STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

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** 42586 Based on observation, interview, and document review the facility failed to determine if self-administration of medication was appropriate for 1 of 1 resident (R 25) reviewed who was left alone to administer a medication with out staff present. Findings include: R25's quarterly Minimum Data Set (MDS) assessment, dated 5/15/24, indicated intact cognition, diagnosis of interstital pulmonary disease, and required assistance from staff for activities of daily living (ADL) and mobility. R25's physician's orders dated 4/10/24, indicated Budesonide inhalation suspension 0.5 milligram (mg)/2 milliliter (ml), 0.5 mg inhale orally via nebulizer two times a day related to interstitial pulmonary disease. Rinse mouth with water after use to reduce after taste and incidence of candidiasis (yeast infection). Do not swallow. R25's self administer medications (SAM) assessment dated [DATE], indicated R25 required assistance with inhalant medications, although marked in another area she was able to administer her own medications. R25's care plan dated indicated R25 may self administer the following medications: inhalers. Ability to safely and accurately self administer select medications and continued desire to do so, will be evaluated on a quarterly and as needed basis. It also included the following interventions: Medications as ordered. Periodic self administration assessment by licensed nurse. Staff to assess for compliance with keeping mask on after set up and start of nebulizer periodically. Staff to assess periodically for self administration of nebulizer after set up and start. Staff to set up medications as ordered. (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: 245359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/15/24 at 9:37 a.m., R25 was sitting in her room with her mask on receiving a nebulizer treatment and there were no staff present. At 9:42 a.m., she took the mask off, looked at the medication cup, and shut off the nebulizer. She had another vial of medication in her hand and the surveyor asked her what the medication was. R25 responded I don't know, I just take what they give me. She stated she takes a duo neb so staff set up the first one and she puts the medication in for the second one. R25 proceeded to squeeze the vial of medication through the hole hole of the mask (without removing the mask first from the medication cup holder) most of the drops were going into the lip of the mask and not into the cup. R25 stated it would probably work better if she took the mask off. Then she threw the vial into the garbage. During interview on 7/16/24 at 1:37 p.m., trained medication assistant (TMA)-A stated I don't have a good answer for you. when asked how he would know if a resident was able to self administer medication. TMA-A further stated when administering a nebulizer, he would set it up for the resident and then leave the room and wouldn't wait until it had been administered. During interview on 7/16/24 at 1:41 p.m., licensed practical nurse (LPN)-B stated in order for a resident to self administer their medication they need to have a physician's order but don't necessarily need an assessment. LPN-B further stated when administering a nebulizer I'll put the medication in the nebulizer (for the resident) and then walk out and come back to make sure it's being done. R25 should not be setting up her nebulizer/putting the medication in the cup by herself. I've noticed overnights have left the vials of medication in her (R25) room before, and I've had to remove them. During interview on 7/16/24 at 3:12 p.m., registered nurse (RN)-A stated in order for a resident to be able to self administer medications, there needs to be a desire to do so, an assessment (SAM) which included the resident being aware of what medication was being given and a return demonstration. Then they would work with the care team to get a doctor's order. RN-A further stated R25 was able to be left alone once the nebulizer had been set up and verified there was a discrepancy in the SAM assessment. R25's medications should not be left in her room and she shouldn't be setting up her nebulizer treatments on her own. I would expect the medication administration record (MAR) to specify can self administer after set up. If a resident has not been assessed and was unable to administer their own medications, the nurse would need to wait until the medication was taken or the nebulizer treatment was completed. During an interview on 7/17/24 at 2:07 p.m. the director of nursing (DON) stated in order for a resident to administer their own medications there would need to be a SAM assessment to determine which medications they are able to administer, a desire to self administer, and then they would ask the provider for an order. The order would be listed under orders and it should be written on the MAR. She would like the SAM to be more specific indicating R25 could administer medication after set up. The discrepancy could be confusing if it's not filled out completely and would like there to be a note. It was important to ensure a resident has been assessed to self administer their medications because they are constantly changing and we want to know what is going on and why. It's important to keep the residents safe, things change and we need to make sure they are still able to keep administering medications safely. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy on self administration of medication dated 2/2017, indicated Pine Haven Care Center will allow alert, oriented, physically able residents to self-administer their medications. Residents have the right to self administer medication if the interdisciplinary team deems this practice clinically appropriate. Residents who desire to administer their own medications will be assessed to assure that medications will be safely administered.

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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 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. 44647 Based on interview and document review, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 2 residents (R3) reviewed for psychotropic medication use. Findings include: R3's quarterly Minimum Data Set (MDS)assessment, dated 4/23/24, indicated R13 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis. R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of psychotropic medications related to behavior management of depression and delusional disorder. Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes. R3's care plan included the individualized intervention directing staff to provide assurance daughter has perceived missing or stolen items. R3's care plan lacked individualized non-pharmacological interventions to support R3's mood and to minimize self-isolation, lethargy, and refusals of care. R3's Kardex (used by nursing assistants) as of 7/15/2024, directed nursing assistant (NA) staff to not contradict R3's delusions of items being missing or stolen. Staff were directed to inform R3 their daughter has taken them to be repaired. R3's Kardex lacked interventions to support R3's mood and to minimize self-isolation, lethargy, and refusals of care. When interviewed on 7/17/24 at 11:51 a.m., nursing assistant (NA)-B stated the Kardex should have information to let staff know what distractions or redirections worked for residents who were in an off mood or had behaviors. NA-B further stated R3 had good and bad days. Some days she was out and involved in activities and other times remained in her room. R3 also had days where she was sleepy or lethargic at times. NA-B encouraged R3 to get out for activities and to sit in the sunshine. NA-B further stated R3 liked to read. NA-B was not aware of any verbal behaviors or thinking items were stolen from her room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/17/24 at 1:24 p.m., licensed practical nurse (LPN)-A stated if a resident was having increased anxiety or delusions, they would review the care plan and chart for guidance on what interventions worked for the resident. LPN-A further stated what works for one resident may not work for another one and how to address the behavior and be successful and decreasing it was important. LPN-A was not aware of any behaviors or refusal of cares. LPN-A further stated R3 had no verbal or aggressive behaviors and was generally calm. LPN-A verified the only individualized intervention listed in the care plan was to let R3 know her family had items she thought were stolen. LPN-A stated she was not aware of that behavior and had not known R3 to think items were missing or stolen. When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) stated residents on psychotropic medications required monitoring of behaviors the medication was hopefully helping. If behaviors or mood changes were present, staff would provide interventions that were individualized and specific as possible to the resident. Interim DON reviewed R3's care plan and verified it lacked individualized interventions to support R3's mood and behaviors. Interim DON expected staff to review and revise the care plan quarterly and with identified changes to mood or behaviors. Furthermore, the interim DON expected staff to ensure individualized non-pharmacological interventions were in place.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42586

Based on observation, interview, and document review the facility failed to identify and monitor bruising for 1 of 1 residents (R37) observed for skin alterations and failed to ensure open wounds related to moisture associated skin damage (MASD, inflammation and skin deterioration due to moisture) were routinely assessed for healing for 1 of 1 residents (R22) reviewed for non-pressure wounds.

