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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/16/2025 |
| NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on interview, observation and document review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for pressure ulcers for 1 of 2 residents (R16) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R16's admission MDS assessment dated [DATE], indicated R16 was admitted to the facility on [DATE], cognitively intact, no rejection of care, required partial/moderate assistance with personal hygiene, dependent on staff for toileting, shower/bathe, lower body dressing, and transfers; diagnoses included unstageable pressure ulcer of the right heel, and osteomyelitis (infection of the bone); skin conditions indicated R16 was at risk of developing pressure ulcers/injuries, no unhealed pressure ulcers/injuries, had infection of the foot, other open lesion on the foot, surgical wounds; skin treatments included pressure reducing device for chair and bed, surgical wound care, application of ointments/medications other than to feet, application of dressings to feet. The MDS failed to indicate R16 had a unstageable heel pressure ulcer/injury.</p> <p>R16's care plan printed on 1/14/25, indicated R16 had self care deficit related to morbid obesity and decreased functional ability due to bilateral pressure injury to heels, needed assist with ADL's (activities of daily living), alteration in skin integrity r/t (related to) pressure ulcer to bilateral heels and interventions included administer treatments as ordered and observe for effectiveness, assist/encourage to float heels while in bed, measure wound weekly; update MD (medical doctor) PRN (as needed) with change, observe for s/sx (signs/symptoms) of infection, and wound vac in place on right heel wound to promote wound healing.</p> <p>On 1/14/25 at 9:19 a.m., medical doctor (MD)-A and licensed practical nurse were present in R16's room and observed R16's left heel. MD-A stated R16 was admitted to the facility with pressure ulcer of the left heel.</p> <p>On 1/15/25 at 7:56 a.m., registered nurse (RN)-C, also known as the MDS coordinator, confirmed R16's admission MDS was incorrect, and R16 does have a heel pressure ulcer.</p> <p>On 1/15/25 at 9:27 a.m., RN-E confirmed she completed R16's admission MDS and confirmed R16's MDS was inaccurate as the MDS did not include R16's pressure ulcers of the heels.</p> <p>(continued on next page)</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/16/24 12:22 p.m., RN-D, known as the regional nurse specialist, stated R16's MDS should have been completed accurately to reflect the heel pressure ulcers.</p> <p>The facility Minimum Data Set, Management of, Long Term Care policy dated 1/2025, indicated all MDS assessments and records will be completed and electronically encoded into the facility's electronic medical record and transmitted to the state database in accordance with current regulations.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on observation, interview and document review the facility failed to develop a comprehensive person centered care plan to address falls and ensure the care plan was revised with the new fall interventions to prevent further falls for 1 of 2 residents (R79) reviewed for falls.</p> <p>Findings include:</p> <p>R79's admission Minimum Data Set (MDS) assessment dated [DATE], indicated moderate cognitive impairment, dependent on staff for putting on/taking off footwear, sit to stand, chair/bed to chair transfer, toilet transfer, required substantial/maximal assistance with dressing, shower/bathe, personal hygiene, sit to lying, utilized a wheelchair, diagnoses included left femur fracture, non-Alzheimer's dementia, anxiety, depression, age related physical debility, and fall; fall in the last month, and a fracture related to a fall in the last six months, fall since admission or the prior assessment, two or more falls with no injury since admission.</p> <p>R79's care plan printed 1/14/25, indicated potential for injury r/t (related to) impaired mobility due to left hip fracture, impaired cognition dementia, antidepressant, narcotic, diuretic medication, impaired hearing, history of falls, has limited ROM (range of motion) LLE (left lower extremity); interventions included: bed at appropriate height, encourage resident to wear appropriate footwear, keep bed in lowest position, place fall mats on floor next to bed, when resident is in bed, keep call light within reach in bedroom and encourage resident to utilize it, urinal at bedside for falls prevention.</p> <p>R79's fall incident report dated 1/4/25, indicated R79 was on the floor in his room, lying on the floor in front of his recliner with the legs of the chair still extended, resident's positioning appeared R79 had crawled out of the recliner to the floor. R79 indicated he was getting out of that to go do the chores, and unable to tell actual events leading to him being on the floor due to confusion suspected related to his dementia. Immediate action taken included R79 was assessed and denied any pain, no evidence during assessment indicating any injuries occurred; absence of bruising, skin tears, redness, or pain with palpation, vitals taken, assisted to wheelchair appeared pleasantly confused throughout the shift as evidenced by his conversation with staff; several conversations pertained to him having to go get the chores done and/or the acreage he is currently farming, potentially hallucinating. The care plan failed to indicate new interventions related to the fall.</p> <p>R79's fall incident report dated 1/8/25, indicated staff via walkie talkie that assistance was needed in R79's room. Upon arrival, R79 was seated on the floor of his room facing the door and resting his back against recliner. R79 was unable to explain to staff what had happened or what he was trying to do. Resident Immediate Action Taken vital signs, pain, and range of motion were assessed while R79 was on the floor and found to be within normal limits, then lifted from the floor using two assist via the hooyer lift, neurological assessments were initiated d/t (due to) suspicion of a head strike by the kitchen staff who witnessed the fall. The care plan failed to include new interventions to prevent further falls.</p> <p>(continued on next page)</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>Progress note dated 1/10/25 at 11:02 a.m., the administrator indicated in regard to the influenza outbreak, family expressed concerns about R79 being a fall risk, would rather have R79 be out at the nurses station or in activities than be in his room.</p> <p>On 1/14/25 at 11:02 a.m., the administrator stated interventions were expected after each resident fall and expected the care plan updated to include the interventions. The administrator confirmed the director of nursing (DON) was overall responsible to ensure a comprehensive reassessment was conducted after a fall incident to identify root cause and ensure new interventions were implemented to prevent further falls. The administrator stated after R79's fall on 1/4/25, the interventions included observation of R79 while awake and have R79 at the dining area located by the nursing station. The administrator stated she educated the ADON (assistant director of nursing) regarding the interventions and entered a note in the EMR. The administrator confirmed the care plan was not updated as expected with the new interventions.</p> <p>On 1/14/25 at 11:12 a.m., registered nurse (RN)-D, known as regional nurse specialist, stated after a resident fall the nurse as expected to enter the fall into risk management in the EMR. The facility was expected to complete a comprehensive fall investigation which included a root cause analysis, and implement a new intervention, and the care plan updated with the new intervention. RN-D stated IDT met and discussed falls. RN-D stated the DON was responsible to ensure a comprehensive fall investigation was completed, and further stated she was not sure who was responsible for ensuring the care plan was updated. RN-D confirmed a comprehensive assessment and new interventions were not implemented after R79's fall on 1/8/25, and the interventions discussed after R79's fall on 1/4/25 were not included on the care plan.</p> <p>On 1/14/25 at 11:30 a.m., RN-A, known as the assistant director of nursing, stated he was only aware of R79 having one fall since admission. RN-A stated IDT met daily and discussed falls, and were expected to discuss cause and new interventions related to the fall. RN-A stated he was not able to attend IDT daily due to having to work the floor as nurse, pass medications, and complete resident treatments. RN-A confirmed the new interventions were not consistently placed on the care plan, and were important to ensure staff were aware of the interventions to prevent falls. RN-A stated he was not given education regarding R79 expected at the nursing station when awake.</p> <p>On 1/14/25 at 2:17 p.m., R79's door was closed, upon entering R79's room he was awake and seated at the edge of his bed in a gown.</p> <p>On 1/14/25 2:26 p.m., nursing assistant (NA)-E stated R79 was not a fall risk, not aware of any interventions to prevent falls, and fall interventions were expected reported in shift report and on the care plan. NA-E stated R79 had been awake in his room throughout the day.</p> <p>On 1/14/25 at 2:28 p.m., NA-G stated today was her first day at the facility as agency staff. NA-G stated she was not educated R79 was a fall risk, and did not have access to the EMR to access resident care plans to know interventions R79 may have related to falls.</p> <p>On 1/15/25 at 2:31 p.m., RN-H, known as the regional clinical director, stated the facility was expected to review all falls and the director of nursing (DON) was expected to ensure an intervention was implemented and added to the care plan to prevent further falls.</p> <p>The facility Fall Management policy dated 9/2023, indicated:</p> <p>(continued on next page)</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>-a fall risk evaluation include a review of the resident's past history of falls, medical and physical history, medication use in attempts to identify factors which may place the resident at higher risk of falls.</p> <p>- an analysis of the fall will be completed</p> <p>- additional interventions may be imitated and/or updated as applicable.</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on observation, interview and document review the facility failed to ensure residents received assistance with meals for 3 of 3 residents (R1, R2, and R10) reviewed for dining who required staff assistance and/or supervision with meals.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderate impaired cognition, no rejection of care, required setup assistance with eating, utilized a wheelchair, diagnoses included arthritis, dementia, and non-traumatic brain dysfunction.</p> <p>R1's care plan dated 1/3/25, indicated self care deficit related to dementia and intervention included eating: independent after setup.</p> <p>R2's significant change in condition MDS dated [DATE], indicated cognitively intact, required supervision with eating and dependent on staff for ADL's, diagnoses included anxiety, depression, and dysphagia (condition that makes it difficult to swallow).</p> <p>R2's care plan dated 10/22/24, indicated self care deficit and interventions eating: supervision, staff to monitor for swallowing at all meals, may need assistance with cutting up food.</p> <p>R10's quarterly MDS dated [DATE], indicated severe cognitive impairment, no rejection of care, required setup or clean up assistance with eating, substantial staff assistance with personal hygiene and diagnoses included non traumatic brain dysfunction, dementia, Parkinson's disease(progressive brain disorder that affects movement, balance, and coordination), anxiety, depression, and psychotic disorder.</p> <p>R10's care plan dated 11/20/24, indicated self care deficit interventions included eating: set up help only.</p> <p>On 1/13/25 at 12:08 p.m., R1 was seated in a wheelchair in the doorway of his room and a meal tray was located in front of R1 on a three tiered cart. R1 had three drinking glasses with lids not removed. R1 had a covered cup of ice cream on the tray table and was observed to reach for the ice cream and attempted to remove the lid from the ice cream container. R1 was observed to continue to use his hands and attempted to remove the lid and was unsuccessful. At 12:19 p.m., R1 placed the ice cream back on the cart. R1 stated he could not open the ice cream without help.</p> <p>On 1/13/25 at 12:20 p.m., housekeeping (HK)-A stated she delivered R1's tray and stated housekeeping was assisting with meal tray delivery today. HK-A stated R1's lids were not removed as she was unsure of the assistance R1 needed with meal set up.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/13/25 at 12:21 p.m., dietary manager (DM)-F was observed to remove the the lids from R1's ice cream and beverages after surveyor prompted DM-F, that R1 had been observed and attempted to remove lids and was unsuccessful. DM-F stated staff delivering the meal trays were expected to remove lids and provide assistance for R1 with meal set up.</p> <p>On 1/13/25 at 12:24 p.m., R2 was observed lying in bed and nursing assistant (NA)-A placed meal tray on bedside table that was placed over and in front of R2's upper body (add location of were tray was placed). Drinking glasses with lids were not removed and out of R2's reach. R2 stated he was not able to take the lids off without help and stated the drinking glasses were difficult to reach. R2 was observed to eat in bed with no staff assistance.</p> <p>On 1/13/25 at 3:31 p.m., registered nurse (RN)-A, known as the assistant director of nursing and infection preventionist stated residents currently ate in their rooms due to the influenza outbreak.