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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245378  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>05/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Valley View Manor Hcc  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 East Ninth Avenue<br>Lamberton, MN 56152 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to determine whether a resident was safe to self-monitor diabetic medication treatment results (blood glucose levels) for 1 of 1 residents (R13) who had a continuous blood glucose monitoring system (FreeStyle 3 Libre).</p> <p>Findings include:</p> <p>Observation and interview on 5/14/25 at 8:15 a.m., with R13 identified she had a sensor on the back of her arm and a hand held meter. She placed the meter near the sensor and it recorded her blood glucose level. She identified the nurse would come in and ask her what her blood sugar is and she would tell them. If my blood sugar is low they give me orange juice or a snack. R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device.</p> <p>Review of R13's Self Administration of Medications assessment did not identify R13 had been given any guidance or assessed to ensure she was knowledgeable on how to use the monitor or when she would need to complete a manual blood glucose check to ensure accuracy.</p> <p>Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the facility does not have a policy or process for the use of the FreeStyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked. In addition she agreed R13's self administration assessment did not identify if R13 was knowledgeable enough to use the Libre 3 independently and did not identify that any guidance was provided.</p> <p>Review of the current, undated, FreeStyle Libre 3 manufacturer instructions, located at, <a href="https://www.freestyleprovider.[NAME]/us-en/patient-training.html?type=fsI3&amp;&amp;msclkid=137e6c7baf1615aea40e0450ecf20f55&amp;utm_source=bing&amp;utm_medium=cpc&amp;utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&amp;utm_term=freestyle%20libre%203&amp;utm_content=Libre%203&amp;gclid=137e6c7baf1615aea40e0450ecf20f55&amp;gclsrc=3p.ds&amp;gad_source=7">https://www.freestyleprovider.[NAME]/us-en/patient-training.html?type=fsI3&amp;&amp;msclkid=137e6c7baf1615aea40e0450ecf20f55&amp;utm_source=bing&amp;utm_medium=cpc&amp;utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&amp;utm_term=freestyle%20libre%203&amp;utm_content=Libre%203&amp;gclid=137e6c7baf1615aea40e0450ecf20f55&amp;gclsrc=3p.ds&amp;gad_source=7</a>, identified prior to using the device, patients were to review all the product instructions and complete the interactive tutorials. In addition, the instructions identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed.</p> |   |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and document review the facility failed to ensure psychotropic medications had identified target behaviors or symptoms, failed to monitor the target behaviors or symptom, and failed to monitor for adverse effects of the medication for 1 of 4 residents (R4) reviewed for psychotropic medication use. Additionally, the facility failed to have non-pharmacological meaningful interventions that were personalized for target behaviors or symptoms.</p> <p>Findings include:</p> <p>R4's 4/24/25, quarterly Minimum Data Set (MDS) identified R4's cognition was moderately impaired. She had functional limitations of both upper and lower extremities and required extensive to total assistance with cares. R4 took an antipsychotic and antidepressant medication. The MDS identified diagnoses of neurological condition, left side weakness, heart failure, diabetes mellitus, and seizure disorder.</p> <p>R4's 5/13/25, Order Summary Report identified bupropion HCl ER (Wellbutrin XL) 300 milligrams (mg) every day (QD) an antidepressant medication for mood disorder due to known physiological condition. Quetiapine Fumarate (Seroquel) 300 mg at bedtime (antipsychotic medication) for encephalomalacia due to previous stroke (serious brain injury that causes memory loss, changes in personality and behaviors). Vilazodone HCl 20 mg QD (antidepressant) for mood disorder due to known physiological condition. The orders lacked identification of target behaviors or symptoms the medication was ordered to treat and lacked monitoring of the medication adverse effects.</p> <p>Interview on 5/13/25 at 11:32 a.m., with nursing assistant (NA)-B identified R4 has hallucinated and thought there were raccoons in her room. Staff would reassure her when she thought she saw something and reported to the nurse.</p> <p>Interview on 5/14/25 at 2:00 p.m., with NA-A identified R4 reported seeing things like raccoons and opossums in her room, she heard scratching noises all the time, and just last night she thought something was crawling on her. She also reportedly had days when she thought she could still get up and walk which she cannot do. When she had hallucinations like that, staff reassured her and reported to the nurse.</p> <p>R4's 1/24/25, mental health visit provider note identified R4 had a mood disorder NOS (not otherwise specified), anxiety disorder, and unspecified psychosis. R4 was identified to have visual hallucinations about animals being in her bed (opossums). R4 reported she felt like her stroke had really exacerbated her negative mood.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>R4's 4/29/25, care plan identified psychotropic medication management related to insomnia, depression, and anxiety. The goal was the resident would be free from side effects. The intervention was to consult pharmacist to review medications. R4 refused cares at times related to depression, anxiety, and stroke. The goal was the resident will cooperate with care through the review date. The interventions included allow the resident to make decisions about treatment regime, to provide sense of control, encourage participation, staff to give clear explanation of all care activities prior to occurrence, and/or postpone care and re-approach if R4 continued to resist. The care plan lacked what the target behaviors or symptom were and lacked personalized non-pharmacological interventions and lacked identification of R4's hallucinations or delusional thoughts and what staff were to do when these occurred.