STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Nsg & Rehab Center	416 Seventh Street Northeast Bagley, MN 56621

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview, and document review the facility failed to ensure care plans failed to develop a person-centered comprehensive care plan to address resident specific approaches to meet residents psychosocial, mental, and medical needs 3 of 5 (R33, R20, R30) residents reviewed for unnecessary medications. Findings include: R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 had severe cognitive impairment and a diagnosis of dementia. R33's care plan dated 4/11/23, identified R33 received psychotropic medication for dementia. Target behaviors included grinding teeth, resisting cares and grabbing at others. Interventions included attempt non-pharmacological interventions. The plan failed to identify resident specific non-pharmacological interventions. R33's undated orders identified R33 received lorazepam (ordered 9/19/23) and cyclobenzaprine (ordered 3/12/24) twice daily for dementia, and paroxetine (ordered 3/28/24) daily for depression. During interview on 7/17/24 at 3:01 p.m., the director of nursing (DON) stated R33's care plan failed to identify individualized non-pharmacological interventions for behaviors and the plan should be updated to include them. R20's quarterly MDS dated [DATE], identified R20 had moderate cognitive impairment and a diagnosis of chronic pain. R33 had moderate pain on a constant basis that occasionally affected his sleep. R33 received scheduled and as needed pain medication on a daily basis. R20's care plan 8/8/23, identified R20 had complaints of chronic and acute pain. Staff interventions included monitoring and recording R20's complaints of pain, provide medications as ordered, and use non-medicated pain relief measures; however, failed to identfiy what those non-medicated interventions were. R20's undated orders identified R20 received the following medications for pain: - Gabapentin daily (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hydrocodone-acetaminophen three times daily - Meloxicam every morning - IcyHot pain relief cream four times daily - Muscle rub (methyl salicylate-menthol) cream three times daily During interview on 7/16/24 at 3:02 p.m., registered nurse (RN)-B stated care plans were updated by nursing staff when the MDS was due (upon admission, annually, and quarterly) and as needed for changes in the residents condition and should include individualized, patient centered interventions. RN-B stated R20's care plan was very general and did not include individualized non-medication interventions for pain relief, that were specific to the resident. During interview on 7/17/24 at 3:07 p.m., the DON stated R20's care plan failed to include non-medication individualized interventions for R20's pain. 41575 R30's quarterly MDS dated [DATE], identified R30 had intact cognition and required assistance with all activities of daily living (ADL). R30 received antianxiety and antidepressant medications all seven days of the observation period for anxiety and depression. Diagnosis included an anxiety disorder. R30's care plan dated 6/6/24, identified R30 received antianxiety medication related to anxiety with a goal to be prescribed the lowest effective dose of medications. Staff were instructed to attempt non-pharmacological interventions; however, no patient specific interventions were included to direct staff on effective approaches to use with R30. The care plan also identified R30 experienced pain with a goal R30 would verbalize she was free from pain. Staff were also directed to use non-medicated pain relief measures; however, no patient specific interventions were included to direct staff on effective approaches to use with R30. When interviewed on 7/16/24, at 2:45 a.m. RN-A stated interventions that helped R30 calm her anxiety included changing her environment, reminding her to work through her breathing exercises and calling her daughter to chat. RN-A stated interventions should be documented in her care plan clearly and specific to R30 to manage her anxiety, pain and depression and they were not. During interview on 7/17/24, at 9:00 a.m. nursing assistant (NA)-A stated R30 could get weepy or anxious at times. NA-A knew R30 well and she was usually able to distract her with visiting or joking with her. R30 enjoyed visiting about her past and her family. When interviewed on 7/17/23, at 1:40 p.m. DON stated she would expect care planned interventions to be specific to each resident. It was important to provide interventions specific to the resident and that were important and effective for each resident, so all staff could consistently utilize them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Comprehensive Care Plan dated 10/20/22, identified the facility would develop a comprehensive care plan for each resident to meet the resident's medical, nursing, mental and psychosocial needs. The care plan would be designed to incorporate identified problem areas, risk factors associated with identified problems and build on the resident's strengths.