</p> <p>On 1/14/25 at 8:31 a.m., R10 was seated in wheelchair in his room with tray table and meal in front of him. R10's beverages had straws placed in the drinking glasses and the straw wrapper was not removed from the straws. R10 had a banana with peel and not opened, and Styrofoam container with the lid not removed. R10 was observed and attempt to remove the wrapper from the straw and the straw fell on the floor.</p> <p>On 1/14/25 at 8:41 a.m., licensed practical nurse (LPN)-A entered R10's room and stated R10 was not able to remove straw wrappers and expected the staff who delivered the tray to remove the wrapper from the straw, open the banana and remove the lids from the food items.</p> <p>On 1/14/25 at 9:02 a.m., NA-B stated she delivered R10's meal tray today and confirmed the straw wrappers were not removed from R10's beverages as expected. NA-B confirmed R10 required assistance with meal set up when the tray was delivered and stated meal set up included straw wrappers removed, banana opened and lids removed from containers.</p> <p>On 1/16/25 at 12:22 p.m., RN-D, known as the regional nurse specialist, stated staff delivering meal trays were expected to provide meal set up and meal assistance for residents and ensure lids were removed, straw wrappers removed if resident was not able, and ensure food was within reach of the resident.</p> <p>The facility Resident Cares policy dated 4/2024, indicated prior to entering the resident's room ensure you are following the plane of care, assist or prompt with resident cares, ask the resident if there is anything else they need before you leave the room.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Deficiency Text Not Available</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on interview and document review, the facility failed to monitor weights as ordered for 1 of 1 resident (R10) reviewed for edema and 2 of 2 residents reviewed for nutrition (R20 and R23)</p> <p>Findings include:</p> <p>R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, no rejection of care, substantial staff assistance with personal hygiene and diagnoses included coronary artery disease, hypertension, diabetes, non-traumatic brain dysfunction, dementia, Parkinson's disease (progressive brain disorder that affects movement, balance, and coordination), anxiety, depression, and psychotic disorder.</p> <p>R10's care plan dated 11/20/24, indicated nutritional problem or potential nutritional problem r/t (related to diabetic diet restrictions and current dx (diagnosis) of Parkinson's Disease, requires set up assist, high BMI (body mass index) and interventions included monitor weights.</p> <p>R10's provider order dated 1/10/25, nurse practitioner (NP)-H indicated daily weights update provider if greater then three pound gain in one day or five pound gain in a week.</p> <p>R10's treatment administration record (TAR) dated 1/1/25-1/31/25, indicated start date of 1/11/25, daily weights, update provider if greater then three pound gain in one day or five pound gain in a week with start date. The TAR had no documented weights from 1/11/25-1/13/25. On 1/14/25 a weight of 212 pounds was documented.</p> <p>R10's document weight summary reviewed on 1/14/25, indicated on 12/19/24, documented weight was 209.6 pounds and on 1/14/25, a weight of 212 pounds.</p> <p>R10's record review had no documented refusals</p> <p>On 1/14/25 at 8:41 a.m., R10 was seated in a wheelchair in his room and medical doctor (MD)-G and licensed practical nurse (LPN)-A were present. MD-A stated R10 had plus one edema (retention of fluid) in bilateral lower legs and stated staff were expected to follow provider orders for weights.</p> <p>On 1/16/24 at 12:36 p.m., registered nurse (RN)-C, known as the regional nurse specialist, stated staff were expected to follow physician orders and expected R10's weights documented.</p> <p>42073</p> <p>R20's facesheet printed on 1/16/25, included diagnoses of coronary artery bypass surgery, heart failure, diabetes, and chronic kidney disease.</p> <p>R20's admission MDS assessment dated [DATE], indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 required moderate assistance with activities of daily living (ADL) and was independent with eating. R20 had no behaviors except rejection of care 1-3 days during MDS assessment period. R20 walked with staff assistance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R20's physician orders dated 11/27/24, indicated: weights daily in morning; call provider if weight increases by 2 pounds/24 hours and 5 pound/7 days from admission, every day shift for CHF (congestive heart failure).</p> <p>R20's care plan dated 12/10/24, indicated R20 had a behavior problem and frequently refused daily weights necessary to monitor his cardiac status. A goal with revised date of 12/30/24, indicated R20 would have fewer episodes of daily weight refusals by the next review date. An intervention dated 12/10/24, indicated to report daily weight refusals to nurse.</p> <p>Recorded weights (physician order indicated R20 was to be weighed daily):</p> <p>1/7/25 175.0 Lbs (pounds)</p> <p>1/3/25 175.0 Lbs</p> <p>1/2/25 175.0 Lbs</p> <p>12/27/24 173.1 Lbs</p> <p>12/24/24 173.0 Lbs</p> <p>12/23/24 174.4 Lbs</p> <p>12/22/24 175.0 Lbs</p> <p>12/21/24 176.0 Lbs</p> <p>12/20/24 174.6 Lbs</p> <p>12/19/24 176.2 Lbs</p> <p>12/12/24 172.0 Lbs</p> <p>12/10/24 176.4 Lbs</p> <p>12/6/24 171.5 Lbs</p> <p>**Out of 40 opportunities from 12/6/24 to 1/15/25, to obtain a daily weight, only 13 weights were recorded.</p> <p>During an interview on 1/13/25 at 2:51 p.m., R20 voiced concern about food choices, adding he didn't always eat the food because he didn't like it. He did not know if he had lost weight because of this. Upon review of his EMR (electronic medical record), R20 had a physician order for daily weights. Upon review of R20's recorded weights, daily weights were not consistently recorded. The last recorded weight was on 1/7/25.</p> <p>(continued on next page)</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/15/25 at 10:35 a.m., physical therapist (PT)-I stated she knew R20 needed daily weights, so when she walked him, which was about three times a week, she weighed him. PT-I stated she reported the weight to a NA who wrote it down. PT-I stated the facility had two scales and recently they had not been working.</p> <p>During an interview on 1/15/25 at 2:02 p.m., RN-B looked in R20's EMR and read part of the care plan: report daily weight refusals to nurse. RN-B verified R20 had an order for daily weights and that his last recorded weight was on 1/7/25. RN-B did not recall being informed that R20 had refused to be weighed.</p> <p>During an interview on 1/16/25 at 8:23 a.m., nursing assistant (NA)-C stated residents were weighed on shower days. NA-C stated if a resident was supposed to have a daily weight, she did not know that -- someone would need to tell her. NA-C stated if a resident refused a weight, she would tell the NA on the on-coming shift so they could obtain it; she would not tell a nurse.</p> <p>During an interview on 1/16/25 at 8:33 a.m., NA-D stated if a resident needed a daily weight, it would be indicated in POC (Point of Care - an electronic documentation platform used by nursing assistants). NA-D looked and stated R20 got a daily weight in the morning. NA-D stated she would document if he refused and tell a nurse, but that R20 didn't refuse much unless he didn't feel good.</p> <p>During an interview on 1/16/25 at 9:12 a.m., R20 stated the only person who weighed him was PT-I when they walked to the scale. R20 stated if PT-I didn't weigh him, it didn't get done. R20 stated he had not refused a weight if asked.</p> <p>R23's facesheet printed on 1/16/25, included diagnosis of stroke.</p> <p>R23's admission MDS dated [DATE], indicated severe cognitive impairment. R23 had clear speech, was usually understood and could usually understand. R23 required supervision or moderate assistance with most ADLs and was ambulatory with supervision.</p> <p>R23's physician orders dated 11/4/24, indicated weights 2x per week to monitor weight, in the evening every Thursday and Sunday.</p> <p>R23's care plan dated 11/11/24, indicated a potential nutritional problem related to need for mechanically altered diet and to monitor weights.</p> <p>R23's recorded weights (R23 was to have measured weights 2x per week):</p> <p>1/2/25 198.4 Lbs (pounds)</p> <p>12/26/24 196.7 Lbs</p> <p>12/19/24 195.6 Lbs</p> <p>12/11/24 195.0 Lbs</p> <p>12/5/24 199.6 Lbs</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058 | |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>12/1/24 200.0 Lbs</p> <p>**Out of 13 opportunities from 12/1/24 to 1/12/25, to obtain a measured weight, only six were recorded.</p> <p>Review of R23's progress notes indicated a number of refusals for eating and getting up/out of bed. No documentation of refusals to be weighed.</p> <p>During an interview on 1/15/25 at 10:02 a.m., NA-A stated if a resident had an order for measured weights, it would be in POC. NA-A did not know which residents on Prairie unit had orders for a measured weight.</p> <p>During an interview on 1/15/25 at 2:02 p.m., RN-B stated weights were terrible around here, adding she kept reminding the NA's, but guessed they are too busy. RN-B stated some NA's carried a paper task list, but information on the list was minimal. RN-B looked in R23's EMR and verified he was to be weighed twice a week - Thursday and Sunday, and his last recorded weight was on 1/2/25. RN-B stated the scales hadn't been working and thought maintenance had been made aware.</p> <p>During an interview on 1/16/25 at 8:33 a.m., NA-D stated if a resident needed to be weighed, it would be indicated in POC. NA-D looked and stated R23 was to be weighed on Thursday and Sundays. NA-D stated she would document if he refused and tell a nurse. NA-D did not recall R23 refusing to be weighed but she had not worked with him for a while.</p> <p>During an interview on 1/16/25 at 9:25 a.m., RN-A stated the process for communicating to NA's that a resident needed to be weighed started with a provider order which was entered into POC and put on the NA paper task list. RN-A stated it was expected that if a resident refused to be weighed, the NA would tell the nurse, who would evaluate why the resident refused and perhaps get the order modified. RN-A provided a NA task list for Prairie unit which indicated R20 was to have a daily weight. There was no indication for obtaining a weight for R23. RN-A stated not all NA's used the task list. RN-A was aware R20 sometimes refused care, but had not been informed he refused to be weighed. RN-A was not aware of R23 refusing to be weighed.</p> <p>During an interview on 1/16/25 at 11:17 a.m., maintenance director (MD)-A stated staff called him on 1/10/25, about one scale not working and he told them how to replace the battery, adding he guessed it wasn't working right.</p> <p>During an interview on 1/16/25 at 12:56 p.m., in the absence of the DON, regional clinical director and regional clinical support were informed of findings and both indicated they expected staff to adhere to physician orders, policies and procedures and the DON was responsible for ensuring this occurred.</p> <p>The facility Resident Weight & Height policy dated 1/2025, indicated the purpose was to have an ongoing record of the resident's weight as an indicator of nutritional status and medical condition. Ongoing weights should be obtained monthly unless otherwise ordered by the provider. Resident weight results should be documented.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility Requesting, Refusing and/or Discontinuing Care or Treatment policy dated 1/2025, indicated residents had a right to refuse treatment prescribed by his/her healthcare practitioner. If a resident refused care, the unit manager, charge nurse or director of nursing would meet with the resident to determine why the resident was refusing care, address concerns and discuss potential outcomes of the residents decision. Detailed information relating to the refusal of care or treatment would be documented in the resident's medical record. The healthcare practitioner must be notified of refusal of treatment.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on observation, interview and document review, the facility failed to ensure weekly comprehensive skin assessments (including measurements) were completed for 2 of 2 residents (R16 and R20) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R20's facesheet printed on 1/16/25, included diagnoses of coronary artery bypass surgery, heart failure, diabetes, and chronic kidney disease.</p> <p>R20's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 required moderate assistance with activities of daily living (ADL). R20 had no risk of pressure ulcers, no unhealed pressure ulcers and no current pressure ulcers. R20 walked with staff assistance.</p> <p>R20's physician orders dated 12/3/24, indicated skin check on every Tuesday in the afternoon.</p> <p>R20's care plan dated 12/5/24, indicated R20 had the potential for skin integrity impairment related to decreased baseline functional ability due to recent surgery and hospitalization . R20's skin would remain free of skin integrity issues through next review period. Interventions included staff to inspect skin PRN (as needed) with cares and a licensed nurse was to observe skin weekly.</p> <p>R20's care area assessment (CAA) for pressure ulcers dated 12/4/24, triggered for pressure ulcer related to functional limitations and medical diagnosis. MASD (moisture associated skin damage) present to peri area/buttocks, mepilex (foam dressing pad) and barrier cream applied. No pressure ulcers. No scars over bony prominence. No other ulcers, skin tears. Pressure reduction gel cushion in WC (wheelchair). Pressure reduction mattress. Braden score 22 (indicating low risk for development of a pressure ulcer).</p> <p>Review of R20's skin checks titled Skin Evaluation Initial/Weekly since admission on 11/27/24, indicated that over the course of eight weeks, weekly skin checks were done only five times: 11/27/24, 12/14/24, 12/23/24, 12/31/24, and the last skin check was done on 1/14/25. No indication of MASD to coccyx or wound to right heel.