</p> <p>Interview on 5/14/25 at 2:36 p.m., with consulting pharmacist identified she would expect target behaviors or symptoms would be identified for psychotropic medication on either the resident's care plan or on the medication administration record. She further identified she would expect that staff would be monitoring those target behaviors or symptoms for effectiveness of the medication.</p> <p>Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) identified she was unsure how the facility was monitoring target behaviors or symptoms if the facility had not identified what those symptoms were. She further revealed she was unsure how the facility was monitoring for side effects of the psychotropic medications. She confirmed there was nothing on the medication administration record or care plan that identified the target behaviors or symptoms for the medication use. She reported corporate had the facility now using a new library that had pre-defined problems and intervention to create care plans. With the new program the care plans were now lacking individualized problems and interventions as she was required to choose from the library pick list.</p> <p>Review of the 4/25/25, Psychotropic Medication Use policy identified resident would only receive medications that are clinically indicated to treat specific conditions. A comprehensive assessment should be completed, and nonpharmacological interventions identified to minimize the need for a psychotropic medication. Residents on psychotropic medication should receive a gradual dose reduction unless contraindicated to discontinue the medication. Psychotropic medications are prescribed to treat specific condition or symptom which should be documented in the resident medical record. Psychotropic medications are to be monitored for adverse effects.</p> |   |  |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure each resident receives an accurate assessment.</p> <p>Based on interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 12 sampled residents (R24).</p> <p>Findings include:</p> <p>R24's 5/17/24, Preadmission Screening Results (PAS) identified no level II assessment was needed. The PAS identified that R24 had post-traumatic stress disorder (PTSD), anxiety, and depression.</p> <p>R24's 5/27/24, admission Minimum Data Set (MDS) assessment lacked identification of PTSD. R24's 8/27/24, quarterly and the 10/21/24, significant change MDS identified PTSD diagnosis.</p> <p>R24's 5/14/25, medical diagnosis list identified PTSD, depression, and anxiety.</p> <p>Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) identified she would expect the MDS would be coded correctly to reflect the resident's actual condition. She reported R24's admission MDS had been completed by a contracted staff and she now had taken over completing the MDS's at the facility. She confirmed that R24's admission MDS had lacked identification of the PTSD diagnosis. Which would trigger care planning for PTSD to ensure support provided.</p> <p>Review of the Resident Assessment Instrument (RAI) manual 3.0 identified residents MDS submissions must be accurate during the look back period and in accordance with standards of clinical practice and documentation.</p> |   |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that addressed anticoagulant (prevents and breaks down blood clots) therapy with safety precautions for 1 of 1 (R25) resident reviewed for care plan.</p> <p>Findings include:</p> <p>R25's 3/06/25, Significant change Minimum Data Set (MDS) identified R25 was admitted [DATE]. R25 had a diagnosis of atrial fibrillation (irregular heart rhythm) and hip fracture. R25 was moderately cognitively impaired and had taken anticoagulants on a routine basis.</p> <p>R25's current, undated Order Summary Report identified R25 was to receive Eliquis (anticoagulant used to prevent blood clots) 2.5 milligrams (mg) twice a day for atrial fibrillation. The order identified the medication was to start on 8/19/24.</p> <p>R25's current, undated care plan lacked individualized documentation of pharmacological and non-pharmacological interventions for R25, as well as, side effects and/or adverse effects of the medication use.</p> <p>Interview on 5/14/25 at 9:40 a.m., with registered nurse (RN)-A identified the risk of bleeding was an indicator of anticoagulant use. RN-A accessed R25's chart on Point Click Care (PCC), an online medical record, identified R25's care plan lacked evidence of monitoring for anticoagulation therapy.</p> <p>Interview on 5/14/25 at 9:53 a.m., with RN-B identified R25 was administered Eliquis and was to be monitored for symptoms such as, dark color stools, bruising, abnormal bleeding or severe paleness of the skin. RN-B had voiced agreement appropriate interventions should be reflected in R25's care plan.</p> <p>Interview on 5/14/25 4:06 p.m., with assistant director of nursing (ADON) identified R25's care plan should reflect interventions, including drug specific side effects for use of anticoagulant medications.</p> <p>Review of facility current, undated Care Plans, Comprehensive Person-Centered policy indicated care plans was to include services related to the physical, mental and psychosocial well-being of the resident, measurable objectives and timeframes, and desired outcomes. The comprehensive care plan was to include ongoing assessments, revision of services, and interventions related to areas of concern.</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observation, interview, and document review the facility failed to revise 1 of 1 resident (R8) care plan following a change of condition.</p> <p>Findings include:</p> <p>R8's 4/23/25, quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 required extensive assistance by one staff for transfers, toileting, and bed mobility. R8 took insulin daily and a diuretic (medication to remove fluid excess from the body). R8's 5/14/25, diagnosis list identified Alzheimer's disease, congestive heart failure, pain in right toes, pain in left ankle and foot, osteoarthritis, and diabetes mellitus.