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review the facility failed to ensure timely repositioning to assist in the healing and prevention of pressure ulcers for 1 of 2 residents (R1) reviewed for pressure ulcers. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderately impaired cognition and was dependent on staff with all activities of daily living (ADL)s. R1 had a facility acquired stage 3 pressure ulcer (full-thickness skin loss and extends into the subcutaneous tissue layer) as well as a stage 4 pressure ulcer (full thickness skin and tissue loss) that was present on admission. Physician ordered treatments were performed daily. Diagnoses included multiple sclerosis, osteomyelitis, diabetes and edema. R1's care plan dated 4/25/24, identified R1 had a current pressure ulcer to her right upper thigh and buttock. Interventions included staff to turn and reposition R1 every two to three hours as R1 allowed and to use pillow prop to get off her back-she normally refused this but to encourage her when in bed. During continuous observation on 7/17/24, from 8:00 a.m. through 11:30 a.m. R1 was lying in bed on her back. The head of her bed was elevated to obtain a seated position from 8:00 a.m. to 8:48 a.m. to enable R1 to eat her breakfast. At 8:48 a.m. the head of the bed was lowered slightly to semi reclined position and R1 was left to watch her television the remainder of the morning. R1 remained lying in the same position on her back without repositioning of her buttocks until she was assisted up into her wheelchair at 11:30 a.m. During interview on 7/17/24, at 11:10 a.m. nursing assistant (NA)-B stated she was in R1's room and put the head of the bed up for R1 to eat breakfast and then lowered it down slightly after breakfast. NA-B had not repositioned R1 at and just raised and lowered the head of her bed. Putting the head of the bed up and down would not do anything to relieve pressure on R1 buttocks and it was important to reposition residents from side to side. NA-B did not offer to turn and reposition R1 as she knew R1 well, having worked with her for a few years, and R1 would have just refused. On 7/17/24, at 11:20 a.m. R1 remained lying in bed on her back in a semi reclined position. R1 stated she had been lying in bed watching a movie all morning. R1 was unable to turn from side to side herself and no staff had been in her room to offer to help her reposition. R1 thought she maybe would have agreed to reposition if someone had offered it to her, she was not sure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/17/24, at 1:30 p.m. licensed practical nurse (LPN)-A stated the staff had known and cared for R1 for years and knew she did not like to turn and reposition and refused all offers to do so. The newer aides were good about consistently going in to offer to assist her to reposition when R1 was in bed, but the older staff were not so good at offering as they felt she would just refuse it. The staff should still be asking R1 to assist her to reposition every two hours in chance she may accept some of the time and they should be documenting R1's refusals to reposition. Repositioning was important as a preventive measure and to promote healing to R1's existing pressure ulcers. When interviewed on 7/17/24, at 1:45 p.m. the director of nursing (DON) stated she expected all staff to offer repositioning to residents as indicated on their care plan. It was an important intervention to help prevent pressure ulcer development and promote healing of existing pressure ulcers. The facility policy Comprehensive Care Plan dated 10/20/22, identified the comprehensive care plan for each resident included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs. The comprehensive care plan was designed to attain and maintain a resident highest practicable physical, mental, and psychosocial well-being, incorporate identified problems, and risk factors and build on resident strengths. The care plan would reflect treatment goals and objectives in measurable outcomes and identify the professional services that were responsible for each element of resident care and prevent decline in the resident's functional status and/or levels.

