STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	3401 East Medicine Lake Boulevard Plymouth, MN 55441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R19) reviewed for dignity. Findings include: R19's admission minimum data set (MDS) dated [DATE], indicated a brief interview for mental status (BIMS-cognitive test) score of 15/15 indicating cognitively intact, self-care deficit requiring substantial/maximal assistance for toileting hygiene, upper and lower dressing, positioning and transfers. R19's diagnoses included but were not limited to hemiplegia (weakness or paralysis of one side of the body), bipolar disease (a mental health condition that causes mood swings), and hypertension (high blood pressure). R19's care plan dated 2/14/24 indicated R19's ability to perform activities of daily living (ADL's) had deteriorated related to a diagnosis of hemiplegia and required extensive staff assistance of one to two staff for toileting, dressing, bathing, grooming and bed mobility. Total dependence with Hoyer lift (a device designed to assist caregivers in safely transferring patients or individuals with limited mobility) for all transfers. R19's occupational therapy assessment dated [DATE] indicated R19 had diagnoses of hemiplegia and muscle weakness which required the need for assistance with personal cares. The assessment further indicated R19's left upper extremity to include shoulder, forearm, elbow, wrist, and hand were impaired with decreased strength and movement. During observation on 5/29/24 at 03:04 p.m., R19 was driving an electric wheelchair in hallway outside his room and through doorway into his room. R19 was wearing a light brown T-shirt, black basketball shorts, white ankle socks and tennis shoes. R19's shorts were tucked under abdominal fold and t-shirt was pulled up over the abdomen, above the belly button exposing approximately six inches of R19's stomach. A tan Hoyer sling was noted under resident with straps hanging loose. During observation on 5/30/24, at 02:12 p.m., R19 was driving an electric wheelchair towards smoking room on first floor wearing black basketball shorts and green t-shirt. R19's shorts were tucked under abdominal fold, legs (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/30/24 at 10:26, a.m., certified nursing assistant CNA-B stated after transferring a resident into their wheelchair staff should make sure their clothing was pulled down and neat. were bunched together and the shorts were pushed in towards his groin, T-shirt pulled up over abdomen exposing approximately 4 inches of R19's stomach. [NAME] edges of adult incontinent product was exposed at side waist band of basketball shorts. A tan Hoyer sling was visible under R19. During interview on 5/30/24 at 10:51 a.m., CNA-C stated if a resident's clothes were pushed up or under after a transfer, we fix them. During interview on 5/30/24, at 10:59 a.m., DON stated she expected staff to fix the residents clothes after transfers and expected staff to make sure they were happy with how they looked. Additionally, any refusals needed to be documented. DON stated not doing so could be embarrassing to the resident and affect their dignity. DON went on to say it was important to assist residents and ensure they feel good about how they look and feel. During observation on 5/31/24, at 09:19 a.m., R19 was seated in wheelchair in front of nurse desk wearing gray t-shirt, black basketball shorts, white ankle socks and tennis shoes. T-shirt pulled up exposing approximately 3-5 inches of stomach. [NAME] edges of adult incontinent product observed over waist band of basketball shorts. A tan Hoyer sling was under R19 with sling straps behind and to the outside of knees. During interview on 5/31/24, at 11:50 a.m., R19 stated he did not like the sling left under him after transfers, and right now my diaper is showing. R19 went on to say when his shirt was not pulled down everyone can see my fat and stretch marks .it makes me feel bad and people make fun of me. At 12:56 p.m., after transfer from bed to wheelchair R19 asked staff if his pants were up and stated I feel like my diaper is hanging out. Its embarrassing. CNA-D adjusted R19's shirt and shorts to cover R19's exposed skin. A facility policy was requested but none provided.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview and record review the facility failed to ensure the resident received unopened mail for 1 of 2 residents reviewed for their right to receive communication with privacy. Findings include: R55's admission minimum data set (MDS) dated [DATE] indicated a brief interview for mental status (BIMS) was 14 and R55 was cognitively intact. R55's MDS listed the following diagnoses: congestive heart failure (heart does not pump blood efficiently), Diabetes Mellitus, depression, and post traumatic stress disorder (PTSD). On 5/30/24 at 10:29 a.m., resident council met and R15 stated sometimes social services (SS)-A went through their mail for contraband. On 5/30/24 at 11:03 a.m., SS-A stated they were responsible for sorting and delivering the mail on the weekdays. SS-A stated they delivered the mail unopened but had performed searches of the mail for suspected illicit drugs or alcohol, with the consent of the resident. On 5/30/24 at 4:04 p.m., the administrator stated they were unaware SS-A had been going through the mail of some residents. The administrator expected staff to only search the residents mail with probable cause and not with random searches. On 5/31/24 at 11:00 a.m., SS-A stated the resident had opened the mail with them and go through it together. SS-A stated there were only two residents they would regularly check related to concerns in the past. Names were provided. However, R15, the resident who originally brought forth the concern, was not one of them. One resident had discharged and the other was R55. On 5/31/24 at 12:44 p.m., R55 stated approximately one month ago they had received two separate pieces of mail that had been opened prior to him receiving them. One was a medical bill, and the second was paperwork from their case manager. On 5/31/24 at 11:39 a.m., the director of nursing (DON) stated they were unaware of any policy regarding searching the mail, and their expectation was a search would have only been conducted if there was suspicion of drugs or alcohol, probable cause, and they needed to get the resident's consent. The facility's Resident Rights Policy last revised February 2021, indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communicate in person, by mail, email, and telephone with privacy.