STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Homestead	115 10th Avenue Northeast Deer River, MN 56636

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to ensure as-needed (PRN) antipsychotic medication use was limited to 14 days or notes from a provider face to face visit to demonstrate medical justification was provided to support ongoing use for 2 of 5 residents (R16, R20) reviewed for unnecessary medication use. Findings include: R16: R16's quarterly Minimum Data Set (MDS), dated [DATE], identified R16 had severe cognitive impairment, consumed antipsychotic medication daily and on an as needed (PRN) basis. R16's diagnoses included Alzheimer's and dementia. R16's most recent Physician Order Report, dated 5/16/24, identified R16's current physician-ordered medications. These included Haldol and Risperdal (both antipsychotic medication) on a PRN basis. The start date for Risperdal was 5/25/23 with no stop date documented. The start date for Haldol was 10/11/23 with no stop date documented. R16's medical record was reviewed and lacked evidence the provider had done every two weeks face to face visits to justify the continued use of PRN antipsychotic medication or had new orders for the PRN antipsychotics every 14 days. During an interview on 5/16/24 at 9:43 a.m., registered nurse (RN)-A stated all antipsychotic medications ordered PRN could only be ordered for 14 days and then needed a provider in person visit with documented medical need to continue the use. Also, the order had to be reordered every 14 days after the provider in person visit. RN-A was unaware who had the responsibility to ensure the visit and reorder were completed. During an interview on 5/16/24 at 10:56 a.m., hospice registered nurse (RN)-B stated the hospice provider does not round every two weeks and only renews antipsychotic medications yearly, unless there is a change to the dose. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 1:20 p.m., the pharmacy consultant (PC) stated all PRN antipsychotics needed to be renewed every 14 days after the provider performed an in person visit and documented medical need for the continued use. During an interview on 5/16/24 at 1:53 p.m., the director of nursing (DON) stated all PRN antipsychotic medication needed to be renewed every 14 days. It was up to the floor nurses who worked the cart to keep track of when that time was up and communicate the need with the provider. Facility Policy Psychotropic Medication last reviewed 11/27/17, indicated PRN antipsychotic medications would be limited to 14 days and would not be renewed unless the provider evaluated the resident for appropriateness of the medication. 47263 R20: R20's admission Minimum Data Set (MDS) dated [DATE], indicated R20 had severe cognitive impairment with a diagnosis of non-Alzheimer's dementia. The MDS indicated R20 received antipsychotics on a regular basis but did not indicate the use of a as needed (PRN) antipsychotic medication. R20's Physician Order Report dated 4/18/24, had the following order for the antipsychotic medication quetiapine, 12.5 mg three times a day PRN, quetiapine 12.5 mg one time a day between 4:00 p.m. and 6:30 p.m., and quetiapine 25 mg one time a day between 7:00 p.m. and 10:00 p.m. R20's Medication Pharmacy Regimen Review dated 4/30/24, stated if a new 14-day order for antipsychotic med is to be written, need examination by md to determine if still needed. R20's electronic medical record (EMR) lacked evidence that a provider had completed in person assessments of R20 every 14 days for the continued use of PRN antipsychotic medication. In addition, there was not a documented provider response to the pharmacist recommendations made on the 4/30/24. During an interview on 5/15/24 at 9:23 a.m., the director of nursing (DON) stated R20 was admitted to the facility with scheduled and PRN quetiapine. The DON pulled up R20's electronic medical record (EMR) and indicated R20 was last seen by a provider on 4/18/24, and had not been evaluated in person since admit for the continued use of PRN quetiapine. The DON indicated the pharmacy medication review recommendations drove when the provider was notified to complete a in person resident assessment and review of PRN antipsychotic medication orders. The facility did not have additional processes in place that ensured in person provider assessments and order discontinuation, or renewal occurred every 14 days for PRN antipsychotic medication. The facility policy Psychotropic Medication dated 11/27/17, indicated PRN antipsychotic medications would be limited to 14 days and would not be renewed unless the provider evaluated the resident for appropriateness of the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47263 Based on observation, interview, and record review, the facility failed to ensure that residents dining in the main dining room were given an opportunity to sanitize their hands prior to meal consumption. This deficient practice had the potential to impact all resident who dined in the main dining room. Findings include: During a dinner meal observation on 5/13/24 that started at 5:36 p.m., there were residents seated at five tables in the main dining room waiting for their meals to be delivered. None of the tables had hand sanitizing products on them. During dining observation, there were no observations of staff offering hand sanitization to residents that entered the dining room or to those already seated in the dining room. During a breakfast meal observation on 5/15/24 that started at 7:00 a.m., several residents were seated at tables in the dining room. None of the tables had any hand sanitizing products on them tables. Staff were observed assisting residents with clothing protector application. Staff appropriately sanitized their own hands at the sink between residents and tasks; however, staff did not offer hand sanitization to seated residents or to any additional residents as they entered the dining area for breakfast. During a lunch meal observation on 5/15/24 that started at 11:52 a.m., some residents were already seated at tables in the dining room. There was one pack of hand sanitizing wipes at the largest table in the dining room. Three additional residents entered the dining area. Residents were helped with clothing protectors however there was no observation of staff offering residents the opportunity to sanitize their hand prior to eating. Staff sanitized their own hands at the sink appropriately between residents and tasks. During an interview on 5/15/24 at 12:51 p.m., nursing assistant (NA)-A stated they always offered residents hand hygiene when they were in the resident's room but indicated they had not been offering hand hygiene to residents in the dining room prior to meals. NA-A confirmed they had not offered hand hygiene at the breakfast or lunch meals on 5/15/24. This should be done for infection prevention reasons. During an interview on 5/15/24 at 1:13 p.m., NA-B stated the dining room tables normally had hand sanitizer wipes on them, but there wasn't any, and they were not sure what had happened to them. NA-B stated when they brought a resident to the dining room from their room, they usually asked the resident if they wanted to wash their hands at their sink in their room. NA-E confirmed they had not offered hand sanitization to any of the residents in the dining room prior to meals being served on 5/15/24, and indicated it was important to offer residents hand sanitization prior to meals to prevent germs and infection. During an interview on 5/15/24 12:42 p.m., family member (FM)-A stated they had never seen their family member or other residents offered hand sanitization in the dining room prior to meals. FM-C stated they visited over mealtime about three times a week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 1:23 p.m., the infection preventionist (IP) stated it was their expectation that residents were offered the opportunity for hand sanitization prior to meals. Resident's hands could be contaminated just from touching surfaces and or from missed handwashing after bathroom use. The IP stated they needed to make sure resident's hands were sanitized prior to food consumption to help prevent the spread of infection and or illness. During an interview on 5/15/24 at 1:41 p.m., the director of nursing (DON) stated they expected staff to give all residents the opportunity for hand sanitization prior to meals either at the sink or with the hand sanitizing wipes that are normally on the dining tables. The DON stated sanitizing wipes should be on all the dining tables and indicated wipes had been requested earlier that day. Proper hand sanitization for residents was needed to prevent the spread of infection and illness. The facility Stand Work: Activates of Daily Living (ADL's) Standards of Care dated 4/12/24, line item 15. Instructed all residents were to be offered hand hygiene prior to meals.