STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Falls Care Center	1200 First Avenue Northeast Little Falls, MN 56345

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner that promoted dignity for 2 of 3 residents (R8, R9) reviewed for call lights. Findings include: R8's admission Minimum Data Set (MDS) dated [DATE] identified moderately impaired cognition and no behaviors noted. R8 required substantial to maximal assistance with toileting hygiene, partial to moderate assistance with personal hygiene, and supervision or touch with all transfers. R8 used a manual wheelchair for transportation. R8 was always continent of bowel and bladder. R8's diagnoses included non-traumatic dysfunction, Alzheimer's, dementia, and anxiety. R8 was high risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R8 was toileted at 12:00 p.m. and 4:00 p.m. R8's transfers were to be completed with a non-mechanical lift with assistance of one staff. R8's toileting plan required staff to toilet R8 upon rising in the a.m., every three to four hours, at bedtime (HS) (11 a.m . to 12 p. m., 2:00 p.m. to 3:00 p.m., 5:00 p.m. to 6:00 p.m., and as needed (PRN) at night). R8's bowel and bladder risk assessment results dated 1/29/24, identified: R8's cognition was slightly impaired, required extensive assistance with transfers. R8 was frequently incontinent of bladder, had impaired mobility and dependent on staff for transfers. R8 was always continent of bowel. R8 was placed on a scheduled toileting program. R8's call light activity report dated 3/4/24, from 11:54 p.m. through 12:56 p.m. identified: On 3/4/24, the call light was activated at 11:54 a.m. and was responded to 38 minutes 4 seconds after it was activated. On 3/4/24, the call light was activated at 12:39 a.m. and was responded to 16 minutes 39 seconds after it was activated. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview/observation on 3/4/24 at 12:15 p.m., R8 pushed herself to her room doorway in a wheelchair and stated she was looking for staff to take her to bathroom. R8 stated she placed her call light on and knew staff were always busy. R8 stated she waited over 20 minutes sometimes and had urine accidents when unable to get to bathroom on time. R8 indicated she could usually wait, but only because she had to and became uncomfortable which happened daily. R8 stated the staff were busy and arrived to help her when they could but sometimes it got to be over 30 minutes. R8 added she was told not to get up by herself, but with the long wait times, sometimes had gotten up but was afraid of falling. R8 stated sometimes it almost felt like they had forgotten about her. During an observation on 3/4/24 at 12:10 p.m., (16 minutes after call light was activated) activities assistant (AA) walked by R8's room and did not answer call light. During an observation on 3/4/24 at 12:32 p.m., (38 minutes after call light was activated) NA-E entered R8's room turned off light and asked what she needed. R8 stated needed to use bathroom. NA-E stated she would have to wait because the lift she needed was being used by another resident. NA-E exited the room and stood in hallway visiting with another unknown staff. During an observation/interview on 3/4/24 at 12:39 p.m., R8 placed her call light on again and wheeled herself in wheelchair to the doorway of her room, looked around, then pushed her self-back into the room. At 12:41 p.m. activities assistant (AA) entered R8's room and said hello stayed in R8's room until 12:55 p.m. then exited the room. AA stated R8 had requested assistance to go to bathroom but she worked with activities and was unable to assist her. AA also stated staff had been so busy and were helping other residents. During an observation on 3/4/24 at 12:50 p.m., (56 minutes after initial call light was activated) NA-F walked down the hallway past R8's open door and looked at R8, then grabbed sit to stand machine located in the hallway. NA-F pushed stand machine past R8's room to the other end of the hallway. During an observation on 3/4/24 at 12:56 p.m. (1 hour and 2 minutes after this resident initially placed call light on to ask for assistance to bathroom) R8 had pushed herself up to the doorway of her room and NA-D walked up to resident and asked what she needed. R8 stated she need to go to the bathroom. NA-D stated the would be right back with the stand lift, turned off call light, and exited room. At 12:58 p.m. NA-D entered R8's room with stand machine and stated she would assist her to the bathroom. R8 stated good, I had been waiting a long time. NA-D started to lower R8 onto toilet and R8 began voiding right away in midair. R8 stated, I really had to go and had to wait so long. During an interview on 3/4/24 1:00 p.m., NA-D stated R8's brief was soiled with urine, which was normal for her lately, usually urinated four to five times a day, had stress incontinence and placed her call light when she needed to go to the bathroom. R9 admission MDS dated [DATE], identified intact cognition and no behaviors noted. R9 had impairment on upper extremity one side and used a cane, walker, and wheelchair for mobility. R9 required partial to moderate assistance with toileting hygiene, personal hygiene, and all transfers. R9 was always continent of urine and had a colostomy (a surgical opening in abdomen, one of colon is diverted through the incision, where a pouch is attached for collecting feces) and a history of urinary tract infection. Diagnoses included hemiplegia (weakness on one side), anxiety, and depression. R9 was at risk for pressure ulcers. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing assistant (NA) care sheet dated 3/4/24, identified R9 was assisted with toileting at 12:00 p.m. and 5:00 p.m. R9's transfers were to be completed with assistance of one staff. R9's toileting plan required staff to toilet her every three to four hours and required staff to ambulate R9 to and from bathroom. R9's bowel and bladder risk assessment dated [DATE] identified R9 required limited assistance for transfers due limited mobility and stroke, and always continent of bowel and bladder. R9's toilet program included routine scheduled toileting. During an observation/interview on 3/4/24 at 1:00 p.m., R9 wheeled herself to her room (shared bathroom with R8) and stated stated she needed to go to bathroom but the toilet was being used by her roommate (R8). R9 stated she had her call light on for up to 45 minutes at a time in the past and no one came to help her get to the toilet. R9 stated she needed assistance from staff to go to bathroom. R9 stated she had been incontinent of urine twice and it made her feel ashamed, belittled, and embarrassed At 1:20 p.m. R9 was assisted to bathroom by NA-D. During an interview on 3/4/24 at 1:45 p.m., NA-G stated R8 usually told us when she needed the bathroom and was continent of bladder. NA-G stated staff were expected to answer resident call lights within 15 minutes to meet their needs. During an interview on 3/4/24 at 2:00 p.m. NA-E stated staff were expected to answer call lights within 15 minutes to help prevent falls. R8 was unable to get up by herself. NA-E states went into R8's room between 12:30 p.m. and 12:45 p.m. and asked her was she needed, had call light on. NA-E stated R8 needed to go to the bathroom. NA-E stated she informed R8 both lifts were used and when one was available would take her to the toilet. NA-E stated she had taken another resident after that to the toilet and informed NA-D that R8 had to go to the bathroom, then went on break. NA-E stated R8 was forgetful and got confused at times but was able to hold a conversation and was interviewable. During an interview on 3/5/24 at 11:47 a.m. assistant director of nursing (ADON) stated expected staff to answer all lights within 15 minutes to address needs and assure safety. Staff should follow the toileting program for prevention of skin breakdown, infection, and dignity. During an interview on 3/5/24 at 3:26 p.m. floor manager registered nurse (RN)-A stated call light response time was expected to be three to five minutes and 15 minutes at the most. RN-A stated would most definitely affect dignity when you needed to get to bathroom and can not get there. RN-A stated would not be acceptable when a resident had a urine accident in their pants due to inability to get to the bathroom. Facility policy titled Call Light dated 10/23/17, identified residents who turned on their call light would have them answered promptly and their requested needs met. When responding to call lights, employees shall be prompt, effective, and courteous. Employees should never make the resident feel they are too busy to give assistance. Staff who could not fully address the resident's need shall not turn off the call light and only qualified staff may turn it off once they began to address the resident's care needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Dignity dated 4/17/23, identified staff were expected to maintain and enhance resident's dignity and assisted in maintaining and enhancing his or her self-worth. Additionally staff will provide care that can help avoid things that could be demeaning to the residents such as compliance with resident's request for bathroom assistance and provide timely response to call lights to prevent adverse events such as accidents or incontinent episodes.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observations, interview, and record review, the facility failed to respond to call lights timely for 2 of 3 residents (R8, R9) reviewed for call light responses and accommodation of needs Findings include: R8's admission Minimum Data Set (MDS) dated [DATE] identified moderately impaired cognition and no behaviors noted. R8 required substantial to maximal assistance with toileting hygiene, partial to moderate assistance with personal hygiene, and supervision or touch with all transfers. R8 used a manual wheelchair for transportation. R8 was always continent of bowel and bladder. R8's diagnoses included non-traumatic dysfunction, Alzheimer's, dementia, and anxiety. R8 was high risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R8 was toileted at 12:00 p.m. and 4:00 p.m. R8's transfers were to be completed with a non-mechanical lift with assistance of one staff. R8's toileting plan required staff to toilet R8 upon rising in the a.m., every three to four hours, at bedtime (HS) (11 a.m . to 12 p. m., 2:00 p.m. to 3:00 p.m., 5:00 p.m. to 6:00 p.m., and as needed (PRN) at night). R8's bowel and bladder risk assessment results dated 1/29/24, identified: R8's cognition was slightly impaired, required extensive assistance with transfers. R8 was frequently incontinent of bladder, had impaired mobility and dependent on staff for transfers. R8 was always continent of bowel. R8 was placed on a scheduled toileting program. R8's call light activity report dated 2/29/24, through 3/6/24 identified: On 2/29/24, the call light was activated at 6:28 p.m. and was responded to 22 minutes 50 seconds after it was activated. On 3/2/24, the