Findings include:

R37's quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated a diagnosis of dementia and severe cognitive impairment with behaviors of inattention, and disorganized thinking. It further indicated R37 required staff assistance with activities of daily living (ADL) and mobility.

During observation on 7/15/24 at 7:55 a.m., R37 was sitting in her room and had a golf ball sized bruise (above her wrist) on her left forearm.

During observation 7/16/24 at 12:56 p.m., R37 was laying in bed resting, R37 was sitting in her room and had a golf ball sized bruise (above her wrist) on her left forearm.

R37's physician's orders dated 6/30/24, indicated complete weekly skin inspection progress note for resident skin check every day shift on Sunday.

R37's care plan dated 1/3/23, indicated R37 had an ADL self-care performance deficit r/t Activity Intolerance, confusion, dementia, limited mobility, terminal diagnoses R37 requires a skin inspection weekly and as needed by nursing. Daily by nursing assistant (NA) observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.

R37's progress notes dated 7/14/24, indicated skin check was completed and there was no new skin issues.

During interview on 7/16/24 at 1:26 p.m., nursing assistant (NA)-A stated NA's were responsible for bathing residents once a week and the nurses were responsible for completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can document and monitor it. NA-A verified the bruise on R37's left wrist.

During interview on 7/16/24 at 1:41 p.m., licensed practical nurse (LPN)-B stated NA's bathe the residents at least once a week and on bath day, the nurses complete skin checks even if the resident refuses to take a bath. The nurses were also responsible for documenting the skin check in a progress note. The NA should report skin alterations to the nurse so they can document and monitor it until it was resolved. The nurses should also let the nurse manager know. LPN-B verified the bruise on R37's arm and stated she had never seen it before. LPN-B also stated it looked like it's new and the NA's should've reported that to her. It was not documented anywhere in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/16/24 at 3:12 p.m., the registered nurse (RN)-A stated NA's were responsible for giving residents a bath once a week and the nurses were responsible for completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can try to determine the cause, document it, and monitor it to make sure it doesn't get worse or until it's resolved. During an interview on 7/17/24 at 2:07 p.m., the director of nursing (DON) stated stated NA's were responsible for giving residents a bath once a week and the nurses were responsible for completing skin checks on bath day. The nurses were also responsible for documenting the skin checks. If the NA's noticed skin alterations in between bath days they should report it to the nurse so they can try to determine the root cause, document it, and monitor it to make sure it doesn't get worse or until it's resolved. There may also need to be a call to the provider. It's important to document and monitor skin alterations in order to keep the residents safe. A facility policy on skin alteration was asked for and received, however it did not address the monitoring and documentation of bruises. 44647 R22's quarterly MDS dated [DATE], indicated R22 was cognitively intact and had diagnoses of diabetes weakness and chronic non-pressure skin breakdown to left buttock. Furthermore, R22's MDS indicated R22 had MASD. R22's skin care area assessment (CAA) dated 9/7/23, indicated R22 had limited physical mobility, had MASD to buttock and was at risk for skin breakdown. R22's care plan revised 9/7/23, indicated R22 had MASD due to immobility and refusal of assistance with personal cares. Interventions included to follow facility protocols for treatment of injury. R22's nursing progress note dated 4/17/24 at 11:24p.m., indicated a weekly skin inspection was completed and abrasions on bilateral buttocks and left posterior upper thigh were present. No further assessment or measurements were obtained. R22's nursing progress note dated 6/5/24 at 14:08p.m., indicated R22 had bleeding from the open areas on bilateral buttock. The note further indicated measurements of open areas will be obtained during wound cares the following day. R22's situation background assessment recommendation (SBAR) note dated 6/24/24 at 9:52 p.m., indicated R22 had a wound on the left and right buttocks with some drainage. R22's SBAR requested a treatment plan. R22's SBAR lacked any further description of the wounds or measurements. R22's medical record lacked indication a R22's open areas were assessed or measured since identification of them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 7/17/24 at 9:47 a.m., licensed practical nurse (LPN)-A entered R22's room to provide wound care. R22 was assisted to their side and after performing hand hygiene, gown and glove, LPN-A removed the foam dressing that was in place on R22's bottom. R22 had blanchable reddened excoriated area on bilateral buttocks. On the right side there were 2 small open areas with slight bleeding. On the left upper thigh/bottom buttock were several scattered open areas that were slightly bleeding. LPN-A completed wound cares without taking any measurements of R22's open areas. When interviewed on 7/15/24 at 8:23 a.m., R22 stated he had some wounds on his bottom that were bleeding all over the place a few weeks ago. R22 stated the provider was trying to get things healed and had been dealing with this off and on for over a year now. When interviewed on 7/17/24 at 10:25 a.m., LPN-A R22's wounds were looking better and had much less bleeding. LPN-A stated an SBAR was placed to the provider a few weeks back when there was so much drainage occurring. LPN-A further stated the initial wound assessment/measurements should be included in the SBAR. LPN-A reviewed the SBAR and verified there were no measurements taken. LPN-A further stated the provider would determine if any further assessments or measurements were needed in addition to the treatment orders. Since there is no order for assessment or wound measurements that was not completed. LPN-A stated description and measurements could be placed in a progress note, but there was no other place to document that. When interviewed on 7/17/24 at 12:05 p.m., registered nurse (RN) stated not all open areas were reviewed during weekly wound rounds. MASD skin issues were assessed by the bedside nurses. RN stated nurses could not do a skin/wound assessment note as it needed to be completed capturing a photo. However, nurses were expected to assess the area and document any open areas. When interviewed on 7/17/24 at 3:50 p.m., the interim DON expected staff to assess and document any open areas. Not all residents were seen during wound rounds, and bedside nurses need to ensure wound assessments and measurements are completed. If there are not monitoring orders in place, the interim DON expected staff to obtain them. A facility policy titled Pressure Ulcer/Skin breakdown- clinical protocol revised 3/2018 directed staff to initiate a skin form (pressure or non-pressure) when a skin alteration was found. Furthermore, assessment should include the wound and surrounding skin for edema, redness, drainage, healing progress and wound stage.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure proper catheter management for 1 of 1 resident (R207) reviewed for catheters. Findings include: R207's admission Minimum Data Set (MDS) assessment, dated 7/4/24, indicated intact cognition, had an indwelling catheter, a trial of a toileting program had not been attempted, and was dependent on staff for toileting hygiene, and toilet transferring. R207's care area assessment (CAA) dated 7/10/24, indicated R207 had a diagnosis of urinary retention requiring foley catheter placement and was treated for a urinary tract infection upon admission with antibiotic therapy completed and her goal was to avoid complications such as infection. R207's Medical Diagnosis form identified the following diagnoses: retention unspecified, acquired absence of left leg above the knee, disorientation, contracture of the right knee, osteoarthritis to the right knee, pain in right hip, and rheumatoid arthritis. R207's Physician's Orders Summary form identified the following orders: 7/15/24, contact precautions due to a history of CDIFF (Clostridiodes difficile, a bacteria that causes infection of the colon), MRSA (methicillin resistant staphylococcus aureus, an infection that has become resistant to many antibiotics) in left lower quadrant/left groin wound. Resident also has a urinary catheter. 6/29/24, urinary output every shift. The orders lacked information indicating when the catheter was last changed, when it should be removed, type of catheter and when to change the catheter. R207's medication administration record (MAR) and treatment administration record (TAR) for July 2024, was reviewed and lacked information regarding when catheter should be removed, and information regarding the type of catheter and when to change it. R207's care plan dated 6/28/24, indicated R207 had an indwelling catheter related to urinary retention and the goal indicated R207 would show no signs or symptoms of urinary infection through the review date. Additionally, R207's sole intervention indicated to monitor, record, report to MD (medical doctor) for signs and symptoms of a urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan lacked information on the type of catheter used, when it should be changed, when it should be removed, education provided on the risks and benefits for the use of the catheter, and interventions to restore as much urinary function as possible without the use of a catheter. R207's history and physical dated 7/1/24, indicated R207 had urinary retention in the past and currently had a Foley catheter in place and recently completed cefdinir (an antibiotic) for Klebsiella UTI. The note further indicated R207 denied urinary symptoms, and did not see a voiding trial. Additionally, R207 wished to keep the catheter as she worked on transfers with therapy and was open for a trial of voiding once transfers improved. Additionally, the foley catheter had been placed during a prolonged hospitalization [DATE]. A follow up visit was requested for one week to reassess the need for the catheter and if transfers