</p> <p>R8's 4/30/25, emergency department (ED) provider note identified R8 had presented to the ED for evaluation of increased weakness and falls. Assessment noted bruising with some swelling and tenderness of the left lower leg and ankle area. Some bruising was noted as being present on the right lower leg but without any tenderness. X-ray of left ankle revealed a fractured ankle and the ankle was splinted. The note indicated R8 would benefit from orthopedic follow-up to discuss whether surgical options would be helpful given she is ambulatory at baseline (prior to the fall). R8 was discharged back to the facility.</p> <p>Observation on 5/13/25 at 11:10 a.m., 2 staff exiting R8's room one with the Hoyer mechanical lift (full body lift) and 1 staff pushing R8 in her wheelchair.</p> <p>Interview on 5/13/25 at 11:47 a.m., with nursing assistant (NA)-B identified R8 used to transfer with one staff assist but since she fractured her ankle, she now required use of a total body mechanical life (Hoyer) with assist of 2 staff as she was non-weight bearing.</p> <p>Interview on 5/13/25 at 11:47 a.m., with nursing assistant (NA)-B identified R8 used to transfer with 1 staff assist but since she fractured her ankle, she required a Hoyer lift with 2 staff as she was non-weight bearing.</p> <p>Interview on 5/14/25 at 2:00 p.m., with NA-A identified R8 was not previously transferred using a Hoyer mechanical lift with 2 staff. R8 used to transfer with 1 staff and ambulate with 1 staff prior to her fall and fractured ankle.</p> <p>R8's undated, care plan identified R8 required extensive assist of 1 staff for toileting, bathing, bed mobility, dressing, and transferring. R8 required extensive assist of 1 staff and a front wheeled walker for ambulation. The care plan lacked revision that R8 now required total assist by 2 staff using a Hoyer mechanical lift for transfers as R8 was non-weight bearing on her left leg after her fall.</p> <p>Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) confirmed R8's care plan had not been updated to reflect her current care needs following her fractured ankle. She reported R8 currently required a Hoyer mechanical lift for all transfers with 2 staff assist.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of 4/22/25, Care Plans, Comprehensive Person-Centered policy identified that resident assessments were ongoing and care plans are revised as the resident's condition changes.</p> |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on observation, interview, and document review, the facility failed to ensure staff were competent to use a continuous glucose monitoring device (FreeStyle Libre 3) for 1 of 1 resident (R)13 who had a diagnosis of diabetes.</p> <p>Findings include:</p> <p>R13's admission Minimum Data Set (MDS) assessment identified her cognition was intact, she required assistance from staff to complete activities of daily living (ADL)'s, and had diagnosis of diabetes, heart failure, respiratory failure, bi-polar disorder, borderline personality disorder, and depression.</p> <p>R13's May 2025, administration record identified she was to have her blood glucose level monitored and recorded three times a day before meals. R13 was to be administered 40 units of insulin aspart protamine and insulin aspart (a combination of fast acting and intermediate acting insulin to keep blood sugar levels under control) subcutaneous two times a day at 8:00 a.m., and 4:00 p.m. In addition, R13 was to be administered a correction dose based on her blood sugar levels at the time of administration.</p> <p>R13's 4/30/25 through 5/13/25, documented blood glucose levels identified her blood sugars ranged from 70 Milligrams per deciliter (mg/dl)- 403mg/dl. Target blood glucose levels for people with diabetes is 80-130mg/dl.</p> <p>Interview on 5/14/25 at 8:02 a.m., with registered nurse (RN)-B identified she was familiar with these types of devices similar to what R13 used for blood glucose monitoring because she had used them at other facilities. She revealed she had not received training on the device since working at this facility and had not completed a competency. She identified she did not know where the manufacturer directions were but thought they were on the charge nurse med cart or in the medication room.</p> <p>Interview on 5/14/25 at 8:07 a.m., with registered nurse (RN)-A identified he was the charge nurse and had never worked with a continuous blood glucose monitoring device. He was not aware of what type of device R13 used and was not aware if the facility had manufacturer directions or where they would be located if they did. He identified they may be on the other medication cart with R13's other medications. He revealed he had not been trained how to use the device and had not completed a competency.</p> <p>Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the facility does not have a policy or process for the use of the FreeStyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked.</p> <p>Interview on 5/14/25 at 8:15 a.m., with R13 identified she told the nurse what her blood sugar was. If R13's blood sugar was low they [nurses] gave R13 orange juice or a snack. R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Interview on 5/14/25 at 4:11 p.m., with the administrator identified she would expect the facility would ensure nursing staff were trained and competent in the use of any medical equipment used for the treatment and medication therapy of residents who reside at the facility.</p> <p>Review of the FreeStyle Libre 3 manufacturer directions identified that prior to using the device, review all the product instructions and complete the interactive tutorial at <a href="http://www.FreeStyleLibre.com">www.FreeStyleLibre.com</a>. In addition, the instruction identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed.</p> |   |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>Based on observation, interview, and record review the facility failed to ensure dietary staff had appropriate training with competencies to carry out the function of monitoring the dish machine temperatures to ensure appropriate sanitation occurred.