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on interview and document review, the facility failed to ensure advanced directives were accurately documented in the resident's electronic medical record (EMR) under physician orders for 1 of 1 residents (R109) reviewed for accurate code status. Findings include: R109's hospital discharge orders dated [DATE], identified the need for postoperative care and an order for full code (the initiation of cardiopulmonary resuscitation (CPR) in the absence of a pulse). R109's facility signed physician order report dated [DATE], identified an order dated [DATE] for full code. R109's EMR banner identified a code status of do not resuscitate (DNR). R109's facility face sheet dated [DATE] identified an admitted [DATE], diagnoses of cholecystectomy (a procedure to remove the gallbladder) aftercare, abscesses (confined pockets of pus caused by infection) of the liver and peritoneum (the tissue that lines the abdominal wall and pelvic cavity). The face sheet identified R109's code status as DNR. R109's facility signed limited treatment consent form dated [DATE] found in the resident's paper chart at the nurse's desk, identified resident wishes for no CPR and for CPR to be withheld in the event of a cardiac event. (DNR) R109's signed provider orders for life-sustaining treatment (POLST) dated [DATE] and found in the resident's paper chart kept at the nurse's desk, identified DNR if having no pulse and is not breathing. When interviewed on [DATE] at 5:35 p.m., R109 confirmed his wishes as DNR and stated he was full code in the hospital for his surgical procedures only. When interviewed on [DATE] at 5:48 p.m., nursing assistant (NA)-A stated when a resident was found unresponsive or not breathing, a licensed nurse was notified via walkie and someone remained with the resident. When interviewed on [DATE] at 5:51 p.m., registered nurse (RN)-A stated when notified a resident was found unresponsive or not breathing, he immediately checked the resident EMR banner for code status or the paper form in the resident paper chart at the nurse's desk to ensure implementing appropriate response according to their wishes. RN-A stated he would not look to the resident physician orders because it would take longer to scroll through them. RN-A identified R109's code status as DNR on the EMR banner. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 6:01 p.m., RN-B stated when a resident was found unresponsive or not breathing she looked at the EMR banner or the paper chart because they were the most up to date and current. RN-B identified R109's code status was DNR on the resident's EMR banner. RN-B would not look to the physician orders. RN-B acknowledged the physician order was for full code but that was an error. RN-B stated she would check with the resident and notify the provider to clarify and correct. When interviewed on [DATE] at 2:06 p.m., health unit coordinator (HUC) stated the assistant director of nursing (ADON) reviewed the admission referral information including orders and background information before a resident arrived. The HUC stated after she entered the orders a second check was completed by the ADON or a floor nurse. The HUC stated R109's orders upon admit were for full code but may have changed after someone discussed and went through the admission forms with him. The HUC acknowledged R109's signed code status form did not get communicated to her and therefore the order was not updated or accurate. When interviewed on [DATE] at 12:30 p.m., the director of nursing (DON) stated the admission orders were entered by the HUC and then a paper form regarding code status wishes was reviewed and signed by the resident or representative. The DON stated when the admission orders and signed forms did not match, they were clarified right away. The DON stated resident's code status was in several different parts of the EMR and paper charts. They need to match. This was important to ensure the appropriate interventions per resident wishes were implemented in an emergency situation. The facility policy Advanced Directives dated [DATE], identified The resident has the right to formulate an advance directive, including the right to accept or refuse medical treatment and The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on observation, interview and record review the facility failed to ensure resident rooms were kept clean and in good condition for 1 of 2 residents (R36) reviewed for environment. Findings include: R36's quarterly minimum data set (MDS) dated [DATE] indicated a brief interview for mental status (BIMS) of 9, moderately cognitively impaired, and diagnoses included: heart failure (heart not pumping blood efficiently), hypertension (HTN), and hemiparesis (inability to move part of the body). On 5/28/24 at 12:51 p.m., R36's room had large amount of what resembled brown ground meat across the floor starting from approximately 2 feet to the left of the bed across the main walkway of the room and under the table across from the resident's bed about 2 feet into the room's threshold, spanning approximately 3 feet across the floor. There were straw wrappers and other paper debris on the floor. The resident was in bed resting. On 5/28/24 at 4:52 p.m., the resident's family member (O)-G stated they had recently