improved would plan to remove the catheter and implement post void residual (PVR) monitoring given reported retention in the past. R207's faxed order scanned in the Documents tab in the electronic medical record (EMR) dated 7/8/24, indicated to encourage removal of the indwelling catheter in the next 1 to 2 weeks as R207 regains function. R207's care conference note dated 7/1/24, indicated the physician proposed removing the catheter, however R207 was not ready and physical and occupational therapy was working with R207 on a slide board transfer with therapy and a hoyer with nursing staff. R207's care conference note dated 7/11/24, indicated R207 was not in agreement to remove the catheter. Additionally, R207 was working with physical and occupational therapy and was close to switching from a full body mechanical lift to a slide board, but had since refused to get up. R207's progress notes were reviewed from 6/28/24, to 7/17/24, and indicated the catheter was in place for urination. The progress notes lacked evidence of any counseling to assist R207 in understanding clinical implications and risks associated with the use of the catheter. During interview and observation on 7/15/24 at 1:15 p.m., R207 stated she did not know why she had a catheter. During interview on 7/17/24 at 1:00 p.m., physical therapist assistant (PTA)-D stated she was working with R207 on slide board transfers and leg strengthening and R207 was doing well this week. PTA-D further stated she had been working with R207 since admission and was still using a hoyer lift with nursing staff due to pain and was mainly using a bed pan. PTA-D further stated she had not seen bladder retraining completed here and did not have experience in bladder retraining. During interview on 7/17/24 at 11:42 a.m., LPN-D stated they looked to the care plan or the MAR and TAR to know what cares a resident required. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/17/24 at 1:05 p.m., LPN-D stated they documented whether they provided education to a resident in a progress note and stated sometimes the MAR and TAR would identify what they needed to provide education on. LPN-D stated R207 had an indwelling catheter and it was up to the physician to determine whether or not R207 still needed the catheter and stated if there was an order to remove the catheter, they would do a bladder scan and remove the catheter and educate R207 if she refused on the risks and document in the progress notes. LPN-D further stated she was not aware R207 declined to have the catheter removed and viewed the medical record and stated she did not see an order regarding the catheter, and verified documentation lacked evidence of education completed regarding the catheter and stated she should ask R207 why she wanted to keep the catheter. LPN-D stated it would be important to educate R207 the catheter can cause an infection and further stated she could talk to R207 and determine R207's reasoning for why she was not ready to remove the catheter. During interview on 7/17/24 at 1:33 p.m., the director of nursing (DON) stated if a catheter was placed for retention, they would try to check a post void residual to try to eliminate unnecessary catheter placement and stated she expected staff provide education to the resident and stated she would enter education in R207's care plan and further stated education was important because a foreign body increased the risk for infection and catheters need to be medically necessary. A policy, Catheter Care Protocol, undated, lacked information regarding removal of catheters as soon as possible when no longer necessary, care plan interventions for resident education, and documentation in the medical record of implications of continued use.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46885 Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was delivered according to physician orders, and failed to ensure oxygen tubing was properly maintained per professional standards for 1 of 1 resident (R17) reviewed for respiratory care. Findings include: R17's admission Minimum Data Set (MDS) assessment, dated 7/1/24, indicated moderate cognitive impairment, did not have behaviors, did not reject cares, did not have SOB (shortness of breath). R17's Medical Diagnosis form indicated the following diagnoses: acute systolic congestive heart failure, disorientation, unspecified dementia, anemia, and chronic obstructive pulmonary disease. R17's physician orders dated 7/11/24, indicated supplemental oxygen at 2 to 3 liters via nasal cannula every shift to maintain oxygen saturations of 90% or higher. The orders lacked information when to change the oxygen tubing. R17's medication administration record (MAR) and treatment administration record (TAR) for July 2024, were reviewed and lacked information when oxygen tubing was changed. R17's care plan was reviewed and lacked information R17 required oxygen. R17's progress notes dated 7/13/24 at 11:41 a.m., indicated R17 had 2 liters per minute (LPM) of oxygen on. R17's progress notes dated 7/15/24 at 8:53 p.m., indicated R17 had oxygen on at 1 lpm. R17's progress notes dated 7/15/24 at 10:51 p.m., indicated R17 was on 2 lpm of oxygen. R17's progress notes dated 7/16/24 at 12:37 p.m., indicated R17 was on 1 lpm of oxygen. During interview and observation on 7/15/24 at 8:17 a.m., R17 stated she started oxygen over the weekend but was not currently wearing oxygen and stated she has had trouble breathing from smoking and no longer smoked and denied any difficulty breathing at time of interview. R17 had a cart with an oxygen tank inside in her room along with a concentrator. The nasal cannula piece of oxygen tubing that goes into the nares was located on the floor and the tubing was connected to the concentrator. During observation on 7/16/24 at 11:38 a.m., R17 was in her recliner chair and her oxygen on. During observation on 7/16/24 at 3:00 p.m., R17 was brought back to her room and had the oxygen on and was connected to the O2 tank on her wheelchair. During observation on 7/16/24 at 5:24 p.m., R17 was sitting up in her wheelchair with the oxygen on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 7/16/24 at 7:00 p.m., R17 was in her wheelchair and the oxygen tank in the back of the wheelchair indicator amount was in the red. R17's oxygen tubing was attached to her concentrator which was on at 1 liter per minute. During observation on 7/17/24 at 9:24 a.m., R17 was not in her room and the oxygen tubing including the nasal cannula was located on the floor. During observation on 7/17/24 at 9:28 a.m., staff brought R17 to her room and R17 did not have oxygen on and left the room and the nasal cannula was still located on the floor. During observation on 7/17/24 at 10:30 a.m., R17 was in bed and the nasal cannula was located on the floor and the concentrator was on but R17 was not wearing oxygen. During interview on 7/17/24 at 10:33 a.m., registered nurse (RN)-C stated she had been at the facility a few weeks and guessed oxygen tubing was changed when residents got a new tank and if they had a concentrator. RN-C verified R17's concentrator was on and running at 1 liter per minute (LPM) and verified the nasal cannula was located on the floor and stated she expected staff to follow up to see if oxygen was needed if oxygen was turned on and follow up for new tubing because the nasal cannula should not be located on the floor. RN-C reviewed R17's medical record and verified the record lacked information on when to change the tubing. At 10:44 a.m., RN-C checked R17's oxygen and stated she would try 2 liters of oxygen because R17's oxygen saturations were not consistently staying above 90%. During interview on 7/17/24 at 10:50 a.m., the director of nursing stated if the nasal cannula was located on the floor she expected the tubing be changed and expected staff follow oxygen orders and stated it was important for infection control. A policy, Oxygen Administration and Cleaning of O2 Equipment, dated 4/2022, indicated oxygen tubing needs to be stored off the ground when not in use by a resident. Oxygen tubing and cannula set up must be changed weekly, do this every Thursday on the night shift. Chart on treatment sheet in the MAR. Concentrator filters are to be cleaned weekly with baby shampoo and rinsed with water.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46885 Based on observation, interview, and document review, the facility failed to ensure collaboration with the dialysis facility for 1 of 1 resident (R14) reviewed for dialysis. Findings include: R14's admission Minimum Data Set (MDS) assessment, dated 6/16/24, indicated intact cognition, required substantial assist for dressing, and was dependent for transfers, was frequently incontinent of bowel and bladder, and received dialysis. R14's Medical Diagnosis form indicated the following diagnoses: acute kidney failure unspecified, chronic kidney disease stage 3, anemia in chronic kidney disease, arthrosclerosis of native arteries of left leg with ulceration of other part of foot, arthrosclerosis of native arteries of right leg with ulceration of heel and midfoot, type 2 diabetes mellitus, unspecified open wound of abdominal wall unspecified quadrant without penetration into peritoneal cavity, and peripheral vascular disease. R14's physician's orders included the following orders: 6/12/24, administer all a.m. medications after dialysis in the morning every Tuesday, Thursday, and Saturday. 6/10/24, complete pre-dialysis assessment and send with resident to dialysis. Complete post- dialysis assessment once resident returns to facility one time a day every Tuesday, Thursday, Saturday post-dialysis assessment. 6/10/24, complete pre-dialysis assessment and send with resident to dialysis. Complete post- dialysis assessment once resident returns to facility one time a day every Tuesday, Thursday, and Saturday pre-dialysis assessment. 