</p> <p>Findings include:</p> <p>Observation and interview on 5/13/25 at 9:30 a.m., with dietary aide (DA)-A who ran a load of dishes through the dish machine. The gauge located on the right side was at 170 degrees and did not move. The gauge, located on the left side moved during the wash and rinse cycle showing the wash cycle was to be 160 degrees and the rinse cycle was 180 degrees. DA-A reported she observed and documented temperatures once a shift. She reported the left gauge was the wash cycle, and the right gauge was the rinse cycle. When DA-A was asked if the temperature needed to reach a certain temperature, she replied there was no special temperature it had to be.</p> <p>Interview and observation on 5/13/25 at 10:11 a.m., with maintenance director identified one gauge read both the wash and rinse temperature. The maintenance director accompanied the surveyor to the dish machine and ran a cycle confirming that the left gauge read both the wash and rinse temperatures. He reported he did not think that the right gauge was even working.</p> <p>Review of the Dish Machine Temperature logs for March, April, May of 2025, identified the logs identified the rinse temperature fell below a safe sanitizing level of 180 degrees Fahrenheit (F) during the following meal services in:</p> <p>1) March 2025: Breakfast 18 of 31 days, Dinner 4 of 31 days, Supper 4 of 31 days. Staff failed to document any temperature level for 11 of 31 days.</p> <p>2) April 2025: Breakfast 13 of 30 days. There was no documentation sanitation had been achieved for 4 of 30 days during the breakfast meal service. During the dinner meal, 6 of 30 days fell below 180 degrees F. Further review of the dinner meal service identified 6 of the 30 days also had no documentation to support staff had monitored rinse temperatures. Supper meal service fell below safe temperatures 2 of 30 days. Staff failed to document 12 supper meal service rinse temperatures for the 30 days in April.</p> <p>3) May 2025: Breakfast 8 of 13 days fell below 180 degrees F. Dinner 1 of 12 days fell below, with the Supper meal service falling below 2 of 12 days reviewed with 1 of those 12 days having no documentation to support staff had monitored temperatures.</p> <p>On the form, it was noted if the rinse temperature fell below 180 degrees, F, staff were to contact the dietary manager.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Interview on 5/13/25 at 10:16 a.m., with dietary manager identified staff were to contact her or the maintenance director if the wash or rinse temperature was not at the correct temperature. She reported staff were to use the gauge on the left side for monitoring the wash and rinse cycles and staff had been trained on that but did not always follow directions. She confirmed monitoring the wash and rinse cycles was a problem and she reviewed the logs to monitor for a pattern. She confirmed several rinse temperatures were under 180 degrees. Additional interview on 5/13/25 at 1:40 p.m., confirmed she had not addressed the low rinse temperatures with any staff previously. She reported staff completed training on Relias, the facility online training system. Then before staff start in the kitchen, she trained staff on the cleaning dishes machine policy.</p> <p>Review of DA-A, DA-B, and cook-A training and competencies identified:</p> <p>1) DA-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. There was no documentation the dietary policies had been read or reviewed.</p> <p>2) DA-B, had no documentation of competencies or the policies had been read and reviewed.</p> <p>3) Cook-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. She signed on 9/11/24, she read the dietary policies.</p> <p>Interview on 5/13/25 at 1:40 p.m., with dietary manager revealed DA-B had no competencies related to her job functions, she only had received initial training which included an overview of food service.</p> <p>Interview on 5/13/25 at 2:58 p.m., with maintenance director identified both gauges were working on the dish machine. He confirmed the Ecolab data plate located on the dish machine identified minimum temperature for wash was 150 and rinse was 180. The right gauge did not move unless the machine was shut off, and the left gauge bounce back and forth for the wash and rinse cycle. He confirmed if the dish machine did not reach those temperatures staff were to contact the dietary manager or him to address.</p> <p>Interview on 5/14/25 at 9:24 a.m., with dietician identified sometimes the dish machine needed to run a couple cycles to get up to temperature. If the dish machine was not getting to recommended temperature for the wash and rinse cycle, then the dietary manager needed to be notified, and a maintenance request needed to be made. He would expect staff would be knowledgeable about how to read the temperature gauges, daily monitoring was being completed, and staff would report any concerns of the temperatures not reaching recommended temperature for wash or rinse cycles.</p> <p>Interview on 5/14/25 at 12:54 p.m., with dietary manager identified maintenance confirmed both gauges are working, and the maintenance director labeled the gauges for monitoring wash and rinse temperatures. She revealed that had not been how she was trained by Ecolab, but it now made sense.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Review of the undated, ECOLAB XL HT (hot water sanitizing, electrically heated dish machine) Operation Manual identified the wash temperature for 150 degrees minimum in the hot water sanitizing mode. The rinse temperature at 180 degrees minimum in the hot water sanitizing mode. A diagram in the manual identifies on the machine the left gauge as the thermometer rinse temperature and the gauge on the right as the thermometer wash temperature.</p> <p>Review of the undated, Dietary Aide Training list identified staff were to wash dishes and chart dishwasher temperatures.</p> <p>Review of the undated, Cleaning Dishes/Dish Machine policy identified prior to using the dish machine staff were to verify proper temperatures and machine function. Staff were to check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. The policy identified dish machine wash temperature should reach a minimum of 150 and the rise cycle to reach minimum of 180 degrees. Staff were to monitor temperatures and document to assure proper sanitizing of the dishes. Staff were trained to report any problems with the dish machine to the dietary manager. The dietary manager was to take immediate action to assure proper sanitation of the dishes.