STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Healthcare	303 Broadway Avenue South Trimont, MN 56176

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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. 34083 Based on observation, interview and document review, the facility failed to assess, monitor and document pressure injuries weekly for 1 of 2 residents (R14) identified with pressure-induced deep tissue damage (DTPI) (A serious type of pressure injury that occurs when soft tissue is compressed between a bony prominence and an external surface for a long time. DTPI can be invisible for up to 48 hours before rapidly progressing to full-thickness skin and soft tissue loss). Findings include: Review of the documentation included on weekly bath/skin assessments, progress notes, and treatment records identified inconsistent assessment, monitoring and documentation of R14's wounds. The facility failed to follow the policy for assessment and documentation on a weekly basis 14 of 25 weeks from his admission on November 17, 2023 through May 19, 2024. Documentation failed to consistently include date of observation, location, measurements of length x width x depth, appearance, any discharge, surrounding tissue appearance and if pain was present. R14's 2/15/24, significant change Minimum Data Set (MDS) assessment identified intact cognition, and required assistance for most activities of daily living (ADLs). R14 had an indwelling Foley catheter to promote wound healing and was incontinent of BMs. R14's skin section identified he had 1 stage 2 pressure ulcer (PU) and 2 unstageable ulcers that were present on admission. R14's face sheet , included 11/17/23, identified primary diagnoses of pressure induced deep tissue damage of buttocks, high blood pressure, renal insufficiency, arthritis, anxiety disorder, and depression, R14's current 2/26/24, care plan identified he was admitted with wound care orders for treatment to his scrotum and pressure ulcers (PU) to his buttocks. Staff were to provide assistance to reposition frequently (every 2-3 hours) throughout the shift. Pain medication was to be administered as needed for wound care/discomfort and he was identified as at risk of further skin breakdown. R14's heels were to be floated with a pillow when in bed for pressure relief, but there was no identification of weekly assessment, monitoring, and documentation of R14's identified pressure wounds. Over the course of 25 weeks (admission 11/17/23 to 5/21/24), according to wound data collection documents provided by the director of nursing (DON), R14's PU were treated by a nurse or provider and 14/25 weeks lacked a comprehensive assessment to include measurements, wound characteristics and staging. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's 12/23/23, physician orders identified Arginade (supplement to promote wound healing) 1 packet daily. 4/3/24, Paint the abrasion on side of left foot with Betadine daily. 4/23/24, AFO boot at all times to left foot. 12/25/23, Boost nutritional supplement daily. 4/3/24, wound care orders identified - left heel-cleanse, pat dry, calcium alginate AG to wound bed, cover with foam dressing and change every 3rd day. 4/23/24- 1.) Left hip-clean with acetic acid, pat dry, calcium alginate AG cut 4x4 sheet in half, lay into wound bed and tuck into undermining. Fill in the rest of the space with kerlix and cover with foam dressing or ABD. change daily. 2.) Right hip- cleanse area, pat dry, apply non-sting skin prep over entire area including wound bed, fan dry two times daily (BID). 3/20/24- Left lateral foot-half moon abrasion-paint area with Betadine daily and protect feet when using chair. Observation on 5/20/24 at 3:04 p.m., as licensed practical nurse (LPN)- A performed dressing changes to R14's wounds: 1.) Right buttock -1.5 centimeters (cm) depth (D) x 2.0 cm width (W) x 4.0 cm length (L). The wound bed was bright red, with purple discoloration surrounding the wound and small amount of sanguineous drainage was noted from the base of the wound, which LPN-A reported occurred when R14 moved in his wheelchair. 2.) Left buttock extending from the area of the hip bone to the scrotal area. There were three distinct areas of the buttock wound. The upper most portion of the wound was round and had tunneling (opening underneath the surface of the skin) 3.5 cm (tunneling) x 2.5 cm(D), x 3.0 cm (W). The wound bed appeared red with the wound edges curled. The lower area- extended to the scrotum and measured 14.0 cm (L) x 3.0 cm (W) at the center area and 1.5 cm (W), at the bottom of that area The base of the wound extended to the scrotal area and was 2.0 cm (W) at that area. 3.) Left heel - LPN-A reported the area was mushy on the medial aspect and firmer toward the lateral aspect. There was dark red/purple discoloration surrounding the base of the heel. The heel pad had a white yellow appearance which measured 7.0 cm (L) x 1.5 (W) with one area measuring 4.0 cm (W) at the widest point. A small open area that had serosanguinous drainage measured .5 cm (D) x 2.0 cm (W) x 1.0 cm (L). Interview on 5/20/24 at 3:30 p.m., with R14 reported he initially needed pain medication prior to the dressing changes and had some discomfort with dressing changes on the buttock wounds, but none with his heel wound. He reported he didn't need to have pain medication before the dressing changes most of the time, but it was provided if he needed it. He reported staff came and performed his dressing changes and the wound nurse came at times, but he was not aware of the wounds being measured but was told they were getting better. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/20/24 at 9:16 a.m., registered nurse (RN)- B reported R14's wound dressings were to be changed daily and as needed according to the signed physician orders. She reported measurements were to be completed weekly with dressing changes, and documented, but she was not aware of why documentation was not consistent on the medical record. She reported the wound nurse practionier (NP) came and assessed R14's wounds, and documented on her notes, but she did not visit and assess them weekly. Interview on 5/20/24 at 10:13 a.m., with RN-A reported wounds were supposed to be assessed and monitored including measurements weekly. Upon review of R14's medical record she reported measurements of R14's wounds had not been recorded since 3/18/24. She provided the treatment record showing the treatments had completed, but there was no documented assessments or measurements according to the facility policy. Interview on 5/20/24 at 3:56 p.m., with the DON reported skin assessments were to be completed weekly and were to include wound measurements. assessment, any drainage and treatment that was provided. She reported she was not aware complete wound assessments were not being completed and documented weekly according to the facility policy. The facility Skin Issue/Wounds policy dated 5/1/24, identified all skin issues/wounds were to be identified and treated appropriately. Wounds were to be added into Wound Management on Matrix (a cloud based Electronic Medical Record (EMR) software). Licensed nurses were to measure wounds/skin areas weekly and document progression and treatments in Wound Management in Matrix and in the nurse's notes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34083 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 dietary personnel (cook (C)-A) followed appropriate infection control technique while preparing and serving food during 1 of 1 meal service observations. This had the potential to affect all 24 residents who were served food from the kitchen. Findings include: During observation on 5/19/24 beginning at 12:26 p.m. through 12:46 p.m., as C-A was serving the noon meal of pork roast, mashed potatoes with gravy, stewed tomatoes, dinner roll and apple pie. C-A applied gloves and dished food onto plates, then used her left gloved hand to pick up a dinner roll from the tray, tear it open and while holding with her left hand picked up a knife and applied butter to the roll. C-A then placed roll onto the plate of food. This process continued as she prepared several plates and placed covers over the food for delivery to residents in their rooms. At 12:30 p.m. C-A prepared a plate of food, added the buttered dinner roll, walked over to the side counter where she picked up a glass, picked up a gallon jug of milk, opened and poured a glass, and returned to the steam table to pick up the prepared plate, and carried it and the glass of milk to a resident seated in the dining room. C-A placed the plate and milk on the table, then placed her left hand on resident's shoulder and right hand on the table as she leaned and spoke with the resident and then returned to the kitchen. At 12:31 p.m. C-A wearing the same unchanged gloved, returned to the steam table, where she prepared another plate of food, picked up a bottle of ketchup, opened the top and squirted ketchup onto the meat, and returned the bottle to the side tray, picked up the plate of food and delivered to another resident in the dining room. Upon returning to the kitchen, no glove change or hand hygiene was performed, went to the steam table, and picked up a tongs used for the meat, which was dropped, she then went to the side kitchen counter, opened a drawer with her gloved hand and retrieved a new set of tongs, and returned to the steam table, where she continued dishing plates of food, picking up buns with her gloved hands, tearing open and buttering and then placing on the plate of food., then took the plate of food into the dining room and served to a resident. She continued this process with no glove changes, or hand hygiene. At 12:40 p.m. the dietary manager (DM) arrived and