6/10/24, monitor hemodialysis catheter to the right chest wall for signs and symptoms of infection daily and complete SBAR (a communication framework) if signs and symptoms are present every day and evening shift. R14's physician orders lacked information on how to contact dialysis and which dialysis facility R14 used and when to contact dialysis. R14's medication administration record (MAR) and treatment administration record (TAR) indicated R14 was taking amoxicillin-pot clavulanate (an antibiotic) oral tablet 875-125 milligram tablets twice a day for infection for 14 days that started on 7/4/24. R14's MAR and TAR lacked information on how to contact dialysis, which dialysis company R14 used, and when to contact dialysis. R14's Profile form in the electronic medical record (EMR) lacked information regarding the contact number and where R14 went for dialysis and when to contact dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's Dashboard form in the EMR lacked information regarding the contact number and where R14 went for dialysis and when to contact dialysis. R14's care plan dated 6/10/24, indicated R14 needed hemodialysis due to renal failure and R14's goal was to have no signs or symptoms of complications from dialysis through the review date. The care plan included the following interventions: do not draw blood or take blood pressure in the arm with the graft, encourage resident to go for the scheduled dialysis appointments, R14 receives dialysis Tuesday, Thursday, and Saturday, monitor, document, and report to physician as needed any signs or symptoms of infection to the access site: redness, swelling, warmth, or drainage, monitor, document, and report to the physician as needed signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds, obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately. R14's care plan dated 7/15/24, indicated R14 had altered kidney function related to chronic kidney disease, required dialysis, and R14's site of graft was the right chest wall. R14's intervention indicated if bleeding occurs at the access site, apply direct pressure to site for 10 minutes and alert nursing, physician/nurse practitioner, and the dialysis facility. The care plans lacked information on how to contact dialysis, and which dialysis facility R14 used. R14's progress notes dated 6/21/24 at 4:26 p.m., indicated orders were received for Keflex (an antibiotic) 500 milligrams (MG) every 12 hours for 7 days. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/22/24 at 6:34 a.m., indicated R14 chose not to go to dialysis due to not feeling well and had started on antibiotics the previous evening. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/22/24 at 11:47 a.m., indicated R14 refused dialysis due to not feeling well. Documentation lacked evidence the dialysis facility was notified. R14's progress notes dated 6/24/24 at 10:31 a.m., completed by registered nurse (RN)-B indicated the clinic was notified that R14 canceled dialysis on 6/22/24. R14's progress notes dated 7/6/24, indicated R14's right lower extremity was bleeding heavily, saturating the dressing and spilling onto the floor. The on call physician was notified after a pressure dressing was applied and resident was in transportation to dialysis when transportation contacted the facility to report R14 was bleeding through reinforced dressings and R14 decided to go to the emergency department. The progress note lacked information that the dialysis facility was notified. During interview on 7/15/24 at 12:33 p.m., R14 stated she started dialysis at 6:30 a.m., on Tuesdays, Thursdays, and Saturdays and stated her access site was on her right chest. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/16/24 at 5:54 p.m., registered nurse (RN)-D stated R14 went to dialysis three times a week and was not sure which dialysis facility R14 went to. RN-D stated would update the nurse manager, RN-B at the nursing facility if the dialysis facility needed to be notified. RN-D viewed R14's medical records and could not identify which dialysis facility R14 attended and stated it was important to know because sometimes they needed to call the dialysis facility and the last time they needed to contact them, the dialysis facility contacted RN-D. At 6:52 p.m., RN-D stated she contacted RN-E who would update the information in R14's chart to include who to contact for dialysis. During interview on 7/16/24 at 6:35 p.m., RN-E stated they located which dialysis facility R14 attended and stated they added the information in the binder including the phone number, the address, and stated the director of nursing added the dialysis facility in the care plan. During interview on 7/17/24 at 9:59 a.m., a call was placed to the given dialysis facility phone number and the receptionist stated the phone number was the main phone number to the clinic and the dialysis facility was a different number. During interview on 7/17/24 at 10:02 a.m., RN-F from the dialysis facility stated the facility communicated with the dialysis facility via a form that was sent with R14 on dialysis days. RN-F stated the facility should contact the dialysis facility via phone if there was anything out of the baseline, transportation updates, and stated they expected a phone call if a resident started a new antibiotic or if a resident declined to go to the dialysis facility. RN-F stated R14 did not show up for dialysis on 6/22/24, and the dialysis nurse had to contact the nursing facility and reviewed R14's chart and found out R14 started on Keflex. RN-F further provided the number the nursing facility should call for the dialysis facility. During interview on 7/17/24 at 10:56 a.m., the director of nursing stated a booklet had the dialysis information, but the nurse didn't read down far enough and stated nobody took time to rewrite in the location they indicate the name of the dialysis. DON contacted the number per the care plan and verified it was not the number indicated per the dialysis facility. During interview on 7/17/24 at 11:18 a.m., the DON stated she was able to speak with dialysis and confirm the correct number and updated the care plan and stated it was important to have this information in case R14 needed to reschedule and further stated antibiotics can affect R14's labs and to help R14 remain medically stable and was important for the dialysis facility to be aware. The care plan was updated to reflect the phone number identified by RN-F. A policy Care of a Resident with End Stage Renal Disease, dated 2010, indicated residents with end stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed including: how the care plan will be developed and implemented, how information will be exchanged between the facilities; and responsibility for waste handling, sterilization and disinfection of equipment. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. A policy Dialysis Care, dated 3/12/20, indicated dialysis should be contacted for low blood pressures, discuss lab parameters with the dialysis clinic and physician, and communicate electrolyte levels to the dialysis facility. The policy lacked information on contacting dialysis with medication changes and appointment cancellations.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44647 Based on interview and document review the pharmacist failed to identify and report a psychotropic medication (medication to stabilize mood) was increased without implementing non-pharmacological interventions and without indication the increased dose was clinically significant after a gradual dose reduction (GDR) for 1of 2 residents (R3) reviewed who required psychotropic medications. R3's quarterly Minimum Data Set (MDS) assessment, dated 4/23/24, indicated R3 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis. R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of Depakote (psychotropic medication) related to behavior management of depression and delusional disorder. Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes, and provide assurance daughter has perceived missing or stolen items. R3's medication regimen review (MRR) notes to attending provider dated 9/7/23, requested R3's provider to assess R3 for possible GDR for or Seroquel 25 milligrams (mg) every morning and 225mg at bedtime, Depakote 125mg in the morning and 250mg each evening, and Lexapro 5mg daily. Nurse Practitioner (NP)-A responded and agreed with the recommendation and reduced Depakote 250mg every evening to 125mg every evening. NP-A signed R3's MRR note to attending provider on 9/29/23. R3's MRR's dated 10/2023- 6/2024, indicated R3 had no medication irregularities. A review of R3's provider and nursing orders showed: -on 5/11/23, R3 required Depakote 125 mg each morning and 250mg each evening. -on 9/29/23, R3 required Depakote 125 mg each morning and 125mg each evening. -on 11/29/23 R3 required Depakote 375mg daily in the evening. A review of R3's medical record dated 9/15/2023 - 7/14/2024, lacked indication R3 had exhibited behaviors of delusions of items stolen or missing from room, refusal of cares, or increased self-isolation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/17/24 at 1:59 p.m., NP-B stated they were not aware of R3's GDR of Depakote last fall and R3's mood and behaviors had been stable for about a year. NP-B stated they referred R3 back to a psychiatrist for medication management as there had been some concerns of increased drowsiness during the daytime and had not realized R3's Depakote was then increased by the psychiatrist in 11/2023. NP-B stated they had not received any communication from the clinical pharmacist (CP) or nursing staff about the medication changes. If this information was known, NP-B would have followed up to ensure the medication dose was appropriate. This communication was important to ensure minimize risk of residents receiving psychotropic medications unnecessarily. When interviewed on 7/17/24 at 2:52 p.m., CP stated MRR's were completed monthly. CP verified R3's Depakote GDR was ordered in 9/2023, however was not aware of R3's Depakote being increased after the visit with the psychiatrist. CP reviewed the psychiatrist note dated 11/29/23, and felt the psychiatrist was not aware the Depakote dose was being increased and therefore no clinical indication. CP further stated the increased dose was missed in subsequent MRR's and if known, CP would have brought it forward to the team to clarify. When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) was not sure of the details around when R3's Depakote was increased. Interim DON stated the nurse managers on the unit review changes to medications and are involved in the medication review process. Interim DON further stated there was leadership changes at the time that may have contributed to the lack of awareness R3's Depakote was increased. Interim DON expected nursing, pharmacy, and providers to be aware when a resident's psychotropic medication dose was changed, and this was important to ensure psychotropic medications were given appropriately.