</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> DIETARY</p> <p>Observation and interview on 5/13/25 at 9:30 a.m., with dietary aide (DA)-A who ran a load of dishes through the dish machine. The gauge located on the right side was at 170 degrees and did not move. The gauge, located on the left side moved during the wash and rinse cycle showing the wash cycle was to be 160 degrees and the rinse cycle was 180 degrees. DA-A reported she observed and documented temperatures once a shift. She reported the left gauge was the wash cycle, and the right gauge was the rinse cycle. When DA-A was asked if the temperature needed to reach a certain temperature, she replied there was no special temperature it had to be.</p> <p>Interview and observation on 5/13/25 at 10:11 a.m., with maintenance director identified one gauge read both the wash and rinse temperature. The maintenance director accompanied the surveyor to the dish machine and ran a cycle confirming that the left gauge read both the wash and rinse temperatures. He reported he did not think that the right gauge was even working.</p> <p>Review of the Dish Machine Temperature logs for March, April, May of 2025, identified the logs identified the rinse temperature fell below a safe sanitizing level of 180 degrees Fahrenheit (F) during the following meal services in:</p> <p>1) March 2025: Breakfast 18 of 31 days, Dinner 4 of 31 days, Supper 4 of 31 days. Staff failed to document any temperature level for 11 of 31 days.</p> <p>2) April 2025: Breakfast 13 of 30 days. There was no documentation sanitation had been achieved for 4 of 30 days during the breakfast meal service. During the dinner meal, 6 of 30 days fell below 180 degrees F. Further review of the dinner meal service identified 6 of the 30 days also had no documentation to support staff had monitored rinse temperatures. Supper meal service fell below safe temperatures 2 of 30 days. Staff failed to document 12 supper meal service rinse temperatures for the 30 days in April.</p> <p>3) May 2025: Breakfast 8 of 13 days fell below 180 degrees F. Dinner 1 of 12 days fell below, with the Supper meal service falling below 2 of 12 days reviewed with 1 of those 12 days having no documentation to support staff had monitored temperatures.</p> <p>On the form, it was noted if the rinse temperature fell below 180 degrees, F, staff were to contact the dietary manager.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Interview on 5/13/25 at 10:16 a.m., with dietary manager identified staff were to contact her or the maintenance director if the wash or rinse temperature was not at the correct temperature. She reported staff were to use the gauge on the left side for monitoring the wash and rinse cycles and staff had been trained on that but did not always follow directions. She confirmed monitoring the wash and rinse cycles was a problem and she reviewed the logs to monitor for a pattern. She confirmed several rinse temperatures were under 180 degrees. Additional interview on 5/13/25 at 1:40 p.m., confirmed she had not addressed the low rinse temperatures with any staff previously. She reported staff completed training on Relias, the facility online training system. Then before staff start in the kitchen, she trained staff on the cleaning dishes machine policy.</p> <p>Review of DA-A, DA-B, and cook-A training and competencies identified:</p> <p>1) DA-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. There was no documentation the dietary policies had been read or reviewed.</p> <p>2) DA-B, had no documentation of competencies or the policies had been read and reviewed.</p> <p>3) Cook-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. She signed on 9/11/24, she read the dietary policies.</p> <p>Interview on 5/13/25 at 1:40 p.m., with dietary manager revealed DA-B had no competencies related to her job functions, she only had received initial training which included an overview of food service.</p> <p>Interview on 5/13/25 at 2:58 p.m., with maintenance director identified both gauges were working on the dish machine. He confirmed the Ecolab data plate located on the dish machine identified minimum temperature for wash was 150 and rinse was 180. The right gauge did not move unless the machine was shut off, and the left gauge bounce back and forth for the wash and rinse cycle. He confirmed if the dish machine did not reach those temperatures staff were to contact the dietary manager or him to address.</p> <p>Interview on 5/14/25 at 9:24 a.m., with dietician identified sometimes the dish machine needed to run a couple cycles to get up to temperature. If the dish machine was not getting to recommended temperature for the wash and rinse cycle, then the dietary manager needed to be notified, and a maintenance request needed to be made. He would expect staff would be knowledgeable about how to read the temperature gauges, daily monitoring was being completed, and staff would report any concerns of the temperatures not reaching recommended temperature for wash or rinse cycles.</p> <p>Interview on 5/14/25 at 12:54 p.m., with dietary manager identified maintenance confirmed both gauges are working, and the maintenance director labeled the gauges for monitoring wash and rinse temperatures. She revealed that had not been how she was trained by Ecolab, but it now made sense.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Review of the undated, ECOLAB XL HT (hot water sanitizing, electrically heated dish machine) Operation Manual identified the wash temperature for 150 degrees minimum in the hot water sanitizing mode. The rinse temperature at 180 degrees minimum in the hot water sanitizing mode. A diagram in the manual identifies on the machine the left gauge as the thermometer rinse temperature and the gauge on the right as the thermometer wash temperature.</p> <p>Review of the undated, Dietary Aide Training list identified staff were to wash dishes and chart dishwasher temperatures.</p> <p>Review of the undated, Cleaning Dishes/Dish Machine policy identified prior to using the dish machine staff were to verify proper temperatures and machine function. Staff were to check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. The policy identified dish machine wash temperature should reach a minimum of 150 and the rise cycle to reach minimum of 180 degrees. Staff were to monitor temperatures and document to assure proper sanitizing of the dishes. Staff were trained to report any problems with the dish machine to the dietary manager. The dietary manager was to take immediate action to assure proper sanitation of the dishes.