</p> <p>Provider visit notes dated 1/15/25, indicated an approximately 1 cm (centimeter) x 1 cm scabbed area to right heel, and an approximately 2 cm x 1 cm open area to coccyx. Wound bed was 100% slough, no drainage. Assessment and plan indicated pressure injury of right heel, unstageable. Cleanse heel with wound cleaner, apply Betadine (antiseptic) daily to right heel. Wound care referral. Heel protectors on while in bed. Pressure injury to sacral region, unstageable. Cleanse with wound cleaner, apply foam dressing and change every three days. Offload coccyx area.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview and observation on 1/13/25 at 2:42 p.m., R20 stated he had a sore on his right heel, acquired at the facility. R20 was lying in bed and moved his right leg out from under the blankets. Observed a small round, approximately 1 cm diameter wound to the back of his right heel. The wound was dry and the skin around it was pink. R20 stated no one looked at his heels. R20 stated he had a sore on his coccyx too, but it had healed. During review of the EMR did not see skin checks or wound assessments indicating a heel wound. No wound care orders. Nothing mentioned in progress notes.</p> <p>During an interview on 1/15/25 at 9:59 a.m., observed nurse practitioner (NP)-H in room with R20. NP-H stated she was not aware of a wound to R20's heel; she would have to look at her notes.</p> <p>During an interview on 1/15/25 at 10:00 a.m., licensed practical nurse (LPN)-B had not been informed R20 had a sore on his heel but would look when she gave him his medications.</p> <p>During an interview on 1/15/25 at 10:04 a.m., with both registered nurse (RN)-B and NP-H, RN-B stated she was not aware of a wound to R20's heel. NP-H looked in the EMR and stated there was no documentation of it. NP-H stated R20 told her he had it for about a week. NP-H described it as a 1 x 1 cm pressure wound, unstageable. NP-H stated R20 also had a pressure wound on his coccyx that had opened up again. RN-B stated the wound on his heel was likely from R20 wearing leather sandals without socks.</p> <p>During an interview and observation on 1/16/25 from 11:47 a.m. to 11:52 a.m., observed R20's wound to his coccyx. No dressing had been over it. No socks on his feet nor were his heels off-loaded. Observed a small, round, whitish scab, approximately 1 x 1 cm. No drainage. Skin around wound normal color. LPN-B stated she would return later to dress it. LPN-B stated typically this type of information was passed on to the next shift during nurse-to-nurse shift report but it had not been, nor was it noted on their hand written hand-off form.</p> <p>During an interview on 1/16/25 at 12:00 p.m., RN-A stated he was not aware R20 had pressure wounds. RN-A stated he should have been informed as this was urgent - a change in condition. RN-A stated typically RN-B would have told him after provider rounds, indicating this is what we found, this is what the NP wants us to do then I would get started on the nursing end of it by putting prompts in the TAR (treatment administration record) and in POC (Point of Care in the EMR). RN-B stated he would have looked at the wounds himself and made sure they had supplies such as dressings and heel boots. RN-B stated they probably did not have any heel boots on hand. RN-A looked in the EMR and noted RN-B had come back last evening (1/15/25) and entered the new wound care orders into the EMR. RN-A stated skin checks were supposed to be done weekly on shower days. RN-A stated the TAR in the EMR prompted the nurse, and NA's let the nurse know when they were ready for a skin check when giving a shower. RN-A stated nursing staff say they don't have time to do skin checks .a more appropriate answer would be there was no management to make sure it was prioritized .with one nurse, it was hard to do it all.</p> <p>During a telephone interview on 1/16/25 at 12:21 p.m., RN-B stated she came back last evening (1/15/25) to enter wound care orders given by NP-H earlier in the day. RN-B stated she talked to the evening shift nurse but did not specifically tell her to pass R20's new wound findings and orders on to the next shift. RN-B was aware there were no spare heel boots or heel protectors on hand which was why they had not been started right away.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/16/25 at 12:56 p.m., in the absence of the DON, regional clinical director and regional clinical support were informed of findings and both indicated they expected staff to adhere to physician orders, policies and procedures and the DON was responsible for ensuring this occurred.</p> <p>44630</p> <p>R16's admission MDS assessment dated [DATE], indicated R16 was admitted to the facility on [DATE], cognitively intact, no rejection of care, required partial/moderate assistance with personal hygiene, dependent on staff for toileting, shower/bathe, lower body dressing, and transfers; diagnoses included unstageable pressure ulcer of the right heel, and osteomyelitis (infection of the bone); skin conditions indicated R16 was at risk of developing pressure ulcers/injuries, no unhealed pressure ulcers/injuries, had infection of the foot, other open lesion on the foot, surgical wounds; skin treatments included pressure reducing device for chair and bed, surgical wound care, application of ointments/medications other than to feet, application of dressings to feet. The MDS failed to indicate R16 had a unstageable heel pressure ulcer/injury.</p> <p>R16's care plan printed on 1/14/25, indicated R16 had self care deficit related to morbid obesity and decreased functional ability due to bilateral pressure injury to heels, needed assist with ADL's (activities of daily living), alteration in skin integrity r/t (related to) pressure ulcer to bilateral heels and interventions included administer treatments as ordered and observe for effectiveness, assist/encourage to float heels while in bed, measure wound weekly; update MD (medical doctor) PRN (as needed) with change, observe for s/sx (signs/symptoms) of infection, and wound vac in place on right heel wound to promote wound healing.</p> <p>R16's document titled Wound Observation Tool dated 12/11/24, registered nurse (RN)-A, known as the assistant director of nursing and infection prevention nurse, indicated first observation of the wound, admitted with a unstageable left heel pressure wound, 20% epithelial (outer layer) tissue present, 5% granulation tissue present, 75 % necrotic (dead cells) tissue present , 100% moist, scant serosanguinous (containing both blood and serum) drainage, measurements included length 3 cm (centimeters), width 4.5 cm, and depth 0.5 cm, treatment: clean with betadine (topical antiseptic), cover with gauze, wrap with ace wrap.</p> <p>R16's wound observation tool document dated 12/16/24, RN-B indicated length 3 cm, width 4 cm, dept 0 cm, and no drainage, unchanged overall impression, 20 % slough, 90% necrotic tissue.</p> <p>R16's skin evaluation document dated 12/19/24, RN-F indicated previous skin impairments of right iliac crest (redness), left iliac crest (redness), groin (redness), right heel (wound vac), left heel (wound) and posterior left skin fold (redness). The document failed to include measurements.</p> <p>R16's skin evaluation documented dated 1/2/25, licensed practical nurse (LPN)-B indicated previous skin impairments of right iliac crest, left iliac crest, right heel, left heel. The document failed to include type of impairment and measurements.</p> <p>On 1/13/25 at 12:03 p.m., the R16 was lying in bed with foam cushioned boots on bilateral feet, and wound vac present on right heel. R16 stated he was admitted to the facility with pressure ulcers of the right and left heel.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/14/25 at 9:19 a.m., medical doctor (MD)-G and LPN-A were present in R16's room. MD-G observed the left heel, LPN-A removed the dressing from the left heel. MD-G described the left heel and stated new tissue had started to form, and stated the heel was healing. MD-G further stated weekly comprehensive skin assessment with measurements were expected. LPN-A was observed to place a new dressing on the left heel and no measurements were observed.</p> <p>On 1/15/25 at 8:13 a.m., R16 was lying in bed and stated he does not recall the last time staff took measurements of the left heel. R16 stated staff had used his personal cell phone to take pictures of the wound, and R16 stated the pictures needed to be sent to the wound doctor.</p> <p>On 1/15/25 at 8:22 a.m., RN-B stated R16 came with pressure wounds of bilateral heels, and confirmed the last wound check with measurements was 12/16/24. RN-B stated a comprehensive wound assessment with measurements was expected weekly and documented.</p> <p>On 1/15/25 at 8:26 a.m., nurse practitioner (NP)-H stated she was familiar with R16 and confirmed pressure ulcers of bilateral heels. NP-H stated weekly wound assessment with measurements were expected and documented. NP-H stated pictures on R16's phone were not the only documentation expected completed of R16's wounds.</p> <p>On 1/15/25 at 8:32 a.m., RN-G stated skin checks of all residents were expected weekly and the nurse assigned to the hall was responsible for the resident's skin check on their bath day. RN-G stated for residents with wounds a comprehensive wound assessment was expected and documented weekly. RN-G stated due to not enough staff and the acuity of the residents at the facility residents comprehensive wound assessments were not completed weekly.</p> <p>On 1/15/25 at 8:34 a.m., RN-A, known as the ADON and infection prevention nurse, stated nursing was responsible for weekly comprehensive wound assessments and documented measurements. RN-A confirmed R16 did not have weekly comprehensive wound assessments. RN-A stated previously RN-G was responsible for weekly comprehensive wound assessments, however with the shortage of staff, the facility no longer had an assigned wound nurse. RN-A stated the director of nursing and the regional clinical support staff were made aware last week skin checks were not able to be completed due to the acuity of the residents and shortage of staff.</p> <p>On 1/15/25 at 2:31 p.m., RN-D, known as the regional nurse specialist, and RN-H, known as the regional clinical director, stated today when reviewing residents, they became aware missing skin assessments, and stated prior to today they had not been aware skin assessments were not done weekly. RN-H stated pressure ulcers were expected measured weekly with a comprehensive assessment documented, and further stated wounds were expected discussed during IDT (interdisciplinary team) meetings.</p> <p>The facility Pressure Management policy dated 1/2025, indicated federal regulations require long-term care facilities to actively prevent and effectively treat pressure injuries. Each facility was to ensure a resident who enters the facility without a pressure injury doesn't develop pressure injuries, unless the resident's clinical condition demonstrates that they were unavoidable, and that a resident who has pressure injuries receives the necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure injuries.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility Wound Care policy dated 1/2025, indicated complete the necessary documentation within the resident's medical record which may include observations of the wound, Note any abnormal observations made or any change in the condition. Report other information in accordance with facility policy and professional standards of practice.</p> <p>The facility Bathing Assistance policy dated 1/2025, indicated to notify the RN if any new bruises, open sores, or skin irritations are discovered.</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 2 of 2 residents (R20, R22) reviewed for restorative services.</p> <p>Findings include:</p> <p>R20's facesheet printed on 1/16/25, included diagnoses of coronary artery bypass surgery, heart failure, diabetes, and chronic kidney disease.</p> <p>R20's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 required moderate assistance with activities of daily living (ADL). R20 had no behaviors except rejection of care 1-3 days during MDS assessment period. R20 walked with staff assistance.</p> <p>R20's physician orders dated 11/27/24, indicated PT/OT (physical therapy/occupational therapy) for strengthening.</p> <p>R20's care plan dated 11/27/24, indicated R20 had a self-care deficient related to increased weakness from baseline due to recent hospitalization and surgery. R20's care plan goal was to maintain and increase strength by ambulating in the corridor 80-100 feet with gait belt and FWW (front wheeled walker).</p> <p>R20's rehabilitation (rehab) paper communication/instruction sheet for restorative nursing dated 1/6/25, indicated R20 should walk with 4WW (4-wheeled walker) with CGA (contact guard assist -- where caregiver provides light touch to help with balance) to nurses station and back to room three times a day.</p> <p>Review of R20's EMR (electronic medical record) TASK tab, which was where nursing assistants (NA's) looked to determine cares they were to provide for each resident, did not identify R20 to be on a walking program.</p> <p>During an interview on 1/13/25 at 2:45 p.m., R20 stated he was supposed to be walked, but no one ever asked him to walk. R20 stated physical therapy told him nursing staff were supposed to walk, but they don't. R20, who had open heart surgery stated he planned to go home eventually and needed to get stronger to do that.</p> <p>During an interview on 1/15/25 at 10:35 a.m., physical therapist (PT)-I stated she put R20 on a walking program but didn't know what kind of follow through was happening with restorative nursing -- if they were walking R20 or not. PT-I stated R20 never refused when she asked him to walk. PT-I stated staff tell her they walk R20, but likely not as much as she did or potentially as much as he would like. PT-I stated the walking program she put R20 on was for three times a day, walking to the nurses station and back. PT-I stated PT referral forms for restorative nursing were given to the director of nursing (DON) for continuation of care.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058 | |