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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** 44647 Based on interview and record review the facility failed to ensure an increased dose of a psychotropic medication (medication to stabilize mood) was clinically indicated after a gradual dose reduction (GDR) after a for 1 of 2 residents (R3) reviewed who required psychotropic medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had mild cognitive impairment and diagnoses of bipolar disorder (mood disorder that caused intense shifts in mood and behaviors). R3 had no behaviors, delusions, or refusal of cares. Furthermore, R3's MDS indicated R3 received psychotropic medications on a routine basis. R3's psychotropic care area assessment (CAA) dated 11/3/23, indicated R3 currently received psychotropic medications and directed monitoring of R3's behaviors and mood was required. R3's care plan revised 4/23/24, indicated R3 required the use of Depakote (psychotropic medication) related to behavior management of depression and delusional disorder. Non-pharmacological interventions last revised on 7/26/2020, directed staff to discuss ongoing need of medication with provider and family, consult with pharmacy, provider, and family to consider GDR, monitor delusions of items stolen or missing from room, refusal of cares, and increased self-isolation and monitor/document mood or behavior changes, and provide assurance daughter has perceived missing or stolen items. R3's medication regimen review (MRR) notes to attending provider dated 9/7/23, requested R3's provider to assess R3 for possible GDR for or Seroquel 25 milligrams (mg) every morning and 225mg at bedtime, Depakote 125mg in the morning and 250mg each evening, and Lexapro 5mg daily. Nurse Practitioner (NP)-A responded and agreed with the recommendation and reduced Depakote 250mg every evening to 125mg every evening. NP-A signed R3's MRR note to attending provider on 9/29/23. A review of R3's provider and nursing orders showed: -on 9/29/23, R3 required Depakote 125 mg twice daily in the morning and in the evening. This order was discontinued on 11/29/23 and replaced with an order to increase R3's Depakote to 375mg daily in the evening. -on 8/6/20, R3 required behavior monitoring for use of Depakote. Behaviors to be monitored included delusions of items stolen or missing from room, refusal of cares, and increased self-isolation. A review of R3's medical record dated 9/15/2023 - 7/14/2024, lacked indication R3 had exhibited behaviors of delusions of items stolen or missing from room, refusal of cares, or increased self-isolation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's psychiatry provider progress note dated 11/29/23, indicated NP-B had referred R3 back to a psychiatry for medication management due to use of high-risk medications and increased sedation. The progress note indicated concern R3 had increased sleeping/drowsiness during the day and R3's mood was overall stable. Furthermore, the note indicated a plan to change the timing of R3's Depakote order from 125mg each morning and 250mg each evening to a combined dose of 375mg each evening. R3's psychiatric progress note lacked acknowledgement of the R3's recent GDR review on 9/29/23, which lowered R3's daily Depakote dose from 375mg to 250mg and lacked indication of why R3's Depakote was increased back to a total of 375mg daily. R3's psychiatric progress note dated 1/26/24, indicated R3's mood was stable and indicated no medication changes. R3's primary provider progress note dated 6/11/24, indicated R3 had stable bipolar disorder and was followed by psychiatry for medication management. When interviewed on 7/17/24 at 1:24 p.m., licensed practical nurse (LPN)-A stated they were not aware of R3 having delusions or refusal of cares. LPN-A stated when residents who received psychotropic medications had orders to monitor behaviors. When behaviors occurred, it would be documented in the treatment record and then a progress note would be made. LPN-A further stated R3 did not require any redirection or distractions. When interviewed on 7/17/24 at 1:59 p.m., NP-B stated R3 had not seen a psychiatrist for some time prior to 11/2023 as R3's mood and behaviors had been stable. NP-B stated they referred R3 back to a psychiatrist for medication management as there had been some concerns of increased drowsiness during the daytime. NP-B reviewed R3's pharmacy recommendation for a GDR and verified NP-A had made a dose reduction on 9/29/23 but was not aware of it until now. NP-B stated NP-A was another provider within their provider group and was not sure why the dose reduction was made. NP-B verified there was no progress note or communication note from NP-A about R3's dose reduction. NP-B reviewed R3's psychiatrist progress notes from 11/29/23 and verified R3's Depakote order reflected the discontinued dose of 125mg every morning and 250mg every evening. Furthermore, NP-B verified the psychiatrist had not intentionally made a dose increase with R3's medications but only moved them to the evening in attempt to reduce daytime sleepiness. NP-B stated when a provider makes a medication change, they must reconcile the medication list in R3's EPIC record (the clinic electronic medical record) to ensure it was current. NP-B further stated since NP-A had not reconciled the medications in EPIC or made a progress note about the change the psychiatrist likely was not aware of the GDR. NP-B further stated when a GDR was attempted, they would have increased communication with nursing staff pharmacy and psychiatry about behaviors and symptom monitoring. This communication was important to ensure minimize risk of residents receiving psychotropic medications unnecessarily. When interviewed on 7/17/24 at 2:52 p.m., clinical pharmacist (CP) stated they track when GDRs become due and then send out a request to the resident's provider. CP verified R3's Depakote GDR was ordered in 9/2023. CP was not aware of R3's Depakote being increased after the visit with the psychiatrist. CP reviewed the psychiatrist note dated 11/29/23, and verified it indicated risks of a GDR and opted to start with R3 taking the medications in the evening. CP stated the note indicated the psychiatrist was not aware the dose was being increased. CP further stated this was missed in subsequent medication regimen reviews and if known, CP would have brought it forward to the team to clarify. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/17/24 at 3:50 p.m., the interim Director of Nursing (DON) was not sure of the details around when R3's Depakote was increased. Interim DON stated the nurse managers on the unit review changes to medications and are involved in the medication review process. Interim DON further stated there was leadership changes at the time that may have contributed to the lack of awareness R3's Depakote was increased. Interim DON expected nursing, pharmacy, and providers to be aware when a resident's psychotropic medication dose was changed, and this was important to ensure psychotropic medications were given appropriately.