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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** 41575 Based on observation, interview and document review, the facility failed to ensure smoking risks were comprehensively assessed for 1 of 1 resident (R43) who currently smoked on facility grounds. Findings include: R43's admission Minimum Data Set (MDS) dated [DATE], identified R43 required assistance with dressing, and transfers and was unable to ambulate. R43's cognition was undetermined due to inability to communicate effectively. Diagnoses included cerebral infarction (brain injury or ischemic stroke), fibromyalgia, bipolar disorder and nicotine dependence. R43's progress note dated 6/18/24, identified R43 went outside to smoke, staff noticed her attempting to ambulate by herself and intervened. R43's medical record lacked a smoking assessment. R43's care plan dated 6/3/24, failed to identify R43 smoked along with interventions. During interview on 7/16/24, 11:45 a.m. registered nurse (RN)-A stated she was aware R43 would go out to the facility parking lot and smoke. R43 did not require staff to assist R43 with this and had been provided a call light to take with her to use to come back into the facility. Rn-A had been told a smoking assessment was completed and R43's smoking was addressed on her care plan. RN-A reviewed R43's medical record and was unable to find a smoking assessment. During interview on 7/16/24, at 12:58 p.m. nursing assistant (NA)-C stated she was R43 smoking outside the facility the previous Friday. R43 seemed safe enough and NA-C never saw burn holes in R43's clothing. NA-C told the nurse that was working, but was unsure which nurse she reported it to. When interviewed on 7/17/24, at 9:11 a.m. RN-C stated she completed a smoking assessment for R43 on 7/16/24, (after surveyor started investigating the concern) when it came to her attention one had not been completed. RN-C based the assessment on her previous observations of R43 smoking since her admission on 5/16/24. R43's smoking had not been care planned as the smoking assessment had not been completed. R43's Smoking Risk Acuity dated 7/16/24, was completed by RN-C (after surveyor started investigation). The observation starting time was identified as 11:51 a.m. and the completion time as identified as 11:53 a.m. The smoking assessment was completed while R43 was ambulating in the hall with therapy and not while smoking. The assessment identified R43 used cigarettes a couple times per day, did not smoke in unauthorized areas and was not careless with smoking materials. Awareness and behaviors were not of concern; however, a minimal problem was noted with R43 following facility safe smoking policy, and did not identify what the safety concerns were or what the facility was doing to monitor for following the facility smoking policy. The assessment lacked identification on who was responsible for smoking materials and where they would be stored. Smoking risk was identified as level 1 which indicated R43 was a safe smoker and to continue with the current plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/17/24, at 9:20 a.m. NA-B stated she had seen R43 smoking. R43 usually sat outside the facility front doors on the sidewalk. NA-B had never seen how R43 lights or puts out her cigarette but felt R43 must be able to because she was out there by herself smoking. NA-B never saw issues or burn holes in R43's clothing. On 7/17/24, at 9:45 a.m. R43 was observed wheeling herself outside the facility. R43 stopped on the sidewalk outside the facility front doors and lit a cigarette with a cigarette lighter. After smoking her cigarette, R43 put the cigarette out in the rock sidewalk border. R43 wheeled herself back into the facility, to her room and returned her cigarettes and lighter to her bedside table drawer. When interviewed on 7/16/24, at 12:10 p.m. the director of nursing (DON) stated an observation study on smoking was just completed for R43. It had not been done previously as she had not been aware R43 smoked. The proper procedure would have been for licensed staff to perform the assessment as soon as they had become aware R43 was smoking. It was important to assess residents who had a history of smoking to ensure they were safe. The facility policy Tobacco Free Site dated 10/27/16, identified residents currently using or had recent history of tobacco use would be assessed upon admit for their ability to use safely.