call light was activated at 6:23 p.m. and was responded to 20 minutes 22 seconds after it was activated. On 3/3/24, the call light was activated at 8:04 am. and was responded to 17 minutes 55 seconds after it was activated. On 3/3/24, the call light was activated at 6:19 p.m. and was responded to 30 minutes 16 seconds after it was activated. On 3/4/24, the call light was activated at 10:54 a.m. and was responded to 20 minutes 28 seconds after it was activated. On 3/4/24, the call light was activated at 11:54 a.m. and was responded to 38 minutes 4 seconds after it was activated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/24, the call light was activated at 12:39 a.m. and was responded to 16 minutes 39 seconds after it was activated. On 3/6/24, the call light was activated at 6:26 a.m. and was responded to 23 minutes 33 seconds after it was activated. During an interview/observation on 3/4/24 at 12:15 p.m., R8 pushed herself to her room doorway in a wheelchair and stated she was looking for staff to take her to bathroom. R8 stated she placed her call light on and knew staff were always busy. R8 stated she waited over 20 minutes sometimes and had urine accidents when unable to get to bathroom on time. R8 indicated she could usually wait, but only because she had to and became uncomfortable which happened daily. R8 stated the staff were busy and arrived to help her when they could but sometimes it got to be over 30 minutes. R8 added she was told not to get up by herself, but with the long wait times, sometimes had gotten up but was afraid of falling. R8 stated sometimes it almost felt like they had forgotten about her. During an observation on 3/4/24 at 12:10 p.m., (16 minutes after call light was activated) activities assistant (AA) walked by R8's room and did not answer call light. During an observation on 3/4/24 at 12:32 p.m., (38 minutes after call light was activated) NA-E entered R8's room turned off light and asked what she needed. R8 stated needed to use bathroom. NA-E stated she would have to wait because the lift she needed was being used by another resident. NA-E exited the room and stood in hallway visiting with another unknown staff. During an observation/interview on 3/4/24 at 12:39 p.m., R8 placed her call light on again and wheeled herself in wheelchair to the doorway of her room, looked around, then pushed her self-back into the room. At 12:41 p.m. activities assistant (AA) entered R8's room and said hello stayed in R8's room until 12:55 p.m. then exited the room. AA stated R8 had requested assistance to go to bathroom but she worked with activities and was unable to assist her. AA also stated staff had been so busy and were helping other residents. During an observation on 3/4/24 at 12:50 p.m., (56 minutes after initial call light was activated) NA-F walked down the hallway past R8's open door and looked at R8, then grabbed sit to stand machine located in the hallway. NA-F pushed stand machine past R8's room to the other end of the hallway. During an observation on 3/4/24 at 12:56 p.m. (1 hour and 2 minutes after this resident initially placed call light on to ask for assistance to bathroom) R8 had pushed herself up to the doorway of her room and NA-D walked up to resident and asked what she needed. R8 stated she need to go to the bathroom. NA-D stated the would be right back with the stand lift, turned off call light, and exited room. At 12:58 p.m. NA-D entered R8's room with stand machine and stated she would assist her to the bathroom. R8 stated good, I had been waiting a long time. NA-D started to lower R8 onto toilet and R8 began voiding right away in midair. R8 stated, I really had to go and had to wait so long. During an interview on 3/4/24 1:00 p.m., NA-D stated R8's brief was soiled with urine, which was normal for her lately, usually urinated four to five times a day, had stress incontinence and placed her call light when she needed to go to the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9 admission MDS dated [DATE], identified intact cognition and no behaviors noted. R9 had impairment on upper extremity one side and used a cane, walker, and wheelchair for mobility. R9 required partial to moderate assistance with toileting hygiene, personal hygiene, and all transfers. R9 was always continent of urine and had a colostomy (a surgical opening in abdomen, one of colon is diverted through the incision, where a pouch is attached for collecting feces) and a history of urinary tract infection. Diagnoses included hemiplegia (weakness on one side), anxiety, and depression. R9 was at risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R9 was assisted with toileting at 12:00 p.m. and 5:00 p.m. R9's transfers were to be completed with assistance of one staff. R9's toileting plan required staff to toilet her every three to four hours and required staff to ambulate R9 to and from bathroom. R9's bowel and bladder risk assessment dated [DATE] identified R9 required limited assistance for transfers due limited mobility and stroke, and always continent of bowel and bladder. R9's toilet program included routine scheduled toileting. R9's call light activity report dated 2/28/24, through 3/6/24 identified: On 2/28/24, the call light was activated at 5:01 a.m and was responded to 27 minutes 29 seconds after it was activated. On 2/29/24, the call light was activated at 5:29 a.m. and was responded to 25 minutes 28 seconds after it was activated. On 2/29/24, the call light was activated at 6:09 p.m. and was responded to 37 