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NAME OF PROVIDER OR SUPPLIER: Pine Haven Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 Northwest 3rd Street Pine Island, MN 55963	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to ensure a high temperature sanitizing dishwasher reached the rinse temperature required to sanitize of dishware used for resident service . Furthermore, the facility failed to ensure resident water/ice machines and the high temperature dishwasher were cleaned in 2 resident care units. This had the potential to impact all 29 residents who reside in the 500 and 600 care units. Findings include: [NAME] AM15T dishwasher manual no date, directed the high temperature sanitization washers were required rinse temperatures to reach temperatures to be at 180 degrees Fahrenheit (F) to ensure dishes were properly sanitized. A facility document titled Dish Machine Temperature Daily log sheet dated 7/2024, indicated the shift temperature checks completed by staff. At the bottom of the document indicated the rinse cycle was required to be a minimum of 180 degrees F and directed staff not use the machine if incorrect temperatures were noted. Three of the 36 documented entries had rinse temperatures at 180 degrees F. or above. The remainder temperatures documented ranged between 161 degrees F and 177 degrees F. The document lacked indication any follow up or communication had occurred about the low rinse temps. An observation on 7/16/24 at 1:37 p.m., dietary aide (DA)-A was washing dishes in the 500/600 wing kitchenette. DA-A started a load and the rinse temperature reached 170 degrees F. DA-A pushed the rack of dishes through to the clean side and proceeded to start another load. The second load rinsed at a temp of 172 degrees F. The electronic temperature gauge on the wall had not alarmed to alert staff of the low rinse temperatures. When the dishwasher door was lifted, the inside dishwasher frame, door and sprayers had large amounts of white crusty mineral-like substances. The same white substance was on the bottom of the dishwasher door. When interviewed on 7/16/24 at 1:54 p.m., DA-A stated the dishwasher temperatures were checked during each shift and wrote on the temperature log sheet. DA-A stated they were not sure what the temperature should be and further stated the temperature gauge on the wall alarmed if the water was not hot enough and if it didn't alarm, it was ok to use. When it alarms, maintenance is notified, and dishes were then brought to the main kitchen if needed. DA-A further stated rinse temperatures needed to get to 180 degrees F. once a shift and the lower temperatures were ok to use. DA-A was not aware of another way to check the temperatures of the rinse cycle. DA-A verified the white crusted substance on the dishwasher and stated another shift was responsible to complete the de-liming process. DA-A showed the cleaning schedule and stated it should have been done 5 days prior, however stated it looked like it wasn't done in a while. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 7/16/24 at 3:13 p.m. The culinary director verified the dishwasher required high temperature rinse to ensure sanitization. They acknowledged the documented low rinse temperatures and had not been notified of those readings. The culinary director expected staff to notify maintenance of low temperatures and move dishes to the main kitchen to be cleaned until the sanitization temperature was correct. The culinary director further stated recently the de-liming process was recently changed from the dietary team to the maintenance team. The white substance on the dishwasher was due to the lime scale and further stated it likely needed to be done and coordination with the maintenance team needed to be worked on. When interviewed on 7/17/24 at 9:30 a.m., the Ecolab technician acknowledged the machine had been reset to the factory settings and the temperature gauge's factory settings to alarm with a rinse temperature below 160 degrees F. The technician further stated it had not alarmed as the temperatures were above 160 degrees F. The machine was now running around 180-190 degrees F. and the temperature gauge was set to alarm when below 180 degrees F. On 7/15/24 at 8:55 a.m., the 500-unit kitchenette was observed. The ice/water machine had white mineral buildup on the shoot where the ice/water came out as well as the tray below. On 7/15/24 at 10:09 a.m., the 600-unit kitchenette was observed. The ice/water machine had whitish brownish mineral build up on the shoot where the ice/water came out. Streaks of white went down the stainless-steel back splash and onto the tray below. When interviewed on 7/16/24 at 1:54 p.m., DA-A verified the 500-unit ice/water machine had white crusty buildup. DA-A stated the dietary staff was not responsible for the ice/water machine cleaning and thought maintenance completed it. When interviewed on 7/17/24 at 8:27 a.m., maintenance-A stated the maintenance team was responsible for cleaning the ice/water machines. He was unaware of the last time the cleaning was completed and stated cleaning was done quarterly. Cleaning included de-liming of the machine and ensuring the spout, tray and outside were cleaned. When interviewed on 7/17/24 at 4:30 p.m., the covering administrator expected staff to ensure dishwashers ran at temperatures needed to ensure dishes were sanitized. The dishwashers and ice/water machines were expected to be cleaned regularly to ensure cleanliness and minimize any risk of infection to the residents. A facility policy titled Dish Machine All Units dated 7/2024, directed staff to not use machine if rinse temp was not reaching 180 degrees F. Staff were further directed to notify the supervisor and maintenance aware of problem. A facility policy titled Cleaning and Disinfection of Kitchen Equipment revised 9/2022, directed maintenance staff to de-lime dish machines once a week and ice/water machines monthly. All cleaning will be logged.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46885

