STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42587 Based on observation, interview and document review, the facility failed to ensure blood sugars were obtained as ordered for 3 of 3 residents (R2, R7, R11) reviewed for blood glucose monitoring. Findings include: R2's Diagnosis Report dated 12/6/24, identified R2 had type 2 diabetes mellitus. R2's active orders as of 12/5/24, identified the following order: Blood Sugars before meals and at bedtime And: Novolog FlexPen 100 units per milliliter (ml) Solution pen-injector Inject as per sliding scale: 70 - 149 = 0 150 - 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously with meals R7's Diagnosis Report dated 12/6/24, identified R7 had type 2 diabetes mellitus. R7's active orders as of 12/5/24, identified R7 required Humalog insulin per sliding scale: 70 - 149 = 0 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Rush City LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 650 Bremer Avenue South Rush City, MN 55069	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	150- 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously before meals R11's Diagnosis Report dated 12/5/24, identified R11 had type 2 diabetes mellitus with diabetic chronic kidney disease. R11's active orders as of 12/5/24, identified blood sugars needed to be checked three times a day. And: Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: 70 - 149 = 0 Units 150 - 199 = 8 units 200 - 249= 10 units 250 - 299 = 12 units 300 - 349 = 14 units; 350 - 399 = 16 units 400+ = 18 units 400 or greater give 18 units subcutaneously before meals (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer (device to measure blood sugars) in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she thought there would be wipes in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room. R7 stated she had already had her meal, LPN-A stated she could not find R7 before lunch. R7's glucometer reading was 224 milligrams (mg) per deciliter (dl). LPN-A then proceeded to R11's room, R11's meal was in his room, he stated he had finished eating. LPN-A cleaned the glucometer using the purple top wipes she had carried with her and obtained R11's blood sugar which was 244 mg/dl. LPN-A stated she had checked R2's blood sugar in the dining room. On 12/4/24, at 1:10 p.m., the director of nursing (DON) stated she would expect blood sugars to be obtained prior to residents eating their meals. The DON stated she did not have any training for LPN-A on glucometer use. The blood glucose monitoring check list included verify practioner's order as the first step in blood glucose monitoring. The DON stated she would expect any nurse to be trained on obtaining blood sugars as part of their nursing school education. The DON stated she would expect nursing staff to clean a glucometer prior to placing the machine back in the container. The DON also stated each resident had their own glucometer and the glucometer LPN-A was using was only for emergencies.

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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** 42587 Based on observation, interview and document review, the facility failed to ensure repositioning and checking and changing were offered for 1 of 3 residents (R12) reviewed for pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], identified R12 had diagnoses which included fibromyalgia (a long-term condition that involves widespread body pain and tiredness), muscle weakness, hypothyroidism, unspecified mood disorder, restless leg syndrome, and acute pain. R12's MDS identified R12 was cognitively intact, required substantial to maximum assistance with activities of daily living, was always incontinent of bowel and bladder, and was at risk for pressure ulcers. R12's nursing assistant care guide undated, identified staff were to assist with toileting every two to three hours and as needed and to turn and reposition every two to three hours and as needed. R12's care plan dated 2/16/24, identified R12 had an alteration in skin integrity, interventions included to turn and reposition every two to three hours and as needed. In addition, R12 had an alteration in elimination related to urinary incontinence, requiring staff assitance with toileting. Interventions included assist of one with toileting every two to three hours and as resident called. R12 orders dated 11/27/24, identified When resident refusing cares i.e. washing up, changing, repositioning, dressing make a note. Reattempt, utilize other staff and update provider if continued refusals. Every shift A review of R12's progress notes from 11/27/24, through 12/3/24, identified the following: -11/27/24 10:45 a.m., Risk versus benefits form filled out for refusing cares such as showering, turning/repositioning, am/pm cares, incontinence changes, getting up. Resident was educated on potential risks for non-compliance such as risk for infection, impaired skin integrity and pain. Residentwas understanding at this time. -Several notes regarding topical ointments refused, no documented refusals of repositioning or checking and changing. During a continuous observation on 12/4/24 from 7:04 a.m., to 10:05 a.m., no offers were made by nursing staff to reposition, toilet, or check and change. During an interview on 12/4/24 at 9:55 a.m., nursing assistant (NA)-B stated she was responsible for R12's care. She stated she had not offered any cares and would only go in if R12 put her light on. NA-B stated she thought nights had checked on her before they left and R12 only liked certain people like NA-A. NA-B stated she did not have a plan for checking and changing R12. During an interview on 12/4/24 at 10:01 a.m., NA-A stated no one had approached him with a plan for R12's care. NA-A stated R12 would often refuse cares but stated someone should still be offering repositioning and checking and changing every couple of hours. (continued on next page)

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	245348	A. Building B. Wing	12/05/2024