minutes 35 seconds after it was activated. On 3/1/24, the call light was activated at 2:04 p.m. and was responded to 23 minutes 29 seconds after it was activated. On 3/2/24, the call light was activated at 7:41 a.m. and responded to 24 minutes after it was activated. On 3/2/24, the call light was activated at 6:50 p.m. and responded to 33 minutes 23 seconds after it was activated. On 3/3/24, the call light was activated at 5:06 a.m. and responded to 24 minutes and 58 seconds after it was activated. On 3/3/24, the call light was activated at 10:30 p.m. and responded to 25 minutes 45 seconds after it was activated. On 3/4/24, the call light was activated at 6:52 a.m. and responded to 34 minutes 39 seconds after it was activated. On 3/4/24, the call light was activated at 9:09 a.m. and responded to 25 minutes 59 seconds after it was activated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/24, the call light was activated at 6:52 a.m. and responded to 24 minutes 56 seconds after it was activated. On 3/6/24, the call light was activated at 5:27 a.m. and responded to 23 minutes 30 seconds after it was activated. During an observation/interview on 3/4/24 at 1:00 p.m., R9 wheeled herself to her room (shared bathroom with R8) and stated needed to go to bathroom but the toilet was being used by her roommate (R8). R9 stated she had her call light on for up to 45 minutes at a time in the past and no one came to help her get to the toilet. R9 stated she needed assistance from staff to go to bathroom. R9 stated she had been incontinent of urine twice and it made her feel ashamed, belittled, and embarrassed At 1:20 p.m. R9 was assisted to bathroom by NA-D. During an interview on 3/4/24 at 1:05 p.m., NA-D stated staff were expected to answer call light within in 7 to 15 minutes. NA-D stated it was not acceptable for a resident to have call light on to use the bathroom for one hour. NA-D indicated there was not enough staff to answer all the lights in a timely manner and was important to meet the resident's needs as soon as possible. During an interview on 3/4/24 at 1:45 p.m., NA-G stated R8 usually told us when she needed to use the bathroom and was continent of bladder. NA-G stated staff were expected to answer resident call lights within 15 minutes to meet their needs. During an interview on 3/4/24 at 2:00 p.m., NA-E stated staff were expected to answer call lights within 15 minutes to help prevent falls. R8 was unable to get up by herself. NA-E states R8's had call light on, entered her room between 12:30 p.m. and 12:45 p.m. and asked her what she needed. NA-E stated R8 needed to go to the bathroom. NA-E stated she informed R8 both lifts were being used and when one was available they would take her to the toilet. NA-E stated she had taken another resident after that to the toilet, she informed NA-D that R8 had to go to the bathroom, then went on break. NA-E stated R8 was forgetful and got confused at times but was able to hold a conversation and was interviewable. During an interview on 3/5/24 at 11:47 a.m., assistant director of nursing (ADON) stated expected staff to answer all lights within 15 minutes to address needs and assure safety. Staff should follow the toileting program for prevention of skin breakdown, infection, and dignity. During an interview on 3/5/24 at 3:26 p.m. floor manager registered nurse (RN)-A stated call light response time was expected to be three to five minutes and 15 minutes at the most. RN-A stated would not be acceptable when a resident had a urine accident in their pants due to inability to get to the bathroom. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Call Light dated 10/23/17, identified residents who turned on their call light would have them answered promptly and their requested needs met. Staff were expected to assure the residents' quality of life through the care center's effectiveness in answering call lights. The alerted call lights were visually displayed on the consoles and marquees on every unit and all care center personnel must be responsive to call lights at all times. When responding to call lights, employees shall be prompt, effective, and courteous. Employees should never make the resident feel they are too busy to give assistance. Staff who could not fully address the resident's need shall not turn off the call light and only qualified staff may turn it off once they began to address the resident's care needs.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and document review, the facility failed to provide timely incontinence care for 1 of 3 residents (R3) who was dependent on staff to provide assistance with a check and change program for incontinence. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, disorganized thinking, and no behaviors. R3 was independent with activities of daily living (ADLs), ambulation with a walker, and all transfers. R3 was continent of bowel and bladder. R3's care area assessment (CAA) dated 3/5/24, identified R3 had a recent left hip fracture resulted from a fall. R3 diagnoses included dementia, muscle weakness, abnormalities of gait and mobility, bilateral hearing loss, benign prostatic hyperplasia (BPH) (enlarged prostate causes blockage of urine, frequent urination, and/or incontinence) with lower urinary tract systems and urinary urgency. Since R3 fractured hip he has required assistance with dressing, toileting, hygiene, and bed mobility. R3 was incontinent of bowel 0 to 1 times a day and bladder 1 to 2 times a day. R3 wore a pull up and required