

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER First Care Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Hilligoss Boulevard Southeast Fosston, MN 56542	

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 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** 40943</p> <p>Based on observation, interview and document review, the facility failed to perform routine monitoring of a wound to promote healing for 1 of 2 residents (R9) reviewed for wound care.</p> <p>Findings included:</p> <p>R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 was cognitively intact and had diagnoses that included Type 2 diabetes. R9 had a stage 3 pressure ulcer.</p> <p>R9's care plan revised 5/5/24, identified R9 had impaired skin integrity related to incontinence, was at risk for skin breakdown and needed assistance with mobility. Staff were directed to perform weekly wound measurements and documentation.</p> <p>R9's physician order dated 6/1/24, identified a dressing change to the right heel. Moist gauze, light gauze and kerlix every other day. Monitor for infection/redness. Special Instructions: Document date changed in results.</p> <p>R9's Wound Management Detail Report dated 12/13/23 through 4/15/24, identified R9 had a stage 3 (affects the top two layers of skin as well as fatty tissue) pressure ulcer to the right heel. The last documented measurement on 4/15/24, was 1.0 centimeters (cm) x 1.5 cm with edges epithelizing flush with wound base; macerated/soft with well-defined wound edges. However, the report failed to identify any measurements from 4/15/24 through 6/6/24 and defining characteristics.</p> <p>During an interview on 6/4/24 at 12:57 p.m., R9 stated she had a pressure ulcer on her right heel because she rubbed her heel on the bed mattress.</p> <p>R9's progress note dated 4/22/24, identified R9's wound was debrided by podiatry.</p> <p>During an observation on 6/6/24 at 11:18 a.m., licensed practical nurse (LPN)-A stated R9 had a pressure ulcer to the right heel. LPN-A performed a dressing change as ordered. Upon removal of the dressing, there was a moderate amount of purulent drainage and measured 2 cm x 1 cm. LPN-A stated there was an additional reddened area surrounding the wound that measured 1.5 cm.</p> <p>- At 11:31 a.m., LPN-A stated wound documentation was entered into R9's chart on bath days. The staff charted in a progress note and there was an observation that was entered as well.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 6/6/24 at 11:38 a.m., registered nurse (RN)-A stated R9 had a pressure ulcer on her right heel when R9 returned from the hospital on 12/13/23. The facility did have a nurse who was designated to perform wound assessments but left her role in mid-April 2024. After that, not all staff were documenting in the same place. RN-A stated R9's medical record lacked measurements after 4/15/24, and then stated wound monitoring was important to wound healing including preventing infections.</p> <p>During an interview on 6/6/24 at 11:50 a.m., the director of nursing (DON) stated a RN should assess and document wound care. The previous wound nurse left her role mid-April 2024. After that, documentation was not completed consistently with all staff. In observations, there was a wound form for staff to complete, however, the licensed practical nurses did not have access. Because of this, staff did not document the required information such as measurements and description. Wound care documentation was important for tracking of wound condition/healing.</p> <p>A wound care policy was requested but not received.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview and document review, the facility failed to perform hand hygiene for 2 of 5 residents (R20, R29) observed for activities of daily living (ADL's); the facility failed to implement Enhanced Barrier Precautions for 1 of 2 (R9) residents reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Hand Hygiene:</p> <p>R20's quarterly Minimum Data Set (MDS) dated [DATE], identified R20 had severe cognitive impairment, and was dependent on staff in all care areas.</p> <p>During an observation on 6/6/24 at 8:16 a.m., nursing assistant (NA)-B and NA-C assisted R20 to transfer from a shower chair to his bed by a full body mechanical lift. R20 was incontinent of bowel (BM). NA-B and NA-C applied clean gloves and cleaned the BM from R20.</p> <p>- At 8:30 a.m., NA-B and NA-C removed their soiled gloves, did not perform hand hygiene, and applied clean gloves. NA-B and NA-C assisted R20 to dress and transferred R20 back into his wheelchair with a full body mechanical lift.</p> <p>- At 8:34 a.m., NA-C continued to wear soiled gloves and reached into R20's bedside drawer to obtain an oral swab. NA-C unwrapped and wetted the swab and moved to clean R20's mouth. NA-C and NA-B stated they did not perform hand hygiene. NA-C stated she should have performed hand hygiene because she was going to put the swab in R20's mouth.</p> <p>R29's quarterly MD dated 5/22/24, identified R29 had mild cognitive impairment and required assistance with ADL's.