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The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 10:05 a.m., NA-A checked on R12 and asked her if she needed to be changed. R12 replied she thought she was okay and said the night person had changed her around 2:00 a.m., NA-A asked if he could check, R12 said ok but wanted privacy. During an interview on 12/4/24 at 10:19 a.m., NA-A stated R12 was wet, not soaking and said he would check in with her again after lunch. NA-A stated R12 said nights had last changed her between 1:00 a.m. and 2:00 a.m During an interview on 12/5/24 at 9:03 a.m., the director of nursing (DON) stated she would expect staff to offer cares, repositioning, and checking and changing even if the resident had a history of refusals. The DON stated she would expect the NA to tell the nurse and to document the refusals. The Skin Assessment and Wound Management policy dated 3/2024, identified pressure wounds wound be reviewed and the care plan would be updated including interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 5.56 % with 2 errors out of 36 opportunities for error involving 2 of 7 residents (R9, R5) who were observed during the medication passes. Findings include: R9: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 was cognitively intact and had diagnoses which included diabetes mellitus. R9's current order summary report dated 12/5/24, identified R9 had the following order: Lantus Solostar 100 unit per milliliter (ml) inject 10 units subcutaneously at bedtime On 12/2/24 at 6:21 p.m., licensed practical nurse (LPN)-B stated R9 liked to have his bedtime medications at 6:00 p.m LPN-B removed the glargine/lantus insulin from the drawer scrubbed the hub of the insulin pen with an alcohol wipe, dialed up 2 units of insulin, pushed the plunger expelling the insulin, dialed up 10 units of insulin and then put the needle onto the pen. LPN-B then entered R9's room to give the insulin. During an interview on 12/2/24 at 6:27 p.m., LPN-A verified she primed the pen prior to putting the needle on the insulin pen and stated that was how she always did it. R2: R2's annual MDS dated [DATE], identified R2 was moderately cognitively intact and and had diagnoses which included diabetes mellitus. R2's current order summary report dated 12/5/24, identified R2 had the following order: Insulin glargine 20 units subcutaneously in the morning. On 12/4/24 at 8:49 a.m., LPN-A dialed up 20 units of insulin with the cover on the insulin pen and no needle, then placed the pen into the box with the glucometer. LPN-A stated R5 had already refused twice so she was going to ask registered nurse (RN)-B to give the insulin. RN-B went with LPN-A to the dining room, LPN-A dialed the pen back to zero. RN-B cleaned the top of the pen with an alcohol wipe, placed the needle on the pen, dialed 20 units, then brought R5 to his room, he refused the injection initially and then allowed RN-B to give the insulin. During on interview on 12/4/24 at 12:12 p.m., LPN-A stated she checks the insulin order, finds the right pen, checks for the number of units, dials up the units. When prompted about priming the needle LPN-A stated, oh yes need to prime with one unit of insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 12:16 p.m., the director of nursing stated it was her expectation nurses would cleanse the top of the insulin pen, place a needle, and then prime the needle with 2 units of insulin prior to dialing the insulin units. A policy on priming insulin pens was requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42587 Based on observation, interview and document review, the facility failed to ensure a shared glucometer was properly cleaned and disinfected between residents for 3 of 3 residents (R2, R7, R11) reviewed for blood glucose monitoring. Findings include: R2's Diagnosis Report dated 12/6/24, identified R2 had type 2 diabetes mellitus. R2's active orders as of 12/5/24, identified the following order: Blood Sugars before meals and at bedtime And: Novolog FlexPen 100 units per milliliter (ml) Solution pen-injector Inject as per sliding scale: 70 - 149 = 0 150 - 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously with meals R7's Diagnosis Report dated 12/6/24, identified R7 had type 2 diabetes mellitus. R7's active orders as of 12/5/24, identified R7 required Humalog insulin per sliding scale: 70 - 149 = 0 150- 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	350 - 399 = 5 400 - 999 = 6 subcutaneously before meals R11's Diagnosis Report dated 12/5/24, identified R11 had type 2 diabetes mellitus with diabetic chronic kidney disease. R11's active orders as of 12/5/24, identified blood sugars needed to be checked three times a day. And: Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: 70 - 149 = 0 Units 150 - 199 = 8 units 200 - 249= 10 units 250 - 299 = 12 units 300 - 349 = 14 units; 350 - 399 = 16 units 400+ = 18 units 400 or greater give 18 units subcutaneously before meals On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer (a device used to measure blood sugars) in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she thought there would be wipes in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room using one wipe. LPN-A then proceeded to R11's room, R11 stated he had finished eating. LPN-A cleaned the glucometer using one wipe from the purple top wipes container that she had carried with her. She did not clean the glucometer after using the machine. On 12/4/24 at 1:03 p.m., LPN-A brought the plastic bin with the used glucometer and placed it on top of the medication cart. LPN-A did not clean or disinfect the glucometer machine prior to walking away from the cart. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24, at 1:10 p.m., the director of nursing (DON) stated she did not have any training for LPN-A on glucometer use. The DON stated she would expect nursing staff to clean and disinfect a glucometer prior to placing the machine back in the container. The DON also stated each resident had their own glucometer and the glucometer LPN-A was using was only for emergencies. On 12/4/24 at 1:18 p.m., LPN-A stated she thought she had wiped the glucometer off before putting it back in the box. LPN-A stated she thought the glucometer should stay wet for about 20 seconds. The document titled Blood glucose monitoring no date, identified the following: Clean and disinfect the blood glucose meter with a disinfectant wipe, following the manufacturer's instructions wet/kill time. Contaminated blood glucose monitoring equipment increases the risk of infection by such blood borne pathogens as hepatitis B, hepatitis C, and human immunodeficiency virus . The Assure Prism user instruction manual dated 2/2020, page 38 identified the following: Cleaning and Disinfecting: The meter should be cleaned and disinfected after each use on each patient. The products listed were Clorox Healthcare bleach Germicidal Wipes -contact time 1 minute Dispatch Hospital Cleaner Disinfectant Towels with Bleach - contact time 1 minute CaviWipes1 - contact time 1 minute PDI Super Sani-Cloth Germicidal Disposable Wipe - contact time 2 minutes (purple top wipes) Cleaning: Wearing gloves using 1 towelette wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Disinfecting: Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Allow the exteriors to remain wet for the corresponding contact time for each disinfectant.