assistance to transfer to the toilet with a Hoyer lift. R3's toileting plan included every two to three hours during his healing from the hip fracture to help prevent falls. Urinal at bedside has helped to decrease incontinence. Nursing assistance (NA) care sheet undated identified staff were to toilet and reposition R3 every two to three hours and urinal at bedside at night. R3's care plan dated 2/28/24, identified R3 had a deficit in bladder incontinence urgency related to BPH and was at risk for bowel decline in bowel incontinence related to cognitive deficit. Staff were directed to offer toilet every two to three hours and as needed (PRN) with Hoyer lift, assist of two and urinal placed at bedside at night. R3's bowel and bladder risk assessment dated [DATE], identified frequently incontinent of bowel and bladder. Inability to toilet self-due to physical limitations and required routine scheduled toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/1/24 at 1:59 p.m., nursing assistant (NA)-A and NA-C entered R3's room and pushed the mechanical lift. R3 sat in wheelchair with foot protectors and gripper socks on feet fully dressed. NA-A and NA-C hooked up the sling loops to mechanical lift and lifted R3 off wheel chair and lowered him onto the bed. R3 laid flat on his back. NA-C asked R3 if he needed to be changed and he said no do not think so. NA-C pulled down his pants and lifted the front of his brief up and stated, oh yes you do you are very wet, pulled the sides of the brief loose, and lowered the front of the brief down. R3 had a large amount of stool in the front perineal (peri) area, between his legs and brief saturated with urine. NA-A assisted R3 to his left side while NA-C used 10 peri wipes and cleaned off stool from R3's lower back, buttocks, and rectal area with gloves on. R3's stool was pasty and stuck onto his lower back. NA-A removed soiled gloves and placed a clean brief under R3. NA-A applied a clean pair of gloves and assisted R3 onto his back. NA-A cleaned stool from the font peri area and up along the sides of the groin with visible stool on peri wipes. R3 was turned onto his right side and NA-A cleaned stool from right backside and between R3's legs. An additional 10 peri wipes were saturated with large amounts of stool. The brief was removed and another clean one placed underneath R3. NA-A and NA-C removed soiled gloves, sanitized hands and attached the sides of the brief, covered R3 up with a blanket, and placed call light. During an interview on 3/1/24 at 2:36 p.m., NA-C stated R2 had worked the entire day shift and R2 had been checked and changed last at 7:30 a.m. when gotten up for the day, and should have been every two to three hours. NA-C stated we were short staffed and it had been way too long, almost seven hours, so he should have been changed hours ago. NA-C stated R2's stool was stuck onto his lower back and hard to remove. NA-C also stated R2 recently had hip surgery, was independent prior to that, and now required so much more assistance with everything. During an interview on 3/5/24 at 11:05 a.m., NA-A stated had worked the entire day shift along with two other NA's. NA-A stated one of the NA's was removed from floor and sent to the other side of the building. NA-A stated it was hard when they were left with only two NA's, 11 residents required assistance of two staff. NA-A verified R2 had not been changed since 7:30 a.m. and should have been checked and changed around 10:30 a.m. and again at 1:30 p.m. NA-A confirmed they got behind. During an interview on 3/5/24 at 4:03 p.m., registered nurse (RN)-B stated R2 recently had hip surgery and was no longer independent. RN-B stated staff would be expected to offer toilet and/or check or change R2 every two to three hours to protect skin and off load pressure from sitting/lying. Requested ADL policy and was not received.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and document review, the facility failed to follow physician orders and provide appropriate wound care to promote healing and prevent potential worsening of a moisture-associated skin damage (MASD) for 1 of 1 resident (R2) with current MASD. Findings include: R2's annual Minimum Data Set, dated dated dated [DATE], identified intact cognition with verbal behavioral symptoms such as screaming, threatening that significantly interfered with resident cares and disrupted care and living environment 1 to 3 times out of 7 days a week. R2 refused cares 1 to 3 days out of 7. R2 had impairment upper and lower body extremities on both sides and required substantial to maximal assistance with eating, toileting, upper and lower body dressing, roll right and left, chair/bed transfers, and does not walk. R2 was dependent on staff for oral hygiene, showers/bathes, personal hygiene, sit to lying, lying to sitting, sit to stand, and toilet transfers. R2 was frequently incontinent of bladder and always incontinent of bowel. R2 had a current MASD and placed on a turning and repositioning schedule. R2's (CAA) dated 3/4/24, identified diagnoses peripheral vascular disease (PVD) (narrowed arteries reduce blood flow to the arms or legs), cerebral vascular accident (CVA) (Stroke) with right hemiparesis (weakness on one side of the body), emphysema/chronic obstructive pulmonary disease (COPD), dorsopathy (group of diseases of the musculoskeletal system and connective tissue associated with degenerative diseases of the spine). R2 had several risk factors for impaired skin integrity. R2 currently has MASD on his