prior to discovery of the stage III pressure ulcer on 3/5/24, indicated skin audits on 2/8/24 and 2/21/24. Review of facility wound assessments indicated wound measurements and assessments were not completed weekly once the wound developed. Documented completed wound measurements occurred on the following dates: 6/4/24, 6/6/24, 6/13/24, 6/20/24, 7/17/24, 8/6/24, 8/20/24. There was no documentation to indicate the wound was resolved. During interview on 10/23/24 at 10:15 a.m., DON stated she expected weekly skin audits on bath day and weekly measurements and skin assessments of wounds to prevent pressure ulcers and promote healing of developed pressure ulcers. The facility Body/Skin Audit policy dated 4/2018 included: -All residents will have a body/skin audit performed by a licensed nurse for a head to toe skin inspection. -Body audits will be completed weekly, on admission, readmission and as needed. -Body audits will be documented by a nurse in the treatment record and by nursing assist in point of care. -Care plan for skin will be reviewed and revised.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51578 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R314) who was observed using an electric heating pad, was free of potential injury. Findings include: R314's facesheet printed on 10/22/2024, included diagnoses of rheumatoid arthritis, disc degeneration, and age-related osteoporosis. R314's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R314 was cognitively intact and was independent in most activities of daily living (ADL's). R314's MD orders included Aqua-K pad 20 minutes TID (three times a day) as needed for pain relief every 8 hours. R314's care plan dated 1/19/24, indicated to offer warm blanket, massage, cold Pak, repositioning, rest/relaxation. warm bath/ whirlpool, and/ or diversional activities for pain. R314 treatment administration record (TAR) indicted the Aqua-K pad had not been used in September or October 2024. During an observation on 10/22/24 at 10:30 a.m., a heating pad was observed laying over the arm of a recliner in R314's room. During an interview on 10/22/24 at 2:12 p.m., R314 stated she used the heating pad for lower back pain at night when sleeping in her recliner. R314 stated that she thought she had brought it from home or maybe the facility provided it to her. During an observation on 10/22/24 at 5:41 p.m., observed the heating pad plugged into a wall outlet behind the recliner. The approximately 12 x 24-inch heating pad was Walgreen's brand and covered in a tan cloth. Imprinted on the control of the heating pad was, On/off for 2 hours and included ranges of warm, low, medium, and high. An Aqua-K pad as indicated in R314's orders, was not observed in room. During an interview on 10/23/24 at 9:05 a.m., licensed practical nurse (LPN)-C stated she was not aware R314 had a heating pad in her room. During an interview on 10/23/24 at 9:15 a.m., registered nurse (RN)-C stated she was not aware R314 had a heating pad in her room. RN-C looked in the EMR (electronic medical record), stated R314 had an order for an Aqua K pad, and that electric heating pads brought from home were not allowed for use by residents in the facility due to risk of injury. (continued on next page)

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	245280	A. Building B. Wing	10/24/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 12:51 p.m., maintenance director (MD)-A stated heating pads brought from home were not allowed in the facility due to the potential risk of fire and/or electrical shock and was not aware R314 had a heating pad in her room. During an interview on 10/23/24 at 1:15 p.m., the director of nursing (DON) stated she was not aware R314 had a heating pad in her room. The DON stated she would have expected staff to notice the heating pad and inform her. The DON stated heating pads brought from home pose a risk of burning a resident since the temperature could not be regulated. The DON stated she would have the heating pad removed from R314's room right away. A policy on the use of heating pads was requested but not received.

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	245280	A. Building B. Wing	10/24/2024

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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. 51578 Based on observation and interview, the facility failed to ensure beverageware was completely dry before storing, in order to prevent bacterial growth. This had the potential to affect all 29 residents who resided on second floor. Findings include: During an observation and interview on 10/22/24 at 1:51 p.m., observed multiple beverageware stacked on trays, sitting on an open cart located between kitchenettes on second floor. Observed stacked clear plastic cups, light blue plastic cups, and thermal coffee cups. Condensation was visible in the stacked light blue cups. Dietary aide (DA)-A was asked to pick up and separate a stack of blue cups and looking in the cups, verified moisture was present. In addition, DA-A picked up several thermal coffee cups and verified there was moisture inside the cups as well. DA-A explained when she removed beverageware from the dishwasher, she placed them on the counter on top of a piece of rubber shelf-liner to air dry. DA-A acknowledged moisture remaining in cups could lead to bacterial growth. During an interview on 10/22/24 at 2:05 p.m., dietary manager (DM)-C was present in the kitchenette area on second floor and was informed of the wet cups. DM-C stated when removed from the dishwasher, staff were to set beverageware on the rubber shelf-liner to allow time to completely air dry before storing. Further, DM-C stated staff were not to stack beverageware, but instead place cups on a single layer on a tray. DM-C acknowledged moisture in cups had the potential for bacterial growth. During an interview on 10/24/24, at 10:20 a.m., the administrator was informed of findings and acknowledged with four kitchenettes, it required monitoring by dietary leadership staff to ensure policies were adhered to. The facility Dishwashing Machine Use policy dated March 2010, indicated food service staff required to operate the dishwashing machine would be trained in all steps of dishwashing machine use by the supervisor or designee proficient in all aspects of proper use and sanitation. After running the items through an entire cycle, allow to air-dry.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on interview and document review, the facility failed to ensure 2 of 5 resident (R36, R58) were administered the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R36's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, diagnoses included: stroke, hypertension (high blood pressure), and Parkinson's Disease (brain disorder that affects movement and other systems of the body), and was not up to date on her pneumococcal vaccinations R36's Immunization Report dated 10/23/24, indicated on 5/13/24, R36 consented to the Pneumovax (pneumococcal) vaccine. R36's record review failed to indicate the pneumococcal vaccine was administered. R58's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, had diagnoses of anemia, coronary artery disease, hypertension, hip fracture, dementia, and obstructive sleep, and was not up to date on her pneumococcal vaccination. R36's Immunization Report dated 10/23/24, indicated on 9/16/24, R58 consented to the Pneumovax. R58's record review failed to indicate the pneumococcal vaccine was administered. On 10/23/24 at 9:22 a.m., registered nurse (RN)-B known as the infection preventionist stated the facility followed the CDC recommendations for pneumococcal vaccinations. RN-B stated she was responsible to ensure residents were administered vaccinations and confirmed R36 and R58 did not have documentation they received the pneumococcal vaccination. On 10/23/24 at 12:11 p.m., RN-A stated when residents were admitted she reviewed the resident's immunizations, and if residents were due for vaccinations consent was obtained, and then the resident name was placed a on handwritten list and given to RN-B. RN-A confirmed herself and RN-B were responsible to ensure residents received up to date vaccinations. RN-A confirmed R36 and R58 consented to the pneumococcal vaccine and the vaccine was not administered as expected. On 10/23/24 at 12:37 p.m., the director of nursing (DON) stated the facility followed CDC guidance for vaccinations, and stated when a resident consented to the vaccination the facility was responsible to ensure the resident received the vaccination. The facility Pneumococcal 20-Valent Conjugate Vaccine (Prevnar 20) Policy Statement dated 5/10/24, indicated (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days of admission to the community unless medically contraindicated or the resident has already been vaccinated.