Based on observation, interview and document review, the facility failed to ensure staff donned (put on) appropriate personal protective equipment (PPE) for enhanced barrier precautions (EBP), and contact precautions for 2 of 3 residents (R207, R48), and failed to ensure a clean laundry area was maintained. Additionally, the facility failed to ensure resident ice packs were stored separately from food storage on 2 of 4 unit refrigerators. This had the potential to impact the 29 residents who reside on those units.

Findings include:

R207's admission Minimum Data Set (MDS) assessment, dated 7/4/24, indicated intact cognition, had an indwelling catheter, a trial of a toileting program had not been attempted, and was dependent on staff for toileting hygiene, and toilet transferring.

R207's Medical Diagnosis form indicated R207 had the following diagnoses: unspecified wound to left lower leg, atherosclerosis of native arteries of the right leg with ulceration of the ankle, atherosclerosis of native arteries of the left leg with ulceration of the ankle, non-pressure chronic ulcer of other part of right foot limited to breakdown of skin, enterocolitis due to clostridium difficile, and retention of urine,

R207's physician orders dated 7/15/24 at 11:06 a.m., indicated R207 was on contact precautions due to a history of clostridium difficile, and methicillin resistant staphylococcus aureus (MRSA) in the left lower quadrant and left groin wound, additionally, R207 had a urinary catheter.

R207's care plan lacked evidence R207 was on any kind of precautions.

During interview and observation on 7/15/24 between 9:47 a.m., and 9:56 a.m., nursing assistant (NA)-D entered R207's room without first donning gloves or a gown. NA-D closed the privacy curtain by the door. There was signage on the wall next to R207's room that indicated R207 was on contact precautions and everyone must clean their hands including before entering and when leaving the room. Additionally, signage indicated providers and staff must also put on gloves before room entry and discard gloves before room exit, put on a gown before room entry and discard the gown before room exit. Do not wear the same gown and gloves for the care of more than one person. use dedicated or disposable equipment and clean and disinfect reusable equipment before use on another person. All equipment and wheels must be wiped down with bleach wipes immediately after leaving this room. At 9:54 a.m., R207 told NA-D thank you and at 9:56 a.m., NA-D asked R207 if she needed anything else and then walked out of the room. NA-D did not know why equipment needed to be cleaned with bleach and verified she did not donn a gown and stated she was told she had to donn PPE when completing catheter cares and stated she would restock the gowns after looking in the bin to find one gown left. NA-D stated R207 was incontinent of stool and NA-D changed R207's brief.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 7/15/24 at 10:05 a.m., licensed practical nurse (LPN)-C stated R207 was not on contact precautions and was required by the state to donn PPE when emptying drainage from catheters or when completing a dressing change and stated she would not expect staff to donn a gown when changing a brief and stated it was mostly for nurses when changing a dressing. LPN-C further stated she knew someone was on contact precautions because it was identified in the electronic medical record and verified R207 had contact precautions signage located outside the door and stated R207 was not on contact precautions. LPN-C could not state why equipment needed to be wiped down with bleach and added they just wiped down equipment before going in with other residents. During interview on 7/15/24 at 10:23 a.m., trained medication aide (TMA)-B stated if a resident was on EBP or contact precautions, they had signage located outside the door and stated contact precautions was something skin wise that could be transmitted by touching and EBP was used as a precautionary measure for residents with wounds, ostomies, or catheters to limit their exposure to our germs and further verified the electronic medical record lacked information R207 was on any type of precautions. During interview on 7/15/24 at 10:26 a.m., registered nurse (RN)-B stated R207 had an indwelling catheter and wounds and would have to find out whether R207 was on contact or EBP. During interview on 7/15/24 at 10:30 a.m., RN infection preventionist (IP)-H stated R207 should be on contact precautions because R207 had a history of e-coli and placed R207 on full contact precautions instead of EBP and stated staff should donn PPE anytime when going into the room and would have expected staff donn PPE. R48 R48's admission Minimum Data Set (MDS) dated [DATE], indicated R48 had an indwelling catheter, an ostomy, was not on a toileting program, required moderate assist with toileting hygiene, and transfers and had diagnoses of colon cancer, and benign prostatic hyperplasia (BPH). R48's physician orders indicated the following orders: 7/15/24, catheter 16 French 10 cc (cubic centimeter) balloon changed at urology. 7/15/24, resident on enhanced barrier precautions due to urinary catheter. R48's medication administration record (MAR) and treatment administration record (TAR) indicated R48 was on EBP due to having a urinary catheter. R48's care plan was reviewed and identified R48 had an indwelling catheter, and an ileostomy, but lacked evidence R48 was on EBP. During interview and observation on 7/16/24 between 11:50 a.m., and 11:57 a.m., R48 stated he wanted to lie down and nursing assistant (NA)-E transferred R48 to his bed without donning a gown. R48 had signage outside his door that indicated he was on EBP. NA-E stated he should have had a gown on and stated he thought they were supposed to with regulations passed in the beginning of the year and stated R48 had a catheter and verified he did not have a gown on when transferring R48 to bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 7/16/24 at 3:04 p.m., RN-B stated R48 was on EBP because R48 had a catheter and staff should donn PPE during a transfer and further stated she would complete coaching because it was important to protect residents from further infections. During interview on 7/17/24 at 2:09 p.m., IP-H stated RN-B updated her on lack of PPE for R48 and stated she completed coaching and expected staff to gown and wear appropriate PPE during a transfer. Linens During interview and observation on 7/16/24 at 12:29 p.m., a fan with gray particles was blowing on clean laundry and towards clean linens and the clean linen storage room. Additionally, a shelf below the fan was covered with gray particles and a buildup of the particles was clinging onto all three window screens behind the fan, some of the particles measured approximately 2 inches long. Additionally, the pipes behind the washing machine and under the shelf contained a thick layer of gray particles. Housekeeping and environmental services (HE)-A stated the gray particles hanging off the fan was dust and lint, and stated the shelf below the fan contained 1/4 inches of dust and lint and stated it was pretty bad and further stated the pipes had a build up of dust. During interview on 7/17/24 at 2:09 p.m., IP-H stated environmental services was responsible for cleaning the lint and dust and stated it should not blow onto clean linens. Additionally, IP-H stated it was important not to store ice packs in the freezers because the ice packs were on a person's body and was placed in an area where food was stored and was an infection control issue. During interview on 7/17/24 at 3:19 p.m., the director of nursing stated they completed on the spot coaching with staff related to the contact and EBP and stated they needed to complete in-house education because it was important not to spread infection and stated all the ice packs were removed from the freezers and would be further addressed. Further, DON stated they got rid of the dust and it was important to have a clean environment and they needed a clean space and did not want a fire hazard. A policy was requested for laundry and cleanliness, but the facility did not have a policy. A policy, Infection Control Transmission/Isolation Precautions, dated 3/2024, indicated transmission based precautions, are actions that are implemented in addition to standard precautions based on the particular means of transmission. Equipment necessary to carry out precautions/isolation may include gowns, goggles, mask, and gloves. Contact precautions examples included, residents with norovirus, Clostridiodes difficile (C. Diff) wounds, and diarrhea. Hand hygiene, gloves, and gowns are donned upon entry into the room and hand hygiene is completed according to standard precautions when in the room. Remove gloves and gown and perform hand hygiene before exiting the room. Some organisms require hand hygiene to be performed with soap and water after exiting the room and will be designated on the signage. Additionally, EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDROs) to staff hands and clothing. EBP apply to residents with any of the following: infection or colonization with a novel or targeted MDRO when contact precautions do not apply, wounds, and or indwelling medical devices such as central lines, urinary catheters, and wounds. Examples of high contact resident care activities requiring gown and glove use included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care and wound care. 44647 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 7/15/24 t 8:55 p.m., the 500-wing resident food refrigerator was reviewed. The freezer contained three blue ice packs and one white cloth ice pack with a blue clip. Along side the ice packs were individual containers of ice cream. The ice packs were not labeled with who they belonged to. An observation on 4/15/24 at 10:09 a.m., the 600-wing resident food refrigerator was reviewed. The freezer contained blue gel ice packs. The ice packs were not labeled. Along side the ice packs and on the same shelf were individual cups of ice cream and yogurt. When interviewed on 7/16/24 at 3:13 p.m., the culinary director stated dietary aides reviewed the unit fridges weekly. The culinary director further stated ice packs should not be stored in the freezers of the unit fridge as only food was stored there. Storing resident items with food is a risk for contamination. The culinary director further stated diary aides review the fridges they should notify nursing staff to remove ice packs if found in the unit refrigerators. When interviewed on 7/16/24 at 6:18 p.m., nursing assistant (NA)-C stated if a resident wanted an ice pack, there were blue packs that were in the freezer that can be used. NA-C stated the ice packs were stored in the freezer in the medication room and could not be stored in the fridge in the kitchenettes. NA-C verified the refrigerators in the kitchenette were for food items only. A policy titled food storage- fridge/freezer no date, directed staff to maintain procedures to maintain safe food storage and prevent contamination.