lower right buttock and on a scheduled turn and repositioning schedule. R2 refused cares at times and displayed some cognitive deficits. R2 was incontinent of bowel and bladder. R2's Braden assessment score (a tool to assess pressure ulcer risk) dated 1/9/24, was 11 and indicated high risk for skin breakdown. R2's physician order dated 1/10/24, cleanse buttocks with wound daily and apply Med-honey (a brand name honey, Leptospermum, based gel with antibacterial and bacterial resistant properties to help prevent infections, support the removal of necrotic tissue, and encourage the body's natural wound healing process) with adhesive foam dressing and change daily and as needed (PRN). R2's progress notes dated 2/13/24, identified wound is not healing, not blanchable (skin returned back to natural color) area of wound continues to deteriorate. R2 continued to refuse to lay on side and to reposition from side to side. Area frequently had BM (bowel movement) on it and bandage had been changed several times a day. Planned on talking to nurse practitioner (NP) regarding this wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's NP visit dated 2/16/24, identified seen today as requested by R2 and facility administrator for ongoing coccyx wound. Nursing reported recently Medi-honey treatment had been started two to three days ago. Wound margins appeared to be improving per registered nurse today. R2's left buttock just above rectum showed a fifty-cent piece sized macerated area. Same size noted last NP visit on 1/10/24, approximately 3 centimeters (cm) diameter. Appeared to be pressure induced ulcer with less surrounding skin maceration. R2 had chronic moisture associated dermatitis to buttocks which has improved today. Slough remained on wound bed however improvement noted with Medi-honey treatment. R2's order summary report dated 2/29/24, left buttock MASD length 2.75 cm x width 3.5 cm x depth 3.0 cm x 3.0 cm tunneling (a track that occurs from the edge to deep within the subcutaneous tissue and occurs only in one direction) located at the 4 o'clock 3.0 cm, no undermining (dead space in the wound a shelf or lip under edges of wound). Moderate serosanguinous (appears thin, watery, cloudy, and yellow to tan in color and first sign the body is fighting an infection) exudate (wound drainage). Tissue type/color: red 10%, pink/red: healthy granulation (new connective tissue and microscopic blood vessels that form on the surface of a wound during healing process): yellow 90%, adherent fibrinous slough (a by-product of the inflammatory phase of wound healing and can contribute to delayed wound healing, increased risk for infection, and prevent an accurate wound assessment), and loosely adherent clumpy slough. Treatment intervention: Cleanse wound per facility protocol. Lightly pack Sorbact (a hydrophobic microbe binding wound dressing to manage exudate and donates moisture and hydrates the wound bed) 3 inches (in) x 3 in gauze into tunneling area and then up to skin level. Cover with bordered adhesive foam dressing silicone 3 in x 3 in dressing (a high-performance foam adhesive dressing highly absorbent, breathable wound dressing which prevents wound exudate strike-through and acts as a barrier to outside contamination that enhances a moist wound environment which has been shown to enhance wound healing). Change daily. During an observation and interview on 3/1/24 at 2:45 p.m., nursing assistant (NA)-C and licensed practical nurse (LPN)-B entered R2's room, transferred R2 with a mechanical lift from wheelchair to bed, and completed check and change. NA-C pulled down front of brief saturated with urine and cleansed front area with a peri wipe. NA-C and LPN-B turned R2 over onto his side left side and wound dressing located on the right inner buttocks had come loose. LPN-B removed saturated dressing with gloves on and a very strong foul odor was noted. LPN-B removed gloves, sanitized hands and exited room. At 2:50 p.m. LPN-B re-entered room, applied gloves, and sprayed wound cleaner (Sea Cleans) into a kerlix super sponge, dabbed the wound located on the right inner buttock gently, and surrounding skin. LPN-B grabbed a roll of kerlix dressing and cut off a small piece of it, applied normal saline, and attempted to pack the frayed edged piece of Kerlix into the tunneling of the wound with her gloved finger. LPN-B cut another small piece from the roll of Kerlix and placed it on tope of the packing. LPN-B then applied Allevyn Gentle Boarder dressing on top. LPN-B stated measurements were completed by staff nurse daily. LPN-B identified assessment of the wound during dressing change and stated wound had recently gotten worse this past week. R2's had a good amount of slough on top, moderate amount of serosanguinous drainage on the dressing. LPN-B stated R2's tunneling was about three o'clock and was packed with my finger. LPN-B stated a new order was written for a special type of gauze, had been ordered unsure of where from, not here yet, and not sure when it was to be delivered. LPN-B stated R2's surrounding skin was red but blanchable. LPN-B verified no other skin problems were noted on R2 today. LPN-B and NA-C transferred R2 back into wheelchair via mechanical lift. LPN-B and NA-C both grabbed the back of his pants, placed their arms through R2's and lifted him up into the chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/4/24 at 4:07 p.m., nursing assistant (NA)-B entered R2's room with gown, gloves, and mask on. NA-B removed a wedge from underneath R2's