| 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) | | |
| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/16/25 at 8:23 a.m., nursing assistant (NA)-C did not know if R20 was on a walking program. If a resident refused walking, NA-C told the NA on the on-coming shift so she would do it; she did not tell a nurse.</p> <p>During an interview on 1/16/25 at 8:28 a.m., registered nurse (RN)-A stated when therapy placed a resident on a restorative program such as walking or ROM, therapy staff provided nursing with a paper communication/instruction sheet. RN-A stated he then entered the exercise instructions into the TASK tab of the EMR for NA's to carry out. RN-A stated he also added the instructions to the residents care plan and the paper NA task list. RN-A provided a copy of the NA paper task sheet, and a walking program was not indicated for R20. When informed walking was not listed in the TASK tab for NA's to perform, RN-A stated he didn't know why that was as he had only recently started adding to resident care plans and the TASK tab -- usually that would have been done by the DON.</p> <p>During an interview on 1/16/25 at 8:33 a.m., NA-D stated R20 used to be on a walking program, but he wasn't any longer. NA-D obtained her iPad to look at TASKS in the EMR and stated R20 did not have walking listed as a task for NA's to do. If a resident refused walking, NA-D stated she would tell a nurse and try again later. NA-D stated we don't always have time to do restorative nursing - depends on the day - we aren't always staffed like this with four NA's on the day shift. NA-D stated they were only staffed with four NA's because State was here.</p> <p>R22's facesheet printed on 1/16/25, included a diagnosis of amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrigsdisease (a progressive disease that weakens muscles and impacts physical function).</p> <p>R22's significant change MDS assessment dated [DATE], indicated R22 was cognitively intact, had clear speech, could understand and be understood. R22 required substantial assistance or was dependent upon staff for ADLs. R22 did not walk independently.</p> <p>R22's physician orders did not identify physical or occupational therapy evaluation/treatment.</p> <p>R22's care plan dated 9/26/24, indicated to complete ROM exercises per therapy orders. Care plan dated 10/4/24, indicated R22 received restorative nursing related to left shoulder disorder, weakness, ALS, and muscle atrophy (wasting away of part of the body). ROM exercises to upper extremities/shoulders in place to support current level of function and ROM. R22 would continue to be able to participate in ROM exercises daily through next assessment. Report and document resident refusals to participate in ROM exercises. Follow restorative nursing program as noted in TASKS.</p> <p>During an interview on 1/13/25 at 2:19 p.m., R22 stated he was supposed to have ROM to his arms every day. R22 stated he wanted ROM to his arms so they didn't lock up. Observed several sheets of ROM instructions with illustrations taped to R22's wall, between his recliner and bed. Instructions were more for his legs than his arm.</p> <p>Review of the EMR from 12/17/24, to 1/11/25, under the TASK tab which was where NA's looked for what cares to provide residents and to document these cares, indicated the following:</p> <p>1. Passive ROM in all shoulder planes daily as tolerated. Out of 24 opportunities, 20 entries recorded 2 to 25 minutes of ROM to shoulders. Three refusals were documented. The last date of documentation of this task was on 1/11/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. Assist with passive ROM to BUE (bilateral upper extremities) 2 x per day. See handout for help (e.g., instructions taped to R22's wall). Question 1 of the task directed NA's to document the number of MINUTES spent providing passive ROM. Out of 48 opportunities, 21 entries recorded 2 to 25 minutes. Three refusals were documented. The last date of documentation of this task was on 1/11/25.</p> <p>3. Assist with passive ROM to BUE 2 x per day. See handout for help. Question 2 of the task directed NA's to document the number of REPETITIONS of this exercise. Out of 48 opportunities, 19 entries recorded 3-40 repetitions. Three refusals were documented. The last date of documentation was on 1/11/25.</p> <p>During an interview on 1/14/25 at 9:30 a.m., NA-E stated R22 liked when she did ROM to his arms. NA-E stated R22 wanted her to do ROM yesterday, but she did not because she didn't have time, adding they frequently don't have time due to short staffing.</p> <p>During an interview on 1/15/25 at 10:44 a.m., PT-I stated R22 was discharged from occupational therapy (OT) and was handed off to NA's for restorative nursing. PT-I provided a copy of OT's recommendations to nursing for continued therapy, dated 10/8/24. Recommendations included:</p> <p>--ROM LE (left arm) AROM (assisted ROM) with 3-pound weights as tolerated</p> <p>--PROM (passive ROM) 2 x daily (no further specificity)</p> <p>These instructions were different than what was identified in the TASK tab in the EMR and different than the instructions posted in R22's room. PT-I was not aware of that and could not explain why, adding the occupational therapist who wrote the instructions no longer worked at the facility.</p> <p>During an interview on 1/15/25 at 1:47 p.m., RN-B stated R22 refused things, but later complained it wasn't done. RN-B looked at R22's care plan in the EMR and verified R22 was to have ROM exercises to upper extremities and shoulders, and to document if he refused. RN-B confirmed there were no progress notes indicating refusals.</p> <p>During an interview on 1/16/25 at 8:23 a.m., NA-C was asked how she knew if a resident needed ROM exercises. NA-C removed a paper task list from her pocket and there was nothing listed for R22 for ROM -- she was not aware if R22 was to receive ROM. NA-C stated she assumed if exercises were posted on a residents wall, they were for a resident to do on his/her own.</p> <p>During an interview on 1/16/25 at 8:28 a.m., RN-A stated NA's performed restorative services for residents including ROM exercises. RN-A was informed not all NA's knew R22 should have assistance with ROM exercises despite it being on his care plan and in the TASK tab for NA's. RN-A stated he was not aware and generally that would be something the DON would monitor.</p> <p>During an interview on 1/16/25 at 8:33 a.m., NA-D stated R22 received ROM to his arms, but NA's did not always have time to do it -- it depended on the day. NA-D did not recall R22 refusing. NA-D further stated if R22 refused, she would usually ask again later and report it to a nurse.</p> <p>(continued on next page)</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/16/25 at 12:56 p.m., in the absence of the DON, regional clinical director and regional clinical support were informed of findings and both indicated they expected staff to adhere to physician orders, policies and procedures and the DON was responsible for ensuring this occurred.</p> <p>The facility Restorative Nursing Services policy dated 1/2025 indicated residents would receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitation care. The resident or representative would be included in determining goals and the plan of care.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on observation, interview and document review, the facility failed to conduct a comprehensive reassessment after falls to identify root cause and ensure new interventions were implemented to prevent further falls for 1 of 2 residents (R79) reviewed for falls.</p> <p>Finding include:</p> <p>R79's admission Minimum Data Set (MDS) assessment dated [DATE], indicated moderate cognitive impairment, dependent on staff for putting on/taking off footwear, sit to stand, chair/bed to chair transfer, toilet transfer, required substantial/maximal assistance with dressing, shower/bathe, personal hygiene, sit to lying, utilized a wheelchair, diagnoses included left femur fracture, non-Alzheimer's dementia, anxiety, depression, age related physical debility, fall in the last month, and a fracture related to a fall in the last six months, fall since admission or the prior assessment, two or more falls with no injury since admission.</p> <p>R79's care plan printed 1/14/25, indicated potential for injury r/t (related to) impaired mobility due to left hip fracture, impaired cognition dementia, antidepressant, narcotic, diuretic medication, impaired hearing, history of falls, has limited ROM (range of motion) LLE (left lower extremity); interventions included: bed at appropriate height, encourage resident to wear appropriate footwear, keep bed in lowest position, place fall mats on floor next to bed, when resident is in bed, keep call light within reach in bedroom and encourage resident to utilize it, urinal at bedside for falls prevention.</p> <p>R79's fall incident report dated 1/4/25, indicated R79 was on the floor in his room, lying on the floor in front of his recliner with the legs of the chair still extended, resident's positioning appeared R79 had crawled out of the recliner to the floor. R79 indicated he was getting out of that to go do the chores, and unable to tell actual events leading to him being on the floor due to confusion suspected related to his dementia. Immediate action taken included R79 was assessed and denied any pain, no evidence during assessment indicating any injuries occurred; absence of bruising, skin tears, redness, or pain with palpation, vitals taken, assisted to wheelchair appeared pleasantly confused throughout the shift as evidenced by his conversation with staff; several conversations pertained to him having to go get the chores done and/or the acreage he is currently farming, potentially hallucinating. The incident report failed to indicate new interventions related to the fall.</p> <p>R79's fall incident report dated 1/8/25, indicated staff via walkie talkie that assistance was needed in R79's room. Upon arrival, R79 was seated on the floor of his room facing the door and resting his back against recliner. R79 was unable to explain to staff what had happened or what he was trying to do. Resident Immediate Action Taken vital signs, pain, and range of motion were assessed while R79 was on the floor and found to be within normal limits, lifted from the floor using two assist via the hooyer lift, neurological assessments were initiated d/t (due to) suspicion of a head strike by the kitchen staff who witnessed the fall. The incident report failed to include predisposing factors and new interventions to prevent further falls.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Progress note dated 1/10/25 at 11:02 a.m., the administrator indicated in regards to the influenza outbreak, family expressed concerns about R79 being a fall risk, would rather have R79 be out at the nurses station or in activities than be in his room.</p> <p>On 1/13/25 at 12:58 p.m., R79's family member (FM)-K stated R79 had fell three times since he was admitted to the facility. FM-K stated she discussed the falls with the administrator and asked when R79 was awake staff have R79 in his wheelchair at the dining area located near the nursing station for increased supervision. FM-K stated when visiting R79 he was frequently found awake in his room in bed and not located at the nursing station as discussed with the administrator. FM-K stated one fall was from the electric recliner and FM-K was unaware if R79 was assessed to use the recliner, and another fall was related to R79 brought back to his room and seated in the wheelchair or recliner and self-transferred. FM-K stated R79 was frequently confused and required redirection.</p> <p>On 1/14/25 at 11:02 a.m., the administrator stated when a resident had a fall a comprehensive assessment was expected in the electronic medical record (EMR). The administrator stated the nurse present at the facility at the time of the fall was expected to implement immediate intervention, and the IDT (interdisciplinary team) met daily to discuss falls. The administrator confirmed the facility had a large gap related to falls and implementation of interventions and completion of a comprehensive assessment post falls. The administrator stated after a fall a comprehensive assessment into the cause of the fall and implementation of interventions were expected and expected the care plan updated to include the interventions. The administrator confirmed the director of nursing (DON) was overall responsible to ensure a comprehensive reassessment was conducted after a fall incident to identify root cause and ensure new interventions were implemented to prevent further falls. The administrator stated after R79's fall on 1/4/25, the interventions included observation of R79 while awake and have R79 at the dining area located by the nursing station. The administrator stated she educated the ADON (assistant director of nursing) regarding the interventions and entered a note in the EMR. The administrator confirmed the care plan was not updated as expected with the new interventions. The administrator stated R79 had a fall on 1/8/25, and confirmed no new interventions were put in place to prevent further falls. The administrator stated the IDT met and discussed R79's fall that occurred on 1/8/25, and the DON was not able to come to a conclusion regarding the fall to implement fall interventions.</p> <p>On 1/14/25 at 11:12 a.m., registered nurse (RN)-D, known as regional nurse specialist, stated after a resident fall the nurse was expected to enter the fall into risk management in the EMR. The facility was expected to complete a comprehensive fall investigation which included a root cause analysis, and implement a new intervention, and the care plan updated with the new intervention. RN-D stated IDT met and discussed falls. RN-D stated the DON was responsible to ensure a comprehensive fall investigation was completed, and further stated she was not sure who was responsible for ensuring the care plan was updated. RN-D confirmed a comprehensive assessment and new interventions were not implemented after R79's fall on 1/8/25, and the interventions discussed after R79's fall on 1/4/25 were not included on the care plan.