</p> <p>During an observation on 6/6/24 at 7:29 a.m., NA-A assisted R29 with morning cares while R29 was in bed. R29 was incontinent of BM. NA-A applied clean gloves and cleaned BM from R29.</p> <p>- At 7:31 a.m., NA-A removed the soiled gloves and applied clean gloves. NA-A did not perform hand hygiene.</p> <p>- At 7:39 a.m., NA-A assisted R29 to dress, transferred R29 into his wheelchair and assisted R29 into his bathroom. NA-A did not perform hand hygiene and obtained R29's toothbrush, basin, toothpaste from the 2-drawer bin. R29 took the supplies from NA-A, put toothpaste on his toothbrush while NA-A began to obtain a glass of water for R29. NA-A stated she did not perform hand hygiene and she should have. It's the germs. I was getting stuff to go into his mouth.</p> <p>During an interview on 6/6/24 at 10:58 a.m., registered nurse (RN)-B stated staff were expected to perform hand hygiene when they arrived to work, after and before eating, before and after wearing gloves and before and after resident contact; or whenever going from clean to dirty. RN-B stated staff hands were contaminated, especially after incontinence cares.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 11:03 a.m., the director of nursing (DON) stated staff were expected to perform hand hygiene before and after any patient contact and/or after removing gloves. Staff were expected to absolutely perform hand hygiene prior to oral cares. Hand hygiene was important in infection prevention, whether spreading possible organisms to the residents or staff. Handwashing broke the chain of contamination.</p> <p>The facility Hand Hygiene policy revised 11/10/23, identified hand hygiene practices and expectations for healthcare workers, prevent the transmission of pathogens and aid in the reduction of healthcare associated infections. V. All healthcare workers must perform hand hygiene:</p> <p>A. Before patient contact or contact with the patient's environment.</p> <ol style="list-style-type: none"> 1. Before entering a patient's room 2. Before touching a patient 3. Before touching any object or furniture in the patient zone <p>B. After patient contact</p> <ol style="list-style-type: none"> 1. After touching a patient 2. After touching any object or furniture in the patient environment <p>C. Before clean/aseptic procedure</p> <p>D. After body fluid exposure risk</p> <p>E. When moving from a contaminated body site to a clean body site during patient care F'. Before putting on gloves</p> <p>G. After removing gloves or other personal protective equipment.</p> <p>H. Before administering medication.</p> <p>I. Upon arrival and before leaving work.</p> <p>J. After sneezing or coughing.</p> <p>K. Before and after eating.</p> <p>L. After using the restroom.</p> <p>Enhanced Barrier Precautions:</p> <p>R9's quarterly MDS dated [DATE], identified R9 was cognitively intact and had a stage 3 pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's care plan revised 5/5/24, identified R9 had impaired skin integrity related to incontinence and was at risk for skin breakdown. Staff were directed to perform weekly wound measurements and documentation. The care plan failed to identify if Enhanced Barrier Precautions (EBP) was implemented for R9.</p> <p>R9's Physician Orders dated 6/1/24, failed to identify if EBP had been ordered for R9.</p> <p>During an observation on 6/6/24 at 11:18 a.m., no EBP signage or personal protective equipment (PPE) were available for R9. Licensed practical nurse (LPN)-A stated R9 did not require EBP because the wound was not infected. LPN-A performed a dressing change to R9's right heel pressure ulcer while wearing gloves but wore no other PPE.</p> <p>During an interview on 6/6/24 at 1:22 p.m., RN-B stated if a resident had a draining wound and/or an indwelling device, the resident would be placed into EBP. RN-A did not realize the CDC guidance included EBP for a chronic open wound.</p> <p>During an interview on 6/6/24 at 2:20 p.m., the DON stated she was aware of the guidance to implement EBP for a resident with draining wounds and/or an indwelling device, but the facility had not interpreted the guidance to implement EBP for R9. The DON stated she did expect staff to follow guidance and she needed to provide more staff education when/where EBP should be implemented.</p> <p>The facility Enhanced Barrier Precautions Standard Work approved 11/7/22, identified Enhanced Barrier Precautions expanded the use of PPE and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices were at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities was indicated, when Contact Precautions did not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>The Center for Disease Control and Prevention (CDC) Consideration for Use of Enhanced Barrier Precautions (EBP) in Skilled Nursing Facilities dated 6/2021, identified EBP expanded the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multiple Drug Resistant Organisms (MDROs) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices were at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities was indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> - Dressing - Bathing/showering <p>(continued on next page)</p>		

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