right side of his back, pulled sides of brief down. NA-B wiped R2's front peri area with a peri wipe (Tena Proskin Classic Wipes Freshly scented used on the delicate perineal area. Gentle cleansing formula contains aloe, vitamin E and chamomile pre-moistened for convenient use. No rinsing required). NA-B turned R2 onto his right side, wipe a very small amount of stool and stated the dressing on his buttock wound was 90% saturated with drainage, brief was dry underneath him. NA-B radioed nurse R2's dressing needed to be changed. At 4:16 p.m. licensed practical nurse (LPN)-A entered R2's room with gloves on, removed the saturated dressing from R2's coccyx area. A very strong odor was noted once the dressing was removed, and LPN-A wiped off R2's wound with the same type of peri wipe NA-B had just used to clean his front peri area (Tena Proskin Classic Wipes). LPN-A confirmed R2 did not have packing in the wound. LPN-A packed the wound on left buttock with hydrophobic microbe binding dressing with hydrogel with her gloved finger. LPN-A covered the wound with Allevyn classic adhesive 7.5 cm x 7.5 cm 3 in x 3 in, removed gloves and sanitized hands. LPN-A exited R2's room. At 4:25 p.m. NA-B covered up R2 and removed gown, gloves, mask, and exited room. NA-B stated to surveyor not sure that peri wipe should have been used on the wound but it looks worse than one week ago. NA-B showed surveyor package of peri wipes used on R2 and ingredients listed were: Water/Eau, glycerin, Phenoxyethanol Sodium Benzoate, Sodium Cocoyl, Apple amino acids, Potassium Sorbate, Fragrance, aloe Barbadensis leaf Extract (house plant), chamomilla recutitia (Matricaria/plant) Flower extract, citric acid, tocopherol acetate. Alcohol free. During an interview on 3/5/24 at 4:03 p.m., RN-B stated RN-A and physicians monitored R2's wound on his buttocks. RN-B stated was the first time in two weeks she had seen R2's wound on his buttock and looked worse due to tunneling, covered in slough, and appeared open more. RN-B stated she was aware R2 refused to offload and most likely affected the healing process of his wound. RN-B stated current orders indicated wound cleaner to be used which would have been more effective than normal saline and then pack with blue packing. RN-B stated unaware of where to find a copy of the facility protocols. RN-B stated a big heck no with using a peri wipe to cleanse [R2's] wound, that was not ok. RN-B stated the peri wipes were not designed to be used on or inside wounds and R2's wound needed to be cleaned out, it was in the butt area with poop in it, wound cleaner should have been used. RN-B stated R2 had not refused dressing changes to his wound located on his buttock that she was aware of. During an interview on 3/6/24 at 8:15 a.m., case manager registered nurse (RN)-A stated facility protocol wound cleaning would have been most likely in the standing orders. RN-A stated the wound wash used at this facility was located in a spray bottle. RN-A verified a peri wipe was not appropriate to cleanse a wound on R2's buttocks. RN-A stated a peri wipe would have most likely spread the germs around instead of cleaning it. RN-A stated a new order was written on 2/29/24, and the supplies were not received until Monday 3/4/24. RN-A stated staff were expected to continue the previous wound treatment orders until they received the proper supplies. RN-A indicated R2's wound should have been packed with a small cotton swab and not with a finger. RN-A stated the physician orders were not followed and staff were expected to verify them if unsure or unable to locate supplies. RN-A stated staff were expected to follow the physician orders, would have promoted healing and help prevent infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated staff would be expected to verify physician order and follow them. ADON verified R2's right buttock wound had tunneling and had not three weeks ago. ADON indicated R2 was being followed by a wound nurse once a month and the NP. ADON stated when staff received the new order on 2/29/24, and supplies were not available they would be expected to reach out to triage and provided an update supplies were not available in house, ask for clarification on how they should have proceeded to prevent worsening of the wound and potential infection. ADON verified R2's wound order change had occurred through a third party and the wound dressings /supplies would have been delivered by mail. ADON also stated depending how deep R2's tunneling was a small cotton swab would have most likely been the best way to pack it. Facility House Standing Orders dated 5/18/23, identified cleanse all wounds with wound cleaner. Wound nurse will be notified to conduct a root cause analysis (RCA) to determine wound type and emend dressings. Facility policy titled Implementation of Medication Prescriptions and Treatment and Therapy Orders dated 12/7/22, identified prescriptions for medications and orders for treatments must be implemented as quickly as possible and as prescribed by a qualified person. The DON was responsible to assure the prescriptions and orders have been implemented appropriately through client monitoring, supervision of staff, and review of client records. Additionally the DON or designee was to assure that staff was trained on the tasks required by the new order or prescription and staff been determined competent to follow the written instructions for the client.