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review, the facility failed to attempt a gradual dose reduction of psychotropic medications or provide a rationale why an attempt was not made for 2 of 4 patients (R30, R33) who were reviewed for unnecessary medications. Findings include: R33's quarterly minimum data set (MDS) dated [DATE], identified R33 had severe cognitive impairment, was dependent on staff for activities of daily living (ADL's), and diagnoses included dementia and depression. R33 received medications for anxiety and depression during the assessment period. R33's care plan dated 4/11/23, identified R33 received medication for anxiety related to dementia. The plans goal dated 9/23/24, identified R33 would be prescribed the lowest effective dose of medication and a gradual dose reduction would be attempted per facility policy. R33's undated orders included an order for Ativan (lorazepam) 0.5 milligrams (mg) tablet 0.5 mg twice daily for anxiety, start date: 9/19/23, and end date: open ended; and paroxetine HCL 40 mg daily at bedtime for depression, start date: 3/28/23, end date: open ended. The Consultant Pharmacist's Medication Review form dated 11/1/23, identified Paroxetine 40 mg take as directed and suggested if a dose reduction was not appropriate, a detailed clinical rational, including why the recommendation was rejected, was needed for continuation at the current dose. R33's primary provider rejected the dose reduction, indicated benefits were greater that risks and signed the form on 11/1/23. R33's primary provider failed to provide a detailed clinical rationale for rejecting the dose reduction. R33's progress notes dated 7/6/24 through 5/17/24, failed to identify any physical behaviors displayed by the resident. On 7/17/24 at 2:54 p.m., the director of nursing (DON) stated there was not a clinical rationale or a progress note indicating the clinical rationale for use of Ativan and paroxetine for R33. 41575 R30's quarterly MDS dated [DATE], identified R30 had intact cognition. R30 experienced anxiety and depression and received lorazepam (an antianxiety medication) and escitalopram (an antidepressant medication) all seven days of observation period. A diagnosis of anxiety was identfied. R30's care plan dated 6/6/24, identified R30 received lorazepam and escitalopram with a goal for R30 to be prescribed the lowest effective dose of medication. Interventions included to monitor for drug use effectiveness and adverse consequences and to attempt a gradual dose reduction (GDR). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's undated active orders included lorazepam 0.5 milligram (mg) two times per day, with start date 12/6/23, and escitalopram 20 mg daily with start date 12/6/23. R30's Psychotropic Medication Gradual Dose Reduction (GDR) form dated 10/31/23, identified R30 received Lexapro (brand name for escitalopram) 20 milligrams (mg) every day. Previous dose reductions had not been attempted. Under the nursing summary, a notation indicated R30's behaviors remained stable. Physician response indicated a tapering attempt was not possible at that time. No changes were to be made to R30's current order as risk less than benefit of continue use. The form was signed by R30's primary provider on 11/13/23; however, no rationale why a taper of the medication could not be attempted was not identfied on the form or in R30's medical record. R30's Consultant Pharmacist's Medication Review form dated 3/15/24, identified family was concerned with R30's increased tiredness and were wondering if it could be medication related. The pharmacist (pharm)-A identified R30 was on a higher than recommended dose of escitalopram and suggested a review of her medications to see if any doses could be reduced or discontinued. The primary provider rejected the recommendation with a notation the resident and family declined medication changes at that time. No further rationale was given as to why a taper of the medication could not be attempted o nthe form or in the medical record. R30's Consultant Pharmacist's Medication Review form dated 7/17/23, pharm-A identified R30 was on higher than maximum recommended dose of escitalopram and requested the primary physician to consider a trial dose reduction of the medication unless inappropriate or contraindicated. The primary physician responded risks outweighed the benefits and rejected the recommendation; however, the form and the medical record lacked specifics to what benefits the resident was receiving with the medication at the dose it was prescribed. During interview on 7/16/24, at 1:40 p.m. the (DON) stated they had reached out to R30's provider several times. Some providers documented rationale better than others and the providers had their own way of doing things. The DON reviewed the state operations manual the night before and realized rationale for a GDR of psychotropic medications needed more than just documenting family or resident refusal of medication taper. The DON was unable to find any provider notes or dictation the provider documented any further rationale related to the continued use of escitalopram at a higher than recommended dose. The facility policy Tapering Medications and Gradual Drug Dose Reduction dated 11/14/22, identified residents who used antipsychotic drugs would receive GDR and behavioral interventions, unless clinically contraindicated, to discontinue those drugs. The staff and practitioner would consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of the medication was benefiting the resident. The staff and practitioner would consider tapering under certain circumstances, including when the resident's clinical condition had improved or stabilized, underlying causes of the original target symptoms had resolved, non-pharmacological interventions had been effective in reducing symptoms or the resident's condition had not responded to treatment or had declined despite treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview and document review the facility failed to ensure medications were properly labeled to prevent medication errors for 1 of 6 residents (R37) observed during medication pass. In addition, the facility failed ensure 1 of 2 medication rooms had stored medications that were not expired and prescription medication had identfiying labels for 6 of 8 residents (R13, R10, R15, R27, R35, R41) who's medication were observed in the medication room. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 was cognitively intact with a diagnosis of gastro-esophageal reflux disease (GERD). R37's physician orders report dated 9/19/23 through 10/19/23, identified on 10/9/23, R37's Omeprazole 20 mg was increased to twice daily. R37's undated orders identified R37 was to receive Omeprazole 20 mg twice daily, with a start date of 10/9/23. On 7/16/24 at 3:32 p.m., trained medication aid (TMA)-A removed one pill from a bottle. The label on the bottle identified the medication belonged to R37 and was Omeprazole 20 mg once daily. R37's current medication administration record (MAR) identified R37 was to receive Omeprazole 20 mg twice daily. TMA-A stated if a medication bottle did not have the correct information, he would always go by what the MAR said. TMA-A stated the label on R37's omeprazole bottle was different than the MAR and there was no identifying marks or stickers on the label to indicate the medication orders had changed. There was a risk R37 would not get the correct medication dose because the label was incorrect. On 7/16/24 at 3:51 p.m., the director of nursing (DON) stated medication labels should identify the most up-to-date instructions for the medication. When staff identify an incorrect medication label they are directed to double check the order and when needed, place an order change sticker on the label so other staff are know there is a change. R37's omeprazole was changed on 10/9/23, and the label was not corrected to reflect the change and there had not been a sticker placed on the label. The DON stated adverse effects of the wrong medication label include the resident not getting the correct medication, correct dose, over/under medicating, as well as side effects from the medication itself. The staff should have placed a label change sticker on the bottle until a new label could be placed. On 7/17/24 11:50 a.m., medications in the cabinet of the North medication room were observed with licensed practical nurse (LPN)-A. A random sample of medications were reviewed. At 11:56 a.m., the administrator entered the North medication room and observed LPN-A going through each of the unlabeled and expired medications in the cabinet and identified the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12 unlabeled individual envelopes of prescribed Lidocaine Patch 5% 700 mg (50 mg per gram adhesive). All 12 envelopes were not contained in the original box and failed to identify the resident prescription label. There was no original box observed in the cabinet. - A bottle of [NAME] lotion 7.5 oz. A label on the bottle identified the medication belonged to R13 and had an expiration date of 5/16/24. - A bottle of Minocycline 100 mg with a label identifying the medication belonged to R10 and dated 4/25/24. The label failed to identify if the date was an open date or an expiration date and was unable to identify if R10 had a current prescription for the medication. - 1 bottle of Clonidine 0.1 mg take 1 tablet by mouth every day. The label on the bottled identified the medication belonged to R15. The label further identified R15 needed an appointment for refills and not to use the medication beyond 6/12/24. - A bottle of potassium chloride with an expiration date of 2/4/24. A label on the bottle identified the medication belonged to R27. - A bottle of Allopurinol 100 mg. The label on the bottle identified the medication belonged to R35 and had an expiration date of 5/22/24. The bottle had tape from one side, over the cap and down the other side of the bottle. - A bottle of Cognitive Health supplement with a label identifying the medication belonged to R41 and had an expiration date of 10/23. - A bottle of sennosides 8.6 mg tablet with a label, however, the name and instructions were blacked out with a black marker making the bottle unidentifiable. The bottle had an expiration date of 3/25. - An opened and unlabeled tube of Medihoney wound and burn dressing gel 1.5 oz tube. There was no indication when the medication was opened or who used the medication. - 1 box of Coagucheck XS Pro PT controls with an expiration date 9/30/23 printed on the box. - 1 box of Acetaminophen suppository. The box listed the dose of 650 mg, NDC #45802-730-30, and expiration date 10/24. The box contained two individually wrapped and sealed suppositories with an expiration date of 12/23. On 7/17/24 11:50 a.m., LPN-A stated the Coagucheck was used ensure the test machine was working properly and thought it needed to be checked once monthly. The two Acetaminophen suppositories should not have been placed in a box with a different expiration date. If the suppositories were used staff could not ensure the resident would get the correct dose of medication since they were expired. All the other expired medications in the cabinet, including medications labeled for R10, R15, R27, R35 and R41, should not be dispensed to the residents because they were expired. Residents could have adverse effects including under/over medicating, and increased side effects from receiving expired medications. (continued on next page)