</p> <p>Review of the 5/12/25, Facility Assessment identified staff training/education and competencies from other departments other than nursing was completed initially upon hire and annually. Annual online Relias training was to be completed by all staff. The Relias training included infection control as part of the facilities infection prevention training that covered written standards, policies, and procedures. The facility assessment further identified for Food and Nutrition Services, the facility would employ staff with appropriate competencies and skill sets to caring out the functions of the nutritional services.</p> <p>Review of the 5/12/25, Facility Assessment identified staff training/education and competencies from other departments other than nursing was completed initially upon hire and annually. Annual online Relias training was to be completed by all staff. The Relias training included infection control as part of the facilities infection prevention training that covered written standards, policies, and procedures. The facility assessment further identified for Food and Nutrition Services, the facility would employ staff with appropriate competencies and skill sets to caring out the functions of the nutritional services.</p> <p>Based on interview and document review the facility failed to develop and implement 1 of 1 facility assessment to ensure staff were trained and deemed competent for blood glucose monitoring and device usage. In addition, the facility failed to ensure 1 of 1 dietary aides (DA-A) was trained to ensure appropriate sanitation occurred in the dishwashing machine.</p> <p>Findings include:</p> <p><b>BLOOD GLUCOSE MONITORING</b></p> <p>Observation and interview on 5/14/25 at 8:15 a.m., with R13 identified she had a sensor on the back of her arm and a hand held meter. She placed the meter near the sensor and it recorded her blood glucose level. She identified the nurse would come in and ask her what her blood sugar is and she would tell them. If my blood sugar is low they give me orange juice or a snack. R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Review of R13's Self Administration of Medications assessment did not identify R13 had been given any guidance or assessed to ensure she was knowledgeable on how to use the monitor or when she would need to complete a manual blood glucose check to ensure accuracy.</p> <p>Review of the FreeStyle Libre 3 manufacturer instructions, located at <a href="https://www.freestyleprovider.[NAME]/us-en/patient-training.html?type=fsl3&amp;&amp;msclkid=137e6c7baf1615aea40e0450ecf20f55&amp;utm_source=bing&amp;utm_medium=cpc&amp;utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&amp;utm_term=freestyle%20libre%203&amp;utm_content=Libre%203&amp;gclid=137e6c7baf1615aea40e0450ecf20f55&amp;gclidsrc=3p.ds&amp;gad_source=7">https://www.freestyleprovider.[NAME]/us-en/patient-training.html?type=fsl3&amp;&amp;msclkid=137e6c7baf1615aea40e0450ecf20f55&amp;utm_source=bing&amp;utm_medium=cpc&amp;utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&amp;utm_term=freestyle%20libre%203&amp;utm_content=Libre%203&amp;gclid=137e6c7baf1615aea40e0450ecf20f55&amp;gclidsrc=3p.ds&amp;gad_source=7</a>, identified prior to using the device, patients were to review all the product instructions and complete the interactive tutorials. In addition, the instructions identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed.</p> <p>Interview on 5/14/25 at 8:02 a.m., with registered nurse (RN)-B identified she was familiar with these types of devices like R13 used for blood glucose monitoring because she had used them at other facilities. She revealed she had not received training on the device since working at this facility and had not completed a competency. She identified she did not know where the manufacturer directions were but thought they were on the charge nurse med cart or in the medication room.</p> <p>Interview on 5/14/25 at 8:07 a.m., with registered nurse (RN)-A identified he was the charge nurse and had never worked with a continuous blood glucose monitoring device. He was not aware of what type of device R13 used and was not aware if the facility had manufacturer directions or where they would be located if they did. He identified they may be on the other medication cart with R13's other medications. He revealed he had not been trained how to use the device and had not completed a competency.</p> <p>Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the facility does not have a policy or process for the use of the Freestyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked.</p> <p>Interview on 5/14/25 at 4:11 p.m., with the administrator identified she would expect the facility would ensure nursing staff were trained and competent in the use of any medical equipment used for the treatment and medication therapy of residents who reside at the facility.</p> <p>Review of the 5/12/25, Facility Assessment identified the facility was to provide for services to residents in relation to diabetic management. All nursing staff were required to complete general orientation and competencies upon hire. Ongoing training/education opportunities were to be completed annually. Competency testing was to be done on an annual basis. Training topics were to include identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life and include medication administration and resident assessment and exam and providing specialized care for diabetic glucose testing.</p> |   |  |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>Based on observation, interview and document review, the facility failed to have an integrated care plan to coordinate and delineate what services hospice was to provide and what services the facility was to provide, to ensure oversight and services would be provided for 1 of 1 resident (R11) reviewed for hospice care.</p> <p>Findings include:</p> <p>R11's 3/9/25, annual Minimum Data Set (MDS) assessment identified R11 was dependent on staff for all cares, he received hospice services.