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/14/25 at 11:30 a.m., RN-A, known as the assistant director of nursing, stated he was only aware of R79 having one fall since admission. RN-A stated IDT met daily and discussed falls, and were expected to discuss cause and new interventions related to the fall. RN-A stated he was not able to attend IDT daily due to having to work the floor as nurse, pass medications, and complete resident treatments. RN-A confirmed the new interventions were not consistently placed on the care plan, and were important to ensure staff were aware of the interventions to prevent falls. RN-A stated he was not given education regarding R79 expected at the nursing station when awake.</p> <p>On 1/14/25 at 2:17 p.m., R79's door was closed, upon entering R79's room he was awake and seated at the edge of his bed in a gown.</p> <p>On 1/14/25 2:26 p.m., nursing assistant (NA)-E stated R79 was not a fall risk, not aware of any interventions to prevent falls, and fall interventions were expected reported in shift report and on the care plan. NA-E stated R79 had been awake in his room throughout the day.</p> <p>On 1/14/25 at 2:49 p.m., R79's door remained closed, and entering the room R79 was still awake and seated at the edge of the bed.</p> <p>On 1/14/25 at 2:52 p.m., trained medication aide (TMA)-A confirmed R79 was a fall risk and stated when R79 was in his room the door was expected open.</p> <p>On 1/14/25 at 3:43 p.m., R79 was seated in the dining area located near the nursing station. R79 stated he gets bored lying in bed all day and was glad to be out of his room.</p> <p>On 1/14/25 at 3:54 p.m., NA-F confirmed R79 had fell while at the facility, and stated R79's door was expected open and while awake he was expected near the nursing station for staff to keep an eye on him.</p> <p>On 1/14/25 at 2:28 p.m., NA-G stated today was her first day at the facility as agency staff. NA-G stated she was not educated R79 was a fall risk, and did not have access to the EMR to access resident care plans to know interventions R79 may have related to falls.</p> <p>On 1/15/25 at 2:31 p.m., RN-H, known as the regional clinical director, stated the facility was expected to review all falls and the director of nursing (DON) was expected to ensure an intervention was implemented to prevent further falls.</p> <p>On 1/16/25 at 11:40 a.m., RN-D stated an electric lift chair assessment was expected prior to R79 having access to the lift chair, and confirmed R79 had not been assessed to safely use the lift chair in his room, and the lift chair was now unplugged and a sign on the chair not to use.</p> <p>The facility Fall Management policy dated 9/2023, indicated:</p> <ul style="list-style-type: none"> -a fall risk evaluation include a review of the resident's past history of falls, medical and physical history, medication use in attempts to identify factors which may place the resident at higher risk of falls. - an analysis of the fall will be completed <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- additional interventions may be imitated and/or updated as applicable.</p> <p>- the circumstances of the fall will reviewed with the IDT</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all residents who resided in the facility.</p> <p>Findings include:</p> <p>Refer to F676: Based on observation, interview and document review the facility failed to ensure residents received assistance with meals for 3 of 3 residents (R1, R2, and R10) reviewed for dining who required staff assistance and/or supervision with meals.</p> <p>Refer to F684: Based on interview and document review, the facility failed to monitor weights per physician order for 1 of 1 resident (R10) reviewed for edema and 2 of 2 residents reviewed for nutrition (R20 and R23).</p> <p>Refer to F688: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 2 of 2 residents (R20, R22) reviewed for restorative services.</p> <p>Refer to F686: Based on observation, interview and document review, the facility failed to ensure weekly comprehensive skin assessments (including measurements) were completed for 2 of 2 residents (R16 and R20) reviewed for pressure ulcers.</p> <p>Refer to F804: Based on observation and interview, the facility failed to ensure meals were served at a warm and palatable temperature to promote quality of life and nutritional intake for 2 of 2 residents (R22 and R16) reviewed for dining.</p> <p>R16's facesheet printed 1/15/25, indicated diagnosis of osteomyelitis (bone infection).</p> <p>R16's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors, independent with eating, dependent on staff for toileting hygiene, and partial assistance with personal hygiene.</p> <p>R22's facesheet printed on 1/15/25, indicated diagnoses of amyotrophic lateral sclerosis (ALS) and repeated falls.</p> <p>R22's significant change MDS assessment dated [DATE], indicated intact cognition, no behaviors, use of a walker and wheelchair, and dependent on staff for eating, dressing, bathing, and personal hygiene.</p> <p>R22's care plan revised on 9/18/24, indicated a self-care deficit and dependent on staff for his activities of daily living with intervention of one staff assist for bathing.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>R3's facesheet printed 1/15/25, indicated diagnoses of anemia, type 2 diabetes mellitus, chronic pain, and muscle weakness.</p> <p>R3's admission MDS assessment dated [DATE], indicated intact cognition, no behaviors, use of a wheelchair, set up assistance for eating, and substantial assistance with personal hygiene.</p> <p>R2's facesheet printed 1/15/25, indicated diagnoses of heart failure, pain syndrome, and kidney disease.</p> <p>R2's significant change MDS assessment dated [DATE], indicated intact cognition, no behaviors, and dependent on staff for personal hygiene and transfers.</p> <p>R2's care plan printed 1/15/25, indicated self-care deficit and dependent on staff for bathing assistance.</p> <p>R21's facesheet printed 1/15/25, indicated diagnoses of dementia, failure to thrive, and anxiety.</p> <p>R21's quarterly MDS assessment dated [DATE], indicated severely impaired cognition, physical and verbal behaviors, and dependent on staff for personal hygiene and bathing.</p> <p>R21's care plan revised 1/3/25, indicated self care deficit, resident will appear clean, neat, and well kept, and bathing assist of one staff on Monday AM.</p> <p>Call light observations/ staffing interviews</p> <p>During continuous observation on 1/13/25, from 11:40 a.m. to 1:35 p.m., extended call light times were observed for R16, R22, and R3. At 11:40 a.m., R16, R22, and R3 all had their call lights on indicating the need for assistance. R3's call light was answered at 12:54 p.m., R16's call light was answered at 1:12 p.m., and R22's call light was answered at 1:26 p.m. R3's call light was on for one hour and 14 minutes, R16's call light was on for one hour and 32 minutes, and R22's call light was on for one hour and 46 minutes.</p> <p>During interview on 1/13/25, at 12:49 p.m., R22 stated he had been waiting for over an hour to use the urinal. R22 further stated it took up to two hours for his call light to be answered some days and he would be uncomfortable and incontinent if it took too long. R22 stated his son was coming to help him use the urinal due to the long wait time. R22 stated the staff were good, there just were not enough of them to help everyone. R22's son was observed arriving at R22's room and assisting with urinal use.</p> <p>During interview on 1/13/25 at 3:45 p.m., R16 stated it always took a long time for staff to answer his call light, sometimes up to two hours. R16 stated it was a common situation and the facility needed more staff so they could help him sooner and not be so rushed when they did come to help him.</p> <p>During interview on 1/13/25 at 11:46 a.m., nursing assistant (NA)-A stated they did not have enough staff to take care of the residents and it had been happening a lot lately. NA-A stated they got busy after breakfast and were still trying to catch up. NA-A further stated they were not able to answer call lights because so many residents required assistance of two staff and kept them in a residents room for over an hour, and they only had two staff working for the whole building.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058 | |
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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>During interview on 1/14/25 at 8:59 a.m., NA-B stated today had been a better day because state was here so they had started using agency staff so it looked like they had more staff. NA-B further stated they never had four NA's working, but today they were letting four NA's work and were letting people get overtime and stay longer to help, and were offering bonuses, but that never happened.</p> <p>During an interview on 1/14/25 at 9:30 a.m., NA-E stated she had worked at the facility for over a year and had never seen it this bad. Sometimes there were only two NA's on duty and sometimes she was the only NA on duty for a while for the entire facility. Agency NA's started today (1/14/25) and it was her understanding just for the outbreak.</p> <p>During interview on 1/14/25 at 11:11 a.m., NA-E stated she had only worked with herself and one other NA for multiple days and at one time worked by herself. NA-E further stated it was hard to get her work done, she could not get her baths done, and even with three NA's it was hard to take care of the residents because so many residents required two NA's to assist them. NA-E stated she did not get baths done again this morning, could not get walking or range of motion done, and at times residents who were not usually incontinent would be incontinent because she could not get to them in time.</p> <p>On 1/14/25 at 2:26 p.m., NA-E stated resident vitals, weights, baths, and range of motion was not done as expected due to shortage of staff and the length of time some the residents require to assist with their cares.</p> <p>A facility document titled Residents needing assist of two for transferring printed on 1/14/25, indicated 13 of 25 residents required two staff assist for transfers and toileting.</p> <p>Facility call light response logs were requested and not received.</p> <p>Baths</p> <p>During observation on 1/13/25 at 7:00 p.m., no baths were observed completed. Review of the facility bath schedule indicated R22, R2, and R21 were scheduled for baths on 1/13/25. The facility bath schedule printed 1/14/25, indicated R2 and R21 had weekly scheduled baths on Monday and R22 had a scheduled bath twice per week on Monday and Thursday.</p> <p>During interview on 1/14/25 at 9:47 a.m., R2 stated he had not had his bath yesterday because staff told him they were too busy. R2 further stated he would not get a bath until his next bath because staff didn't have time for extra baths.</p> <p>During interview on 1/14/25 at 2:29 p.m., R22 stated he did not get his scheduled bath and it was not offered to him. R22 further stated staff try, but they can't get it all done. R22 stated he didn't think he would get his bath until his next scheduled bath day, but wanted his bath.</p> <p>During interview on 1/14/25 at 2:16 p.m., nursing assistant (NA)-F stated they did not get any baths done yesterday (1/13/25) due to being too busy. NA-F stated she documented that R2 had a bath, but he did not have a bath, and she did that because they had not been able to get baths done and had gotten in trouble for not giving baths so staff document was done so not get in trouble. NA-F stated she was unsure if the baths were rescheduled.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>During interview on 1/15/25 at 8:20 a.m., NA-A stated if baths were missed was not sure how they were rescheduled, or if they just had to wait until the next scheduled bath. NA-A further stated she thought the next shift should do it, but they were busy too.</p> <p>During interview on 1/14/25 at 12:14 p.m., licensed practical nurse (LPN)-C stated she worked on 1/13/25, and was not aware baths were not done. LPN-C further stated NA's were supposed to tell the nurse if baths were not completed.</p> <p>During interview on 1/15/25 at 8:47 p.m., registered nurse (RN)-C, also known as regional clinical director, stated if residents missed their baths they should have a bath within the next 24 hours if they can. RN-D further stated she was not aware of a facility bath policy.</p> <p>During interview on 1/16/25 at 12:09 p.m., RN-H, also know as regional clinical director, stated she would expect a bath that was missed on 1/13/25 to have happened by now, and should have happened within a reasonable time.</p> <p>A review of facility electronic health record (EHR) task logs for bathing on 1/16/25, indicated R22, R2, and R21 had not had a bath since missing their schedule baths on 1/13/25.</p> <p>Meal assistance</p> <p>On 1/13/25 at 1:47 p.m., the administrator stated she was asked by the nursing assistants to assist feeding R22 his meal. The administrator stated residents were crying to go back to bed, and stated when we only have two NA's on the floor things don't function and we need three NA's to function. The administrator stated when the facility doesn't have three NA's during the day shift, its a bad day, stressful things might get put behind. The administrator stated the nurse managers help when they are present at the facility, however RN-A and RN-B had to go home so they can can work evening and overnight shift. The administrator stated due to the staffing shortage and situation she had opened shifts to agency staff starting tomorrow (1/14/25).