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	245307	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Nsg & Rehab Center	416 Seventh Street Northeast Bagley, MN 56621

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24, at 11:56 a.m., the administrator stated the medications should have a resident label, and expiration date, an opened date if appropriate and dosing instructions on the labels. If the medication had been discontinued it should clearly be identified on the medication. The facility Storage of Medications policy dated 4/1/22, identified drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on observation, interview and document review, the facility failed to ensure standard precautions and proper disinfecting of equipment was followed for 1 of 4 residents (R13) receiving dressing changes. Finding included: R13's 5-day Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment. Diagnosis included peripheral vascular disease and diabetes. R13 had four venous/arterial ulcers. R13's care plan dated 6/27/24, identified R13 had wound on both lower legs. The facility would continue to follow wound clinic instructions for care and cleaning. R13 orders dated 7/4/24, directed staff to apply saline moistened Hydrofera (special wound dressing) to wound base, cover with an absorbent dressing, secure with Kerlix (roll bandage) and tape, and change every day to both lower legs. During observations on 7/16/24 at 9:10 a.m., registered nurse (RN)-A sanitized their hands and then put on a gown and gloves upon entering R13's room. RN-A gathered the supplies needed for the dressing changes on both legs and placed chux (clean barrier) under both of R13's lower legs. With a bandage scissors RN-A cut the Kerlix dressing on right leg and removed the dressings from the wound on the leg and discarded in the trash. RN-A took a gauze pad and cleaned the wound with normal saline and patted dry, wearing the same contaminated gloves. RN-A then took the dirty bandage scissors and trimmed the clean Hydrofera (dressing) to fit the wound and then moistened the dressing and placed it in the wound bed, covered with an absorbent dressing, wrapped with Kerlix, and placed a tubigrip (sock like covering) over the dressing while wearing the same dirty gloves. - RN-A then moved to the left leg, wearing the same contaminated gloves, and removed R13's sock with a blood-soaked toe from R13's right foot and tossed it on the floor. RN-A, with the same contaminated gloved hands got a trauma scissor and removed the Kerlix and dressings from the right leg. There was reddish clear drainage on the dressing. The dressing was discarded in the garbage. RN-A then removed their contaminated dirty gloves, did not perform hand hygiene, and placed a clean pair of gloves on. RN-A then cleansed the wound with gauze pads and saline spray. RN-A then used the contaminated bandage scissors and trimmed the Hyrofera to fit in the wound on the right leg, applied the absorbent dressing, wrapped with Kerlix, and placed a tubigrip over the dressing. RN-A noticed a dressing came off R13's left heel. RN-A then gathered Mepilex (absorbent foam dressing), cleaned the area on the left heel and placed the Mepilex on R13's heel wearing the same contaminated gloves used on R13's right leg dressing change. RN-A then picked the bloody toed sock off the floor and placed in a biohazard bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 9:42 a.m., RN-A stated when she did dressing changes, she would change gloves whenever going from dirty to clean and between different dressings. Anything with blood or body fluid on it should not be placed on the floor, but instead would be placed in a biohazard bag to ensure everything remained clean. R13 was on contact precautions and required to wear a gown and gloves when completing dressing changes. RN-A stated she might have for gotten to change gloves and do hand hygiene when she should have, not used a dirty bandage scissors on clean dressings, nor have placed anything bloody on the floor. During an interview on 7/16/24 at 1:27 p.m., the director of nursing (DON) stated she would have expected nursing staff to follow proper infection control procedures when doing dressing changes and the handling of bloody clothing. The facility's Dressing Dry/Clean policy dated 10/20/22 identified when soiled dressing was removed gloves were to also be removed and hand hygiene performed, and new gloves were to be put on prior to cleaning wound. Gloves were to be changed and hand hygiene performed between each wound.