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43367 Based on observation, interview and document review, the facility failed to implement recommended influenza A infection control procedures for the use of personal protective equipment (PPE), for masks, during direct cares with residents to prevent the spread of infection for 2 of 3 residents (R2, R7) observed. This deficient practice had the potential to affect all residents currently residing in the facility. Findings include: R2's influenza nasopharynx/nasal test results dated 3/1/24 at 5:54 p.m. revealed positive for influenza A. During an observation on 3/4/24 at 10:56 a.m., R2 laid in bed with curtain pulled to room. Sign posted before room entrance revealed STOP! Contact precautions, Gloves, Gown, Equipment, Transport (nothing on sign about a mask). Registered nurse (RN)-C entered R2's room with a mask, isolation gown, gloves on and pushed a vitals machine. At 11:00 a.m. RN-C exited R7's room, wiped off vitals machine and cuff, removed gloves, mask, isolation gown, and sanitized hands. R2 was heard coughing frequently, with his couch sound loose and wet. During an observation on 3/4/24 at 3:25 p.m. and 4:30 p.m,. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can located outside R2's room. During an observation on 3/4/24 at 4:16 p.m., licensed practical nurse (LPN)-A entered R2's room with only gloves on, and no mask or gown. LPN-A removed R2's dressing from the coccyx saturated at least 90% with wound drainage, cleaned the skin, radioed RN-C and requested more supplies. R2 talked to staff continuously and had a frequent loose cough during observation. R2 was unable to physically cover his mouth. RN-C dropped off supplies at door and LPN-A applied dressing, visited with R2 then removed gloves, sanitized hands, and exited the room. During an observation on 3/5/24 at 11:54 p.m. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can on floor located outside room. R7's influenza nasopharynx/nasal test results dated 3/2/24 at 2:14 p.m., revealed positive for influenza A. During an observation on 3/4/24 at 3:35 p.m., R7 resident sat in recliner with door open with an occasional loose cough. Contact precaution sign was posted on outside of door (no mention of mask on it). An additional sign posted outside R7's room indicated KEEP DOOR CLOSED. The isolation storage container outside the door had masks and one disposable gown in it and a garbage can located on floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/5/24 at 11:55 a.m., R7 sat in recliner with door open with a frequent loose cough. There was a contact precaution sign reminder outside his door (no mention of mask on it). Masks were located on top of isolation cart along with gowns in bottom drawer. Three sizes of gloves in boxes hung out side of door. During an interview on 3/5/24 at 11:05 a.m., nursing assistant (NA)-A stated R2 tested positive for influenza A on Friday 3/1/24, and should have been placed on droplet precautions right away. NA-A stated the sign posted outside of R2's room was for contact precautions only. NA-A stated the sign was unclear, asked case manager (RN)-A, and clarification had not been provided yet. NA-A stated influenza A was spread through the air, staff should have been required to wear a mask to avoid breathing in the flu bug and would have helped prevent the spread of influenza A. NA-A indicated the other two residents tested positive for influenza A should had droplet precaution signs posted on their door. NA-A stated was unaware if any other residents had contracted Influenza A other than those three. During an interview on 3/5/24 at 3:26 p.m., RN-A stated once the resident was confirmed to have influenza A and droplet precaution signs should have been immediately placed outside the resident's door by the floor nurse. RN-A stated a mask would be required to be worn in the room to help prevent the spread of the infection. During an interview on 3/5/24 at 4:03 p.m., RN-B verified three residents on the 100 wing tested positive for influenza A. RN-B stated those three residents should have been placed on Influenza A precautions with a droplet sign posted outside their door. RN-B stated staff were required to wear a mask prior to entering each room to help prevent the spread of infection to themselves and others. During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated the infection control nurse was currently on vacation. ADON stated once the resident was confirmed positive for influenza A, staff would be expected to immediately place the droplet precaution sign outside the resident's door and resident on droplet precautions to help prevent the spread of infection. Facility policy titled Standard Precautions dated 5/8/17, identified standard precautions are used to prevent spread of infections. A mask, eye protection or face shield maybe worn to protect mucus membranes of the eyes, nose, and mouth at any time during procedures and patient care activities that are likely to generate splashes, or sprays of blood, body fluids, sections, or excretions. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than five microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. Influenza A would be considered an exampled of an infection that required droplet precautions. In addition to standard precautions a mask must be worn when working within three feet of resident. Use color coded signs and/or other measures to alert staff of the implementation of isolation or droplet precautions, while protecting the privacy of the resident. Yellow was the color code for droplet precautions.