</p> <p>On 1/14/25 12:48 p.m., activities aide (AA)-B stated all the food had been delivered to resident, expect for R19's food as he required staff assistance with eating.</p> <p>On 1/14/25 12:53 p.m., NA-C stated R19 required staff assistance with eating and there were not staff available to help him eat yet.</p> <p>On 1/14/25 at 12:56 p.m., the administrator stated R19 was expected to have not had to wait for until now for staff assistance with eating.</p> <p>Facility Assessment</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Review of facility assessment dated ,d+[DATE], indicated the facility reviewed acuity within their resident population and listed 15-25% of residents and clinically complex and 30-40% of residents with reduced physical function. The facility assessment listed 30-40% of residents dependent for transfers and 25-35% dependent for toileting, and 87% of residents in a chair most of the time. The facility uses a comprehensive admission assessment process to identify individualized resident care needs and determine if the facility can meet the resident's need. The facility staffing plan within the facility assessment indicated they used a resident based approach to staffing which was based on the resident population and adjusted as necessary based off of shift day, evening, and overnight.</p> <p>Staffing Schedules</p> <p>Review of facility's nursing schedules for 12/15/24 through 1/14/25 lacked the required nursing assistants and nurses for the following based on facility assessment:</p> <p>12/15: NA 6 hours</p> <p>12/16: NA 3 hours</p> <p>12/17: NA 2 hours, Nurse/TMA 3.5 hours</p> <p>12/19: NA 2 hours</p> <p>12/23: NA 8 hours</p> <p>12/25: NA 8 hours</p> <p>12/26: NA 8 hours, Nurse/TMA 8 hours</p> <p>12/27: Nurse/TMA 8 hours</p> <p>12/28: NA 2 hours, Nurse/TMA 3.5 hours</p> <p>12/29: NA 2 hours</p> <p>12/30: NA 1.5 hours, Nurse/TMA 3.5 hours</p> <p>01/02: NA 2 hours</p> <p>01/03: NA 3 hours, Nurse/TMA 4.5 hours</p> <p>01/04: Nurse/TMA 2.5 hours</p> <p>01/06: NA 3.5 hours, Nurse/TMA 7 hours</p> <p>01/07: NA 4.5 hours, Nurse/TMA 8 hours</p> <p>01/08: NA 2 hours</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>01/09: NA 18 hours</p> <p>01/11: NA 4 hours</p> <p>01/12: NA 16.5 hours, Nurse/TMA 8 hours</p> <p>01/13: NA 24 hours, Nurse/TMA 8 hours</p> <p>01/14: NA 10 hours</p> <p>44630</p> <p>On 1/14/25 at 2:37 p.m., RN-A, known as the assistant director of nursing and infection prevention nurse, confirmed due to not enough staff NA's were not able to give scheduled baths, answer call lights timely, walk or complete ROM with residents. RN-A stated the information about not enough staff was shared with the administrator, and administrator educated nursing staff to have a positive attitude, and help the NA's. RN-A stated the administrator was helping on the floor with resident cares due to the shortage of staff, and the administrator had pulled the business office staff to help with resident cares.</p> <p>The Le Sueur Facility Assessment policy revised 3/2024, indicated the below staffing ratios from the staffing plan: (ratios are staff/residents)</p> <p>Nurses/TMAs</p> <p>Days and evenings:</p> <p>2 licensed nurses 1:22-1:35 ratio</p> <p>1 TMA 1:22-1:35 ratio</p> <p>Nights:</p> <p>1 licensed nurse 1:35 ratio</p> <p>Nursing assistants:</p> <p>Days and Evenings: 1:10 ratio</p> <p>Nights: 1:22 ratio</p> <p>42073</p> |

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| <p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observe each nurse aide's job performance and give regular training.</p> <p>50764</p> <p>Based on interview and document review, the facility failed to ensure annual performance reviews were completed for 4 of 4 nursing assistants (NA-A, NA-F, NA-B, NA-E) whose files were reviewed. This had potential to affect all residents who currently resided in the nursing home and who could receive care from these staff.</p> <p>Findings include:</p> <p>The following nursing assistants (NA)'s personnel records were reviewed for annual performance reviews and identified the following:</p> <p>NA-A was hired on 6/14/23. NA-A's personnel record lacked evidence an annual performance review was ever completed.</p> <p>NA-F was hired on 11/7/23. NA-F's personnel record lacked evidence an annual performance review was ever completed.</p> <p>NA-B was hired on 7/16/18. NA-B's personnel record lacked evidence of a current annual performance review.</p> <p>NA-E was hired on 6/7/21. NA-E's personnel record lacked evidence an annual performance review was ever completed.</p> <p>During interview on 1/15/25 at 8:10 a.m., administrative support stated she did not have any performance reviews for staff in personnel files. She further stated there had been too much leadership turnover and the performance reviews had not been completed.</p> <p>During interview on 1/15/25 at 9:08 a.m., administrator stated she did not have any completed performance reviews that she was aware of. Administrator further stated they had not been done due to change in leadership but she planned to start doing them when she knew the staff better.</p> <p>A policy on performance reviews was requested but not received.</p> |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 1 of 5 residents (R10) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, no rejection of care, required setup or clean up assistance with eating, substantial staff assistance with personal hygiene and diagnoses included non-traumatic brain dysfunction, dementia, Parkinson's disease(progressive brain disorder that affects movement, balance, and coordination), anxiety, depression, and psychotic disorder, taking an antipsychotic.</p> <p>R10's care plan dated 11/20/24, indicated potential for drug interactions and adverse effects r/t (related to) polypharmacy interventions included administer medications as ordered, observe for effectiveness and adverse effects, update MD (medical doctor) PRN (as needed) monthly medication regime review by pharmacy consultant, forward recommendations to MD for review.</p> <p>R10's medication administration record dated 1/1/25-1/31/25, indicated start date 8/6/24, quetiapine fumarate (antipsychotic medication) oral tablet give 50 mg (milligrams) by mouth two times a day related to unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease.</p> <p>R10's Pharmacist Recommendations to Nursing documented dated 10/11/24, consulting pharmacist (CP)-L indicated please add an order for monthly blood pressures or document why this not able to be completed. On the document registered nurse (RN)-B dated 10/13/24, indicated order placed.</p> <p>R10's treatment administration record (TAR) dated 10/1/24-10/31/24, indicated start date 10/14/24, and end date 11/5/24, orthostatic blood pressure one time a day every one month(s) starting on the 14th for 28 day(s) related to anxiety disorder, after resident has been lying down for at least five minutes, measure resident's blood pressure and pulse.</p> <p>R10's record review indicated the last documented orthostatic blood pressure was dated 11/5/24, and R10's record review did not include an order for current monthly orthostatic blood pressures.</p> <p>On 1/16/25 at 12:22 p.m., RN-D, known as the regional nurse specialist, stated R10's order for monthly orthostatic blood pressures was entered incorrectly and the order fell off. RN-D confirmed there was not a correct order for R10 to have monthly orthostatic blood pressures.</p> <p>On 1/16/25 at 12:45 p.m., CP-L stated would expect monthly orthostatic blood pressures on resident on Seroquel, to monitor for side effects.</p> <p>(continued on next page)</p> | | |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility Consultant Pharmacist Medication Regimen Review policy dated 1/2025, indicated evaluating response to drug therapy to assure that each resident receives optimal medication therapy. The residents response to drug treatment is evaluated through the use of lab, physical assessment, medication administration record and other data to determine if the therapeutic goals are achieved. Side effects, adverse reactions and interactions lab test and drug disease. Medical condition and response to drug therapy are used to evaluate medication regime for unnecessary medications.</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on observation and interview, the facility failed to ensure meals were served at a warm and palatable temperature to promote quality of life and nutritional intake for 2 of 2 residents (R22 and R16) reviewed for dining. This had the potential to affect all 25 residents who resided in the facility.</p> <p>Findings include:</p> <p>R22's facesheet printed on 1/16/25, included a diagnosis of amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrigsdisease (a progressive disease that weakens muscles and impacts physical function).</p> <p>R22's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R22 was cognitively intact, had clear speech, could understand and be understood. R22 required substantial assistance or was dependent upon staff for activities of daily living (ADL) including eating. R22 did not walk independently.</p> <p>R22's physician orders dated 9/19/24, indicated a regular diet and assistance with eating meals.</p> <p>R22's care plan dated 9/18/24, indicated R22 had a potential nutritional problem related to diagnosis of ALS, was unable to feed himself and needed total staff assistance at meals. Care plan with revised date of 12/15/24, indicated to serve diet as ordered. Regular diet. Total staff assist with meals in his room.</p> <p>R16's admission MDS dated [DATE], indicated R16 was cognitively intact, no rejection of care, required partial/moderate assistance with personal hygiene, dependent on staff for toileting, shower/bathe, lower body dressing, and transfers; diagnoses included unstageable pressure ulcer of the right heel, and osteomyelitis (infection of the bone).</p> <p>R16's care plan printed on 1/14/25, indicated R16 provide and serve diet as ordered, regular diet, provide and serve supplements as ordered, ensure with meals for nutritional support and to promote wound healing, provide, serve diet as ordered, monitor intake and record meal.</p> <p>Prairie wing/ Kitchen</p> <p>During an observation on 1/13/25 at 12:12 p.m., observed meal trays for Prairie unit left in the hallway on a tall, multi-tiered, open-sided cart on wheels.</p> <p>During an interview on 1/13/25 at 12:18 p.m., R22 stated his meals were always late and his food was always cold - particularly breakfast. R22 stated he always ate in his room. R22 stated this morning (1/13/25), he received a cold fried egg with toast, stating he forced it down and was used to it (cold food).</p> <p>(continued on next page)</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation on 1/14/25 at 8:44 a.m., activity director (AD)-A and activity aide (AA)-B were observed passing breakfast trays. AD-A stated they only set-up meal trays for residents who were awake, otherwise they just left the trays in the residents' rooms. In R22's room, observed R22 was sleeping, and his breakfast tray was setting on his overbed table.</p> <p>During an interview on 1/14/25 at 10:50 a.m., R22 stated his breakfast that morning - a breakfast sandwich - had been cold, but he ate it anyway.</p> <p>During an observation on 1/14/25 at 10:58 a.m., observed cook (C)-A measure the temperature (temp) of food on the steam table:</p> <p>--Turkey and wild rice casserole - 200 degrees Fahrenheit (F)</p> <p>--Mashed potatoes (instant) - 180 degrees F</p> <p>--Mixed vegetables - 194 degrees F</p> <p>During observation on 1/14/25 at 11:30 a.m., in the kitchen, observed staff dish up room trays. (The facility was in influenza outbreak and all residents received meals in their room during the survey period). C-A dished up food onto Styrofoam plates, set the plate on a plastic thermal base (not heated), and covered it with a plastic dome (not heated). Other dietary staff set the plates on trays that were on a tall, multi-tiered, open-sided cart on wheels.</p> <p>Lunch tray delivery observations and interview on 1/14/25:</p> <p>--At 11:42 a.m., the cart on wheels arrived from the kitchen to Prairie unit and was left in the middle of the hallway by the nurse's station.</p> <p>--At 11:47 a.m., the first tray was delivered.</p> <p>--At 12:10 p.m., only two nursing assistants passing meal trays, despite other staff walking past the cart.</p> <p>--At 12:13 p.m., social worker (SW)-A began helping deliver trays.</p> <p>--At 12:26 p.m., requested AD-A to remove the last tray not yet delivered and take it to the dining room off the kitchen to measure temperatures. AD-A was accompanied to the dining room and both the administrator and dietary manager were requested to be present.</p> <p>On 1/14/25 at 12:31 p.m., dietary manager (DM)-F measured the food temps with a digital thermometer as follows:</p> <p>--Mashed potatoes - 129.7 degrees F (approximately five degrees below optimal serving temp)</p> <p>--Mixed vegetables - 125 degrees F (approximately 10 degrees below optimal serving temp)</p> <p>The administrator and surveyor tasted the food for the purpose of assessing the temperature. The administrator stated the potatoes and vegetables were lukewarm. Surveyor concurred.</p> <p>(continued on next page)</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/14/25 at 12:43 p.m., the administrator stated lunch was supposed to be served to residents at 11:35 a.m. The administrator was informed that the last tray on Prairie unit was still on the cart at 12:26 p.m., after standing in the hallway for approximately 45 minutes before all residents received their trays. The administrator stated her expectation was for meal trays to be delivered right away. The administrator stated they would probably go back to using regular plates with warmers instead of Styrofoam plates to retain the heat better. The administrator stated she expected nurses, activities staff and the social worker to help pass trays too. The administrator did not know why more staff didn't assist with meal tray delivery today.