</p> <p>R11's undated facility care plan identified activities of daily living (ADL) deficit related to dementia and muscle/skeletal impairment. R11 was dependent on staff for care needs. The nutrition focus area identified R11 had nutritional problem related to diagnosis of alcohol dependency, anxiety, hepatitis C, dementia, epilepsy, hypertension, insomnia, depression, seizures, psychosis, and hospice status. There was no other mention of hospice as a whole, nor was there mention of what services the facility was to provide, or what services hospice was to provide mentioned on R11's care plan.</p> <p>R11's direct care staff Kardex (care plan) that staff review identified bathing, R11 required 2 staff assist. There was no mention of hospice on the Kardex and no mention staff were to assist hospice once a week with ensuring R11 had a bath.</p> <p>R11's 4/20/25, hospice care plan identified services required for R11 were providing a home health aide, massage therapy, social services, nursing, and spiritual care visits. R11 required 2 persons for transfer with a mechanical lift. Hospice would provide a tub bath or shower with facility staff assistance. If there was no facility staff assistance, the hospice aide would complete a bed bath weekly. Massage therapy was to be provided to reduce muscle tension. The interdisciplinary team would review and update R11's care plan and family's understanding as R11's condition requires, but no less than every 15 days. R11's hospice diagnosis was Alcohol dependence with alcohol-inducing persisting dementia.</p> <p>Interview on 5/13/25 at 1:52 p.m., with assistant director of nursing (ADON) identified the facility switched care plan libraries within point click care (PCC) (the facilities electronic medical record program). The new care plan library did not allow the facility to personalize the care plan like they had done in the past. She confirmed R11 had no mention of hospice on the facility care plan. Further interview on 5/14/25 at 3:52 p.m., with ADON identified the facility had a binder located at the nurse's station with the phone number to contact hospice if needed. Hospice staff would typically call prior to coming to the facility. She felt the hospice care was available to direct care staff however, the hospice binder at the desk could be beefed up and include a copy of the hospice care plan. She confirmed the facility care plan should identify hospice but did not feel it necessary to include when staff should update the provider, or hospice as she felt the facility communicated with hospice via phone calls or in person and acknowledged occasionally there had been laps in communication and that could be improved upon. The ADON agreed hospice was not mentioned on the facility's care plan nor had it delineated who was to provide what services and or note how the facility would ensure those services would be provided if for some reason hospice was unable to be at the facility.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview on 5/14/25 at 2:00 p.m., with nursing assistant (NA)-A identified R11 received two baths a week, one from the facility and one from the hospice provider. The hospice provider also did special things with R11 like provide a massage each week.</p> <p>Interview of 5/14/25 at 2:12 p.m., with hospice provider identified they faxed the hospice care plan to the facility to communicate what hospice was providing for the resident. Typically, hospice left an orange folder or binder with the resident's hospice information however, We have learned sometimes we place the information into the binder and the facility would remove that information. She was unsure what the facility did with the information.</p> <p>Review of the undated, hospice policy identified hospice responsibility was to determine an appropriate plan of care, address the changing level of services needed and provide medical direction for nursing management of the terminal illness. The facility was responsible for meeting the resident's personal care. The facility would coordinate with hospice, and the resident's representative to ensure the care provided was appropriately based on the residents' individual needs. The facility would notify hospice with a significant change in condition, any clinical complications, a need to transfer out of the facility, and the resident's death. The facility was to coordinate care plans for residents receiving hospice services.</p> <p>Review of the 2013, Hospice Agreement identified a plan of care and individualized written care plan would be established, maintained, reviewed, and modified as needed by the interdisciplinary group. Hospice and the facility will jointly develop and agree upon a coordinated plan of care.</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p>Based on interview and document review, the facility failed to ensure 1 of 5 staff (housekeeping aide (HK)-A) was appropriately given a second tuberculosis test within 1-2 weeks after the first step was completed upon hire.</p> <p>Review of the current, undated Regulations for Tuberculosis Control in Minnesota Health Care Settings, located at <a href="https://www.health.state.mn.us/diseases/tb/rules/tbregmanual.pdf">https://www.health.state.mn.us/diseases/tb/rules/tbregmanual.pdf</a> for Tuberculosis Control in Minnesota Health Care Settings, identified baseline TB screening is required for all healthcare workers (HCW). Baseline TB screening consists of three components:</p> <ol style="list-style-type: none"> <li>1. Assessing for current symptoms of active TB disease,</li> <li>2. Assessing TB history, and</li> <li>3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA before hire. The second TST may be performed after the health care worker (HCW) starts working with patients.</li> </ol> <p>An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients.</p> <p>Review of employee health file for HK-A, identified HK-A was hired on 4/08/25 and completed a baseline TB symptom screen. HK-A's 4/08/25, Baseline TB Screening for HealthCare Workers (HCW) form indicated, HK-A had received both first and second TST tests on 4/08/25 at 8:20 a.m., and again at 9:30 a.m., which were read on 4/10/25 at 11:00 a.m., and aghain at 2:30 p.m., and were negative. The form indicated if the results of the first test were negative, the second TST series was to be completed in one to three weeks.