began taking plates of food from C-A to serve to residents in the dining room. At 12:38 p.m. the DM mentioned residents had not received their pie, and C-A turned from the steam table, walked across the kitchen to open a cabinet, and retrieve a tray, placed plated pieces of pie onto the tray and took into the dining room to serve to the residents. She returned to the kitchen placed more plates of pie on the tray and served to residents in the dining room. and was observed pushing up her glasses with her gloved right hand. She finished serving the pie to the residents and at 12:45 p.m. C-A returned to the kitchen, removed her gloves, and stated she was out of silverware and needed to wash some before dishing another room tray. C-A proceeded to rinse dishes and place onto the dishwasher rack with her ungloved hands, placed into the dishwasher, washed her hands, and applied new gloves. She then returned to the steam table where she dished a plate of food, picked up the ketchup bottle with her gloved hands, opened it and squeezed ketchup onto the meat. She then covered the plate with a piece of foil and covered. C-A using same gloved hands poured juice and milk into glasses and opened chest cooler to place tray inside. She then went to cabinet, opened with gloved hands, retrieved glass covers and returned to cooler to place on glasses on tray. C-A then removed her gloves and stated she was finished serving the noon meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/20/24 at 12:59 p.m., with food service manager identified C -A was aware that gloves or utensils should be used when handling food for consumption. She confirmed staff should never be touching resident food and it was her expectation that staff either used gloves or utensils during preparation of a meal plate. She further reported that if the cook served a meal to a resident, they needed to change their gloves prior to resuming serving food. Interview on 5/21/24 at 10:30 a.m., with the administrator reported her expectation that infection control procedures were followed for preparing and serving of food to residents. The facility Hand Washing policy dated 10/07/20, identified hand washing as a critical element for infection prevention. Hand washing was to be performed after handling soiled equipment or utensils, after food preparations, as often as necessary to remove soil or contamination and to prevent cross-contamination of tasks. A specific policy for hand hygiene in the dietary department was requested but not provided.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42073 Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, including information for agency licensed nursing staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed - Quarter 1, 2024, (October 1 - December 1), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The CMS payroll-based journal (PBJ) staffing data report indicated the following infraction dates: Failed to have licensed nursing coverage 24 hours/day on the following dates: 10/1/23, 10/3/24, 10/7/23, 10/8/23, 10/21/23, 11/4/23, 11/26/23, 12/17/23, 12/21/23. During an interview on 5/20/24 at 9:16 a.m., staffing coordinator (SC)-D, stated she was responsible for creating nursing staff schedules, and stated there were licensed nursing staff scheduled each shift (days, evenings, and nights), every day. Utilizing nursing staff schedules from 2023, and for each infraction date, SC-D identified a licensed nurse by name and title, and whether the licensed nurse was employed by the facility or was agency staff. For a total of 27 possible shifts for the nine infraction dates, an agency nurse was scheduled 18 shifts and an employed nurse was scheduled nine shifts. During an interview on 5/20/24 at 10:20 a.m., administrative assistant (AD)-C stated she was responsible for submitting PBJ data to CMS. Timecard and agency billing information was requested for each of the licensed nursing staff identified by SC-D as being scheduled on the infraction dates. Review of the documentation verified each of the licensed nursing staff worked on the dates they were scheduled. During an interview on 5/20/24 at 12:23 p.m., with the administrator and AD-C, AD-C explained she was accustomed to taking PBJ data provided by agencies and inserting that data into the PBJ report, but now realized that data was not always accurate. Going forward, AD-C stated she would ensure accuracy by entering the data herself and utilizing staff schedules and agency information for further verification of accuracy. The facility Payroll Based Journal Submission policy dated 12/1/17, indicate the system [PBJ] was auditable to ensure accuracy. Agency staff and contracted staff hours were manually entered in to PBJ. If agency staff hours were available in a generated XML zip file that is compatible for upload and submission into PBJ, hours will then be tracked that way.