</p> <p>On 1/14/25 at 2:01 p.m., (C)-A stated dietary was going back to regular dishes and warmers to keep resident food warm until served.</p> <p>During a telephone interview on 1/14/25 p.m. at 4:37 p.m., registered dietician (RD)-E stated the preferred food temperature for meal service was 140 degrees F, but 135 degrees F was acceptable. RD-E was informed of findings from the lunch meal service, e.g., trays left standing on the unit for 45 minutes, and the temperatures obtained on a test tray. RD-E stated proper food temperatures were important for palatability and for residents to enjoy their food.</p> <p>During an observation on 1/15/25 at 8:01 a.m., C-A and DM-F were passing breakfast trays. C-A stated they had a meeting to figure out how they could help get the food out faster and as a result, dietary staff would help pass room trays during the outbreak. In addition, DM-F stated they are not going to deliver all breakfast trays right away - they are going to see which residents were awake first before bringing a tray to their room.</p> <p>44630</p> <p>Meadow wing</p> <p>On 1/13/25 at 12:49 p.m., R16 was lying in bed with a meal tray in front of him. R16 stated his meal tray and food was delivered at 12:45 p.m., and the food was cold and did not eat because of the cold food.</p> <p>On 1/14/25 a 9:32 a.m., R16 was lying in bed and stated his breakfast was cold. R16 stated he did drink his protein drink, but could not eat the rest of the breakfast meal because the food was cold.</p> <p>On 1/14/25 at 11:38 a.m., observed meal trays located on a cart in the meadow wing hallway.</p> <p>-11:50 a.m., meal tray delivery started on meadow wing.</p> <p>-12:11 p.m., social services (SS)-A delivered R16's meal tray to his room</p> <p>The facility Assisting the impaired Resident with In-Room Meals policy dated 1/2025, indicated staff were to check that hot foods were hot and cold foods were cold. To minimize the risk of foodborne illness, the time that potentially hazardous foods remained in the danger zone (41 degrees F and 135 degrees F) would be kept to a minimum. Foods left on trays without a source of heat (for hot foods) or refrigeration (for cold foods) longer than two hours would be discarded.</p> | | |

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| <p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>44630</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on document review and interview, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis.</p> <p>Findings include:</p> <p>Review of the QAPI meeting minutes and agenda identified QAPI meetings held 12/19/24, 7/11/24, 4/11/24. There was no additional documentation of a QAPI meeting provided between 7/11/24-12/19/24.</p> <p>On 1/16/25 at 1:14 p.m., the administrator stated she had worked at the facility approximately four weeks. The administrator stated she did not know if the facility had previously had a QAPI meeting between 7/11/24-12/19/24 , and confirmed she was not able to provide any documentation of any other meetings that had occurred. The administrator stated QAPI meetings were expected quarterly with attendance.</p> <p>The facility Quality Assurance and Performance Improvement (QAPI) policy dated 2/2024, indicated: The QAA committee will meet quarterly. QAPI activities and outcomes will be on the agenda of every staff meeting and shared with residents and family members through their respective councils and monthly newsletter. The minutes from all meetings will be posted throughout the organization. The QAA committee will report all activities to the board of directors during their regularly scheduled meetings.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of influenza A, failed to post appropriate signage for 11 of 11 residents (R2, R9, R10, R79, R12, R4, R16, R1, R18, R22, R3) who exhibited symptoms of influenza A or had tested positive for influenza A, and further failed to ensure correct personal protective equipment (PPE) use. In addition; the facility failed to ensure correct use of gloves during wound care for 1 of 1 resident, (R16). This had the potential to affect all residents who resided at the facility.</p> <p>Findings include:</p> <p>R2's facesheet printed 1/15/25, indicated diagnoses of heart failure, pain syndrome, and kidney disease.</p> <p>R2's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors, and dependent on staff for personal hygiene and transfers.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R2 had symptoms of influenza A that included malaise and fatigue which developed on 1/11/25.</p> <p>R9's facesheet printed 1/15/25, indicated diagnoses of peptic ulcer and septic shock.</p> <p>R9's admission MDS assessment dated [DATE], indicated intact cognition, no behaviors, setup assistance for eating, substantial assistance for dressing and personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R9 had symptoms of influenza A that included malaise and fatigue which developed on 1/11/25.</p> <p>R10's facesheet printed 1/15/25, indicated diagnoses of Parkinson's disease, and neurocognitive disorder with lewy bodies.</p> <p>R10's quarterly MDS assessment dated [DATE], indicated severe cognitive impairment, use of a wheelchair, substantial assistance for upper body dressing, dependence on staff for bathing and personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R10 had symptoms of influenza A that included malaise which developed on 1/11/25.</p> <p>R79's facesheet printed 1/15/25, indicated diagnoses of cardiac pacemaker presence, anemia, and dementia.</p> <p>R79's admission MDS assessment dated [DATE], indicated moderate cognitive impairment, behavioral symptoms not directed towards others, use of a walker and wheelchair, set up assistance for eating, and substantial assistance with personal hygiene.</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 - Many</p> | <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R79 had symptoms of influenza A that included malaise and body aches which developed on 1/11/25.</p> <p>R12's facesheet printed 1/15/25, indicated diagnoses of type 2 diabetes mellitus, obesity, and vascular dementia.</p> <p>R12's annual MDS assessment dated [DATE], indicated use of a wheelchair, setup assistance for eating, dependent on staff for personal hygiene, bathing, and dressing.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R12 had symptoms of influenza A that included cough and fatigue which developed on 1/11/25.</p> <p>R4's facesheet printed 1/15/25, indicated diagnoses of heart failure, kidney disease, and chronic respiratory failure.</p> <p>R4's quarterly MDS assessment dated [DATE], indicated intact cognition, verbal behaviors directed towards others, use of a wheelchair, setup assistance for personal hygiene, and partial assistance for upper body dressing.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R4 developed symptoms of influenza A that included chills, malaise, and cough which developed on 1/10/25, and tested positive for influenza A on 1/10/25.</p> <p>R16's facesheet printed 1/15/25, indicated diagnosis of osteomyelitis (bone infection).</p> <p>R16's admission MDS assessment dated [DATE], indicated intact cognition, no behaviors, independent with eating, dependent on staff for toileting hygiene, and partial assistance with personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R16 had symptoms of influenza A that included cough and malaise which developed on 1/9/25, and tested positive for influenza A on 1/10/25.</p> <p>R1's facesheet printed 1/15/25, indicated diagnoses of alcohol-induced dementia, hypertension (high blood pressure), and weakness.</p> <p>R1's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, no behaviors, use of a wheelchair, substantial assistance with bathing and personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R1 had symptoms of influenza A that included cough which developed on 1/12/25.</p> <p>R18's facesheet printed 1/15/25, indicated diagnoses of pressure injury of left heel, chronic respiratory failure, and history of cerebral infarction (stroke).</p> <p>R18's quarterly MDS assessment dated [DATE], indicated severely impaired cognition, behavioral symptoms not directed towards others, use of a walker and wheelchair, setup assistance for eating, dependent on staff for bathing, and partial assistance with personal hygiene.</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 - Many</p> | <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R18 had symptoms of influenza A that included malaise, cough, and shortness of breath which developed on 1/9/25, and tested positive for influenza A on 1/12/25.</p> <p>R22's facesheet printed on 1/15/25, indicated diagnoses of amyotrophic lateral sclerosis (ALS) and repeated falls.</p> <p>R22's significant change MDS assessment dated [DATE], indicated intact cognition, no behaviors, use of a walker and wheelchair, and dependent on staff for eating, dressing, bathing, and personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R22 had symptoms of influenza A that included diarrhea and cough which developed on 1/9/25.</p> <p>R3's facesheet printed 1/15/25, indicated diagnoses of anemia, type 2 diabetes mellitus, chronic pain, and muscle weakness.</p> <p>R3's admission MDS assessment dated [DATE], indicated intact cognition, no behaviors, use of a wheelchair, set up assistance for eating, and substantial assistance with personal hygiene.</p> <p>Facility outbreak tracking spreadsheet dated 1/14/25, indicated R3 had symptoms of influenza A that included cough, malaise, and diarrhea which developed on 1/9/25, and tested positive for influenza A on 1/10/25.</p> <p>During observation on 1/13/24 at 11:15 a.m., a sign was near the entrance of the facility stating the facility was currently experiencing an influenza outbreak and masks should be worn in the facility.</p> <p>During observation on 1/13/24 at 11:39 a.m., resident rooms of R2, R9, R10, R79, R12, R4, R16, R1, R18, R22, R3 did not have droplet precaution signage to indicate droplet precautions should have been used due to positive or suspected influenza A.</p> <p>Signs on resident room doors at the time of initial observation on 1/13/24 at 11:39 a.m., indicated enhanced barrier precautions (EBP) for the rooms of R9, R10, and R16, but did not indicate the need for further droplet precautions due to influenza A.</p> <p>PPE</p> <p>During observation on 1/13/24 at 11:30 a.m., a large, uncovered garbage bin was in the center of the Meadows hallway with soiled gowns present in the bin.</p> <p>During observation on 1/13/25 at 12:22 p.m., nursing assistant (NA)-A, who was wearing a mask throughout the facility, donned a gown and entered R16's room. During interview on 1/13/25 at 12:39 p.m., NA-A stated she was unsure which rooms to wear a gown in, was not aware which residents had influenza A, and was not told she could not wear the same mask resident room to resident room.</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 - Many</p> | <p>On 1/13/25 at 3:19 p.m., NA-F stated resident rooms were not posted on who had influenza or residents who had signs or symptoms of influenza. NA-F stated the same mask was worn from room to room regardless if a resident had influenza.</p> <p>On 1/13/25 at 3:21 p.m., NA-B stated the facility did not post precautions signs on resident doors that indicated what PPE was needed worn into the resident rooms, or specific reason the resident was on precautions. NA-B confirmed the mask worn into resident rooms was not changed or removed going from room to room of residents.</p> <p>On 1/13/25 at 3:25 p.m., NA-E stated a mask was worn at all times at the facility due to the influenza outbreak. NA-E confirmed the mask was not removed or changed going from room to room.</p> <p>On 1/13/25 at 3:31 p.m., registered nurse (RN)-A, known as the assistant director of nursing and infection preventionist, stated facility was currently in an influenza outbreak as of 1/10/25. RN-A stated there are residents with confirmed positive influenza tests and residents presumed positive due to signs and symptoms. RN-A stated there were also staff with confirmed influenza and staff with signs and symptoms. RN-A stated an electronic message went to all staff on 1/10/25, educating staff the facility needed to follow droplet precautions for all residents. RN-A stated PPE was spread throughout the facility that included gowns, eye protection, masks and hand disinfectant. RN-A further stated stated community dining and activities were stopped and residents have been eating and participating in activities in their rooms. RN-A stated staff were not educated to change masks from room to room and confirmed staff were expected to change masks from room to room. RN-A stated the residents with confirmed influenza and presumed influenza based off signs and symptoms did not have precautions signs posted to make staff, residents, and visitors aware of the specific isolation and PPE needed to be worn entering the rooms.</p> <p>On 1/13/25 at 4:09 p.m., during a follow up interview RN-A stated he arrived this morning for work and then was told he needed to leave and come back to cover the nursing shift for evenings as the there was staffing shortage for evenings and overnights. RN-A stated had not had time to get signs posted, PPE carts readily available and garbage's placed inside and outside resident rooms. RN-A stated the director of nursing was not at the facility due to influenza.</p> <p>During interview on 1/13/25 at 4:29 p.m., RN-A stated he had not had time to work on infection control for this outbreak because he had been working the floor so much and was not allowed any infection control hours. RN-A stated he discussed the first positive cases with the medical director on 1/10/25 and was told to treat anyone with symptoms as if they were positive with influenza A, and to implement appropriate precautions.