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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** 41575 Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 3 of 5 residents (R10, R13, R39) reviewed for immunizations. Findings include: R10's admission Face Sheet dated 5/16/24, identified R10's age of [AGE] years. Diagnoses included chronic congestive heart failure, history of pulmonary embolism, chronic obstructive pulmonary disease, and elevated white blood cell count. R10's Minnesota Immunization Information Connection (MIIC) report dated 1/6/20, identified R10's immunizations. R10 had received the pneumococcal polysaccharide vaccine (PPSV23) 8/4/14, the pneumococcal vaccine Prevnar 13 (PCV13) on 1/8/16. R10's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended pneumococcal conjugate (PCV 15 or PCV 20) had been offered in conjunction with their providers recommendation. R10's electronic medical record (EMR) lacked evidence R10 had been given information or offered the newer recommended PCV15 or PCV20 vaccination. R13's admission Face Sheet dated 8/19/22, identified R13's age of [AGE] years. Diagnoses included chronic congestive heart failure, atrial fibrillation, and peripheral vascular disease. P13's MIIC report dated 7/1/22, identified R13's immunizations. R13 had received the PPSV23 on 1/25/10 and 10/18/17 and PCV13 on 4/12/16. R13's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation. R13's EMR lacked evidence R13 had been given information or offered the newer recommended PCV15 or PCV20. R39's admission Face Sheet dated 11/3/23, identified R39's age 74. Diagnoses included Alzheimer's disease, history of malignant breast cancer and chronic obstructive pulmonary disease. R39's MIIC report dated 11/3/23, identified R39's immunizations. R39 received the PPSV23 on 0/29/10 and 1/29/19 and the PCV13 on 1/18/17. R39's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation. R39's EMR lacked evidence R39 had been given information or offered the newer recommended PCV15 or PCV20 vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview was conducted with director of nursing (DON) and registered nurse (RN)-D on 7/16/24, at 1:55 p.m. RN-D stated the facility reached out to their pharmacy for information regarding the new recommended pneumococcal vaccines and the pharmacy provided a list of residents who should be offered the new vaccinations. The list did not include R10 or R13 and they had intended to offer the new PCV20 vaccination to R39 in a few weeks when they conducted their next vaccination clinic for staff and residents. The facility was under the impression the new PCV 20 should be offered [AGE] years after the last pneumococcal vaccination and did not know it was to be offered to eligible residents 5 years after the last pneumococcal vaccine. The facility policy Vaccination of Residents dated 10/17/22, identified all residents would be offered vaccinations that aid in preventing infectious diseases unless the vaccine was medically contraindicated, or the resident had already been vaccinated. All new residents would be assessed for pneumococcal vaccine status on admission and offered one dose pneumococcal vaccine unless medically contraindicated or the resident had already been vaccinated. Before receiving the pneumococcal vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education would be documented in the resident's medical record. If vaccinations were refused, the refusal would be documented in the resident's medical record.