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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. 34083 Based on observation, interview, and document review, the facility failed to use appropriate infection control technique for 1 of 1 resident (R14) during the provision of personal care. Findings include: During observation on 5/19/24 a 2:03 p.m., nursing assistants (NA)- A and NA-D checked and changed R14 as they prepared to transfer him from his bed to his wheelchair. R14 was identified as on contact precautions due to his indwelling Foley catheter. Both NA's washed their hands and applied gowns and gloves, prior to beginning resident cares. R14 was assisted to turn from side to side as the old brief was removed and he was positioned on his back. NA-D wearing same gloves, obtained new wet wipes and cleansed R14's peri area and around the insertion site of the Foley catheter. R14 was then assisted to turn onto his right side, and NA-D used wipes to clean his buttocks and picked up a new disposable brief and positioned under him. Without changing her gloves NA-D picked up the urinary drainage bag and placed it on the bed, arranged the blankets, and picked up the lift sling and assisted to position under R14 as she and NA-A turned R14 back and forth to position the sling under him. NA-D arranged R14's gown over him and assisted to connect the sling to the mechanical lift using her same gloved hands. R14 was transferred from the bed into his electric wheelchair, with NA-D positioning the wheelchair, and sling to allow R14 to be lowered into the chair. NA-D then positioned R14's feet onto the wheelchair pedals, assisted to unhook the lift straps and tucked into chair beside R14. NA-D picked up a blanket and tucked around R14's lower body still wearing same gloves with which she had provided peri care to R14. NA-D then went over to the bed and removed the bedding placing it into a plastic bag and bagged the trash. She then removed her gloves and washed her hands before taking the trash and bedding to the bins located in the hall. NA-A reported she was going to wipe down the mechanical lift with Sani-cloth wipes which was the procedure after use. Interview on 5/20/24 at 1:30 p.m., with NA-D reported she should have changed her gloves following providing pericares, and she did not realize she had not done so until questioned. When it was identified she had touched multiple items on both resident and in the room without changing her gloves she reported she should have changed her gloves immediately after providing personal cares. Interview on 5/21/24 at 11:55 a.m. with the director of nursing (DON) identified her expectation for all staff was to perform hand hygiene according to infection control policies and procedures. DON reported she expected staff to perform glove changes and hand hygiene between clean and dirty areas when performing personal cares and especially after performing pericares. The DON identified all staff had received education annually on infection control measures, which she expected them to follow. The facility Hand Washing policy dated 10/07/20, identified guidelines for employees to perform appropriate hand hygiene procedures and applied to all staff. hand washing was to be performed: 1.) When hands were soiled, 2.) After prolonged contact with a resident, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) After contact with bare human body parts, blood, body fluids, secretions, excretions, mucous membranes, or broken skin. 4.) After handling items potentially contaminated with a resident's blood, body fluids, excretions, or secretions. 5.) Whenever in doubt of hand cleanliness or after engaging other activities that contaminate hands.

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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** 49336 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R128) were offered pneumococcal PCV-15 or PCV-20 vaccination or declination form, per Centers for Disease Control (CDC) recommendations, reviewed for vaccinations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R128's, 5/14/24 admission Minimal Data Set (MDS) identified R128 was [AGE] years old. R128's MDS under Section O- Special Treatments and Programs indicated his pneumococcal vaccinations were not up to date. The MatrixCare (online electronic health record) lacked documentation to support if R128 had been offered or declined the PCV-15 or PCV-20 to ensure he was up to date the current CDC guidelines. Interview on 5/20/24 at 1:53 p.m., with registered nurse (RN)-A stated that facility had not started the process of obtaining facility wide consents for PCV 15 or PCV-20 vaccinations. She stated R128 had refused vaccinations but could not provide documentation to support R128's declination of the PCV-15 or PCV-20 vaccines. Interview on 5/20/24 at 2:02 p.m., with the director of nursing (DON) stated the facility would collaborate with the local pharmacy to facilitate PCV-15 or PCV-20 vaccines at the facility for resident who would want the vaccine. She stated her expectations would be for all residents to be offered the vaccine and for the facility to comply with the Center of Disease Control (CDC) for vaccinations. The facility Pneumococcal and Prevnar 20 vaccinations policy and procedure dated 5/01/24, identified the facility would assess residents' immunization status upon admit. The facility would provide education for the vaccines and would vaccinate residents unless there was medical contraindication for the vaccine, refusal of vaccine or the resident received it outside of the facility. Lastly, the facility would document refusals on the Matrix (online) electronic medical record.