</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 - Many</p> | <p>On 1/13/25 at 4:42 p.m., the administrator stated she became aware of the influenza outbreak on 1/10/25 at 9:20 a.m., via an email from RN-A. The medical director was made aware the same day at 9:51 a.m., and RN-A sent a electronic message to all staff masks were required throughout the facility. The administrator stated RN-A was also the infection prevention nurse, and was working as a floor nurse during the outbreak. The administrator stated RN-A was not designated time or hours while the outbreak was going on to ensure the correct PPE was available, signs were posted or staff received education. The administrator stated RN-A was expected to delegate tasks if needed, however RN-A was responsible to ensure staff were following correct procedures for the influenza outbreak and was responsible to ensure PPE was available to the staff. The administrator confirmed signs were not posted on the resident doors presumed positive (signs or symptoms of influenza) or the residents with confirmed positive influenza. The administrator stated the signs were expected for residents, staff and visitors to be aware of the isolation precautions and the PPE that was expected worn into the rooms. The administrator stated signs was important to prevent the spread of the influenza, and the administrator was not aware the same mask could not be worn from room to room.</p> <p>During observation on 1/13/25 at 5:53 p.m., RN-D was observed putting droplet precaution signs on the doors of the rooms of R2, R9, R10, R79, R12, R4, R16, R1, R18, R22, R2.</p> <p>During observation and interview on 1/13/25 at 6:07 p.m., NA-F was observed exiting R9's room with a gown on, doffing the gown in the hallway, and disposing of the gown in the large garbage bin located in the meadows hallway. NA-F stated she sometimes wore her gown in the hallway if the garbage in the room was full. NA-F further stated she should remove her gown in the room, rather than in the hallway to prevent the spread of infection.</p> <p>44630</p> <p>During observation on 1/14/25 at 8:53 a.m., LPN-C was observed exiting R12's room with a soiled gown in her hands and disposing of it in the large hallway garbage bin across the hall. LPN-C and NA-E both exited the room without doffing their masks. NA-E then exited the meadows hallway with her same mask on. LPN-C also continued on with the same mask on.</p> <p>During interview on 1/14/25 at 9:03 a.m., NA-E stated she was not aware of any training on how to don/doff PPE other than online training and would have liked to have had in-person training or a demonstration. NA-E further stated she was told she could wear her mask room to room.</p> <p>On 1/14/25 at 9:18 a.m., medical doctor (MD)-G stated signs posted on resident doors with influenza were expected o ensure staff, visitors and residents followed transmission based precautions to prevent the spread of influenza.</p> <p>During interview on 1/14/25 at 12:42 p.m., RN-A stated he would expect that gowns be removed before exiting positive or suspected influenza A rooms and masks should be removed immediately upon exiting the room and not worn room to room to prevent the spread of infection. RN-A further stated that contaminated gowns should be disposed of in the room or should be bagged prior to being brought to the large garbage in the hallway. RN-A stated droplet precaution signs had been put on the door of residents with confirmed or suspected influenza A yesterday 1/13/25, but should have been put in place when the outbreak started on 1/9/25.</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 - Many</p> | <p>During interview on 1/14/25 at 6:15 p.m., RN-D, regional nurse specialist, stated she would expect gowns be removed in the room or bagged and sealed if brought in the hallway. RN-D stated masks should not be worn room to room. RN-D further stated proper signage and PPE use should have been in place to prevent the spread of infection to other residents, staff, and visitors.</p> <p>The facility Policies and Practice- Infection Control policy effective 12/2024, stated the objectives of our infection control policies and practices are to:</p> <ol style="list-style-type: none"> a. Prevent, detect, investigate, and control infections in the facility b. Maintain a safe, sanitary, and comfortable environment c. Establish guidelines for implementing Isolation Precautions, including standard and transmission based d. Establish guidelines for the availability and accessibility of supplies and equipment e. Maintain records of incidents and corrective actions relate to infections f. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment g. The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. <p>Glove use/hand hygiene with wound care</p> <p>R16's admission MDS dated [DATE], indicated R16 was admitted to the facility on [DATE], cognitively intact, no rejection of care, required partial/moderate assistance with personal hygiene, dependent on staff for toileting, shower/bathe, lower body dressing, and transfers; diagnoses included unstageable pressure ulcer of the right heel, and osteomyelitis (infection of the bone); skin conditions indicated R16 was at risk of developing pressure ulcers/injuries, no unhealed pressure ulcers/injuries, had infection of the foot, other open lesion on the foot, surgical wounds; skin treatments included pressure reducing device for chair and bed, surgical wound care, application of ointments/medications other than to feet, application of dressings to feet.</p> <p>R16's care plan printed on 1/14/25, indicated R16 had self care deficit related to morbid obesity and decreased functional ability due to bilateral pressure injury to heels, needed assist with ADL's (activities of daily living), alteration in skin integrity r/t (related to) pressure ulcer to bilateral heels and interventions included administer treatments as ordered and observe for effectiveness, assist/encourage to float heels while in bed, measure wound weekly; update MD (medical doctor) PRN (as needed) with change, observe for s/sx (signs/symptoms) of infection, and wound vac in place.</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 - Many</p> | <p>On 1/14/25 at 9:19 a.m., LPN-A and medical doctor (MD)-G entered R16's room with gloves, gown, and mask. LPN-A with gloved hands, removed the old dressing from R16's left heel, used same gloved hands and opened a betadine gauze package and used the betadine swab on the wound. LPN-A, with same gloves, applied a foam dressing on the left heel and while the dressing was placed the same gloves touched the inside foam of the clean dressing. LPN-C removed gloves and exited the room with a gown on. LPN-A after exiting R16's room removed the gown and placed in opened garbage across the hallway from R16's room.</p> <p>On 1/14/25 at 10:37 a.m., LPN-A confirmed gloves were not changed during R16's wound care and stated she was expected to change gloves and complete hand hygiene after removing the old dressing and place new clean gloves on prior to applying the new dressing. LPN-A confirmed the gown was not removed prior to exiting R16's room, and stated the gown was expected to removed prior to exiting R16's room and stated there were not a garbage available to dispose of the gown at the time.</p> <p>On 1/14/25 at 11:12 a.m., RN-D, known as the regional nurse specialist, stated staff were expected to change gloves after old dressing was removed, wash hands and place new gloves prior to the clean dressing applied.</p> <p>The facility Wound Care policy dated 12/2025, indicated;</p> <p>Don gloves. [NAME] other personal protective equipment as applicable.</p> <p>Remove and discard used dressing, remove and discard soiled gloves.</p> <p>Perform hand hygiene</p> <p>Don gloves</p> <p>Cleanse the wound</p> <p>Discard disposable items remove and discard soiled gloves</p> <p>Perform hand hygiene</p> <p>Don gloves</p> <p>Proceed with dressing the wound as ordered, remove and discard soiled gloves</p> <p>Perform hand hygiene.</p> | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>42073</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 tub/shower rooms were maintained in good repair and sanitary conditions for 15 residents who utilized two tub/shower rooms on the Prairie unit.</p> <p>Finding include:</p> <p>Prairie Unit - East</p> <p>During an observation on 1/14/25 at 2:15 p.m., the tub/shower room on the east Prairie unit was observed to have a large tub and separate walk-in shower, toilet, and vanity with sink and cupboards.</p> <p>A furnace filter measuring approximately two feet by eight inches was observed laying on the floor half-way under the wall-mounted heater. The filter was heavily laden with gray fuzzy material. On top of the heater where air came out where small square grates that had an accumulation of dust and webs on them.</p> <p>Next to the heater was a corner wall where sheetrock was missing on the lower one - two feet. The material exposed resembled cement - white and porous, and was crumbling. These open areas were discolored rust and brown.</p> <p>A ceiling vent, approximately 12 inches x 12 inches was heavily laden with gray fuzzy debris with some of it hanging down like a web.</p> <p>The floor of the walk-in shower was worn looking and stained a tan/rusty color. In addition, the hand-held shower head was attached to the shower with black zip ties.</p> <p>Prairie Unit North</p> <p>The floor of the walk-in shower was worn looking and stained with a tan/rusty color. In addition, the floor seemed to have tiny black marks resembling sand until closer inspection revealed the black marks did not come off.</p> <p>During an interview and observation on 1/15/25 at 1:17 p.m., together with maintenance director (MD)-A, viewed both tub/shower rooms on the Prairie unit. In the tub/shower room on Prairie east, MD-A pulled out and examined the filter and stated it looked pretty bad. MD-A stated he had ordered filters a couple of months ago, but they had not come in yet. MD-A stated he was not aware of the other concerns: crumbling wall, ceiling vent, zip ties and floor of the shower. In the tub/shower room on Prairie north, MD-A tried to scratch off the black marks on the floor of the shower with his fingernail, but it didn't come off. MD-A was not aware of this either and acknowledged these findings did not provide a home-like, nor sanitary environment for residents.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/16/2025 |
| NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur | | STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058 | |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 1/15/25 at 4:01 p.m., with the administrator, looked at areas of concern in each of the Prairie tub/shower rooms. She had been aware of the filters after MD-A reported it to her, but unaware of other issues. The administrator stated she would expect the tub/shower rooms to be clean and in good repair.</p> <p>A policy on physical maintenance of the building, upkeep, and cleanliness was requested. The facility Maintenance - Plumbing, HVAC and Related Systems policy dated 1/2025, was received. The policy indicated to clean or discard filters in individual air-conditioning units in resident rooms at least monthly during the summer. Clear air vents and air handling units at least annually.</p> | | |

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| <p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50764</p> <p>Based on interview and document review, the facility failed to ensure an annual performance review was conducted for 4 of 4 nursing assistants (NA-A, NA-F, NA-B, NA-E) and therefore failed to ensure annual training reflected the NA's areas of weaknesses identified on performance reviews.</p> <p>Findings Include:</p> <p>The following NA's personnel and training records were reviewed for annual performance reviews and training and identified the following:</p> <p>NA-A was hired on 6/14/23. NA-A's personnel record lacked evidence an annual performance review was ever completed.</p> <p>NA-F was hired on 11/7/23. NA-F's personnel record lacked evidence an annual performance review was ever completed.</p> <p>NA-B was hired on 7/16/18. NA-B's personnel record lacked evidence of a current annual performance review.</p> <p>NA-E was hired on 6/7/21. NA-E's personnel record lacked evidence an annual performance review was ever completed.</p> <p>Review of online training transcripts for NA-A, NA-F, NA-B, and NA-E included online trainings on abuse prevention, behavioral health, workplace injury, cultural competency, dementia, dining and food safety, Elder Justice Act, emergency preparedness, fall prevention, HIPAA, infection control, infectious disease, Medicare, OSHA, resident privacy, QAPI, resident rights, substance abuse, trauma informed care, and vulnerable adult. All training logs were the same with no individualized training based on performance reviews.</p> <p>During interview on 1/14/25 at 8:59 a.m., NA-B stated she was not aware of a recent performance review or individualized training. She further stated she did the annual computer training completed by all employees, but was not aware of any other training.</p> <p>During interview on 1/14/25 at 11:11 a.m., NA-E stated she had not had any specific training and had only done the computer training she had to do yearly.</p> <p>During interview on 1/15/25 at 8:20 a.m., NA-A stated she had not had a performance review and did not know she should have had training based on a performance review. NA-A stated she did complete the yearly required computer classes.</p> <p>During interview on 1/16/25 at 12:12 p.m., registered nurse (RN)-A stated he was not aware of any training based off of performance reviews since he had started and further stated he did not know of any individual education provided to NA's.</p> <p>(continued on next page)</p> | | |

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| <p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During interview on 1/15/25 at 9:08 a.m., administrator stated she was not aware of any completed performance reviews and was too new to be sure on training processes.</p> <p>A policy on performance reviews and training was requested but not received.</p> | | |