</p> <p>Review of the current, undated Centers for Disease Control (CDC) Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test, located at <a href="https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html">https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html</a>, identified if the first TB skin test result is negative, a second TB skin test should be done 1 to 3 weeks later. If the second TB skin test result is positive, it is probably a boosted reaction. Based on this second test result, the person should be classified as previously infected. This would not be considered a skin test conversion or a new TB infection. However, the patient is a candidate for treatment for latent TB infection. If the second skin test result is negative, the baseline result is negative, and the person would be classified as uninfected.</p> <p>Interview on 5/14/25 at 1:09 p.m., HK-A stated she had received the first TST once hired. HK-A was not made aware a second TST was to be completed.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 5/14/25 at 4:01 p.m., with ADON would expect new hires to complete all TB screening and testing, per facility policy. The ADON identified HK-A's TB form was filled out incorrectly and the employee did not receive both TB series the same day. The ADON had no documentation to support HK-A had received a second TB test to complete the series and agreed this should be documented as completed.</p> <p>Review of May 2024 Tuberculosis, Employee Screening policy indicated the facility was to screen and test all employees for active TB prior to employment.</p> |

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| <p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Implement a program that monitors antibiotic use.</p> <p>Based on interview and document review, the facility failed to complete a review of antibiotic therapy between 48-72 hours to ensure appropriateness of the continued use of an antibiotic for 1 of 3 (R21) sampled residents.</p> <p>Findings include:</p> <p>Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at <a href="https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf">https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf</a>, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out.</p> <p>Review of the infection control logs from December 2024 through May 2025 identified the following areas of documentation: resident name, admit date, room number/unit, infection onset, type of infection, signs and symptoms, status of the infection, pharmacy orders-order name, order date, prescriber, and a place for comments. The tracking log identified residents that were identified with potential infections.</p> <p>Review of February 2025 infection control log identified R21 had been prescribed ciprofloxacin (an antibiotic) 500 milligram (mg) twice a day for four days for urinary tract infection (UTI). R21 had taken the medication from 2/7/25 through 2/11/25.</p> <p>R21's current, undated diagnosis sheet identified R21 had a diagnosis of neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems).</p> <p>R21's current, undated care plan identified R21 had a risk of infection related to indwelling catheter (tube that collects urine from the bladder). The facility nursing staff was to evaluate R21 for urinary complaints and to manage patency of the catheter to minimize risk of infections.</p> <p>R21's progress notes identified on 2/07/25 at 1:12 p.m., R21 had symptoms of pain, discomfort and urinary retention. Nurse practitioner (NP) started orders for ciprofloxacin medication therapy related to UTI and prostatitis (inflammation of the prostate). R21's medical record lacked any initial comprehensive assessment.</p> <p>Interview on 5/14/25 at 4:03 p.m., with assistant director of nursing (ADON) identified the facility had used Loeb's criteria (surveillance for infections) for criteria for implementing antibiotics. Antibiotic time outs were placed under the assessment tab in the resident's record on Point Click Care (PCC). This was not completed for R21. The ADON would expect an antibiotic time out to be reviewed and completed to determine continued need for residents on antibiotic therapy.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of current, undated Antibiotic Stewardship Procedure policy identified the facility was to record infections, gather clinical documentation, assess appropriateness of antibiotic use, and identify adverse outcome related to antibiotic use.</p> |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure 1 of 5 (R28) were offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC).</p> <p>Findings include:</p> <p>R28's 2/09/25, admission Minimum Data Set identified R28 was [AGE] years old and had a diagnoses of dementia, anxiety and diabetes. R28 was offered but decline the pneumococcal vaccine (PCV).</p> <p>R28's current, undated immunization report indicated R28 had received PCV-7 on 2/16/11, PPV23 on 6/14/13, followed by PCV-13 on 7/12/19.</p> <p>Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at <a href="https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html">https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html</a>, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and a PPSV23 at or after the age of [AGE] years old.</p> <p>R28's 2/03/25, Revolving Immunization Consent or Declination form identified R28 consented for the PCV dose.</p> <p>Interview on 5/13/25 at 1:26 p.m., with the assistant director of nursing (ADON) identified the consent was obtained for R28 to receive the vaccine and was held. The ADON did not communicate with R28's power of attorney (POA) when the vaccine was held nor was R28 re-assessed to identify R28's appropriateness for the administration of the vaccine.</p> <p>Review of the current, undated Pneumococcal Vaccine policy indicated residents were to be assessed and receive the PCV vaccine within 30 days of admission. Residents were to receive the vaccines unless medically contraindicated, previously given and/or refused and to provide documentation in the resident's medical record of refusals.</p> |   |  |