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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 46885

Based on interview, and document review, the facility failed to ensure 2 of 5 residents (R48, R36) were offered or received pneumococcal vaccination in accordance to Center for Disease Control (CDC) recommendations.

Findings include:

The CDC Pneumococcal Vaccine Timing for Adults undated, indicated adults aged [AGE] years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to [AGE] years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old.

R48's admission Minimum Data Set (MDS) dated [DATE], indicated R48 was [AGE] years old, admitted to the facility on [DATE], had intact cognition, and pneumococcal vaccinations were up to date.

R48's Medical Diagnosis form indicated the following diagnoses: malignant neoplasm of colon, anemia unspecified, and hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non dominant side.

R48's Minnesota Immunization Report dated 7/17/24, indicated R48 received the PPSV23 on 10/19/2012, and received Prevnar 13 on 1/12/2017.

R48's Immunization form indicated R48 received the PPSV23 on 10/19/2012, and Prevnar 13 on 1/12/2017.

R48's Vaccination Consent form dated 5/23/24, indicated R48 would like the following vaccinations if overdue or not up to date: the list contained the following items: COVID-19 vaccine, herpes zoster, pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, hepatitis B, influenza, and I do not wish to receive any vaccinations. an X was marked in front of the options: pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, and I do not wish to receive any vaccinations. The consent form lacked any information regarding PCV20.

R48's medication administration record (MAR) and treatment administration record (TAR) dated May 2024, June 2024, and July 2024, was reviewed and lacked evidence PCV20 was offered or administered.

R48's medical record was reviewed and lacked evidence PCV20 was administered or that shared clinical decision making occurred.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A form, Short Term Resident Quality Measures Vaccination Report 2023-2024, indicated R48 had the PPSV23 vaccine on 10/19/2012, and PCV13 on 1/12/2017, and indicated N/A for PCV15 or PCV20. R36 R36's admission MDS dated [DATE], indicated R36 was [AGE] years old, had intact cognition, and pneumococcal vaccinations were up to date. R36's Medical Diagnosis form indicated the following diagnoses: hypertensive chronic kidney disease stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, chronic kidney disease stage 3, and type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage). R36's Minnesota Immunization Report dated 7/17/24, indicated R36 received PCV13 (Prevnar 13) on 9/17/2015, PPSV23 on 5/31/2011, and 9/29/2016. R36's Immunization form indicated R36 received PPSV23 on 2/28/2011 and PCV13 on 9/17/2015. R36's Vaccination Consent form dated 6/18/24, indicated R36 would like the following vaccinations if overdue or not up to date: the list contained the following items: COVID-19 vaccine, herpes zoster, pneumococcal vaccines PCV13, or PPSV23, Tetanus, Diphtheria, and Pertussis, hepatitis B, influenza, and I do not wish to receive any vaccinations. An X was marked in front of the options: COVID-19, herpes zoster, pneumococcal vaccines (PCV13 or PPSV23), tetanus, diphtheria, and Pertussis (TDAP), hepatitis B, and influenza. The consent lacked information on PCV20. R36's medical record was reviewed and lacked evidence PCV20 was administered, or that shared clinical decision making occurred. A form, Short Term Resident Quality Measures Vaccination Report 2023-2024 indicated R36 had PPSV23 on 5/31/2011, and again 9/29/2016, and had PCV13 on 9/17/2015, and indicated N/A for PCV15 or PCV20. During interview on 7/17/24 at 2:09 p.m., the infection preventionist (IP) stated the consent forms indicated which vaccination a resident wanted. IP further stated they were working with the medical director and offering PCV20 if a resident was eligible when a resident had a recertification and stated clinical decision making was documented under immunizations. Additionally, IP verified consent forms lacked information for PCV20 and stated R48 had not been offered PCV20 nor had there been a discussion on clinical decision making and stated it should have been completed the first couple of weeks of admission since he was a short term resident and further stated she had to clarify what R48's wishes were based on the conflicting response on the consent form. Additionally, IP stated R36's medical record contained no documentation regarding PCV20 or whether a shared clinical decision making discussion occurred and stated they utilized the CDC Pneumococcal Vaccine Timing for Adults form and stated it was important to administer vaccinations according to the CDC recommendations because of safety for residents and others in the building. During interview on 7/17/24 at 3:19 p.m., the director of nursing stated they had to establish a short term program for pneumovaccines due to the risk of pneumonia. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Influenza and Pneumococcal Immunizations, dated 2/2020, indicated the facility followed the CDC guidelines for pneumococcal and influenza vaccinations. all residents, [AGE] years of age or older, and those younger than age 65 as recommended by the CDC, should receive the pneumococcal vaccine both the conjugate PCV13, and the polysaccharide PPSV23, if not already immunized, medically contraindicated or refused by resident or responsible party. These vaccines are administered under facility standing orders. All residents on admission will be screened to determine if they are current on influenza and both pneumococcal immunizations. Documentation of the resident's immunization status will be maintained in the medical record. Prior to administration, consent for all vaccinations will be obtained from the resident or a responsible party after current education is provided and documented in the medical record. The facility will follow the CDC guidelines for administration of PCV13 and PPSV23 vaccines for those residents aged 65 or older. The policy lacked information regarding providing shared clinical decision making, or information on PCV20.