come to visit on multiple occasions and there had been wrappers, bottles and garbage on the floor and under the bed. O-G stated they had come visit on a recent weekend, and then came again the following week, and had seen the same piece of garbage under the bed that had been there the previous week's visit. On 5/29/24 at 8:42 a.m., the resident was in bed and the large amount of what resembled brown ground meat was still present on the floor and had not been cleaned up. On 5/29/24 at 8:47 a.m., the housekeeper (HK)-A stated they clean the resident's room daily if all three housekeepers were working, if not they cleaned their assigned wings, and the rooms not cleaned on that day would be done the next time that housekeeper worked. Daily in each room they cleaned the bathroom, [NAME], sweep, mop, and changed the linen. On 5/29/24 at 11:17 a.m., the resident was in his room in bed and the large amount of what resembled brown ground meat was still present on the floor and had not been cleaned up. The hallway directly outside the resident's room had been cleaned and a wet floor sign was placed near the door to R36's room. On 5/29/24 at 1:27 p.m., the resident was watching television in his room and the large amount of what resembled brown ground meat was still present on the floor and had not been cleaned up from the previous day. On 5/29/24 at 2:45 p.m., the director of environmental services (HK)-B stated they expected when any staff saw the large amount brown ground meat on the floor, they stoped and cleaned it up immediately. HK-B stated if all three housekeepers were working all rooms were cleaned daily. HK-B accompanied surveyor to the room. When we had arrived to the room at 2:48 p.m. it had been cleaned. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled Rooms dated 5/24/24 and 5/27/24 through 5/29/24 indicated R36's room had last been cleaned on Friday, 5/24/24, five days prior. On 5/30/24 at 8:49 a.m., the director of nursing (DON) stated their expectation was the rooms were to be cleaned daily and confirmed any items on the floor should have been cleaned up immediately. On 5/30/24 at 4:04 p.m., the administrator stated they expected their staff to have cleaned up any mess or items found on the floor, and it was important to ensure the residents dignity and provide a clean living and working environment for residents and staff. A facility policy for room cleaning was requested and none was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49657 Based on interview and document review the facility failed to ensure a written notification of transfer was sent to the office of the Ombudsman for long term care for 1 of 2 residents (R44) reviewed for hospitalization . Findings include: R44's undated face sheet listed the following diagnoses: heart failure, arthritis, pain, cellulitis (infection of the cell), pleural effusions (collection of fluid, air, pus, or blood between the lining of the lung and the lung itself, causes difficulty breathing), atrial fibrillation (top chambers of the heart beat erratically), lymphedema (collection of fluid in the extremities), chronic obstructive pulmonary disease (COPD- lung disease that makes it difficult to breath), chronic kidney disease-stage 4 (CKD-end stage kidney disease), atherosclerotic heart disease, prosthetic heart valve, pacemaker, obstructive sleep apnea (spells of absent breathing when sleeping), transient ischemic attack (TIA-brief stroke like event), depression, shortness of breath, and dizziness. R44's Interagency transfer orders dated 3/29/24 indicted R44 was hospitalized from 3/22/24 until 3/29/24 for Acute chronic systolic congestive heart failure. R44's progress notes dated 4/25/24 through 4/26/24 indicated R44 was hospitalized after a fall. R44's medical record lacked evidence a written notification of transfer was sent to the Ombudsman for long term care for either hospital transfer. On 5/29/24 at 4:39p.m., an electronic mail (e-mail) was received from the Office of the Ombudsman indicating no notifications of transfer were received for R44. On 5/30/24 at 08:16 a.m., registered nurse (RN)-A, stated when a resident goes into the hospital, they normally update the provider, got an order to transfer, prepared resident information, filled out a bed hold and sent a copy of the transfer to the ombudsman at the time of transfer, however they were unsure if it had been completed for either stay in the hospital for R44. On 5/30/24 at 08:39 a.m., the director of nursing (DON) stated they expected the floor staff at the time of the transfer faxed a copy of the bed hold form to the office of the Ombudsman to inform them of the transfer. The facility policy Discharge/Transfer Notification of Ombudsman last reviewed 10/2022, indicated if a resident was transferred to the hospital for any reason, the nurse who was doing the transfer will complete the notification form and fax it to the State Ombudsman's office.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview and record review the facility failed to accurately implement physician's orders for 1 of 1 resident (R44) reviewed for hospitalization s. Findings include: R44's admission minimum data set (MDS) dated [DATE] indicated the brief interview for mental status (BIMS) of 15/15, cognitively intact. R44's undated face sheet listed the following diagnoses: heart failure, arthritis, pain, cellulitis (infection of the cell), pleural effusions (collection of fluid, air, pus, or blood between the lining of the lung and the lung itself, causes difficulty breathing), atrial fibrillation (top chambers of the heart beat erratically), lymphedema (collection of fluid in the extremities), chronic obstructive pulmonary disease (COPD- lung disease that makes it difficult to breath), chronic kidney disease-stage 4 (CKD-end stage kidney disease), atherosclerotic heart disease, prosthetic heart valve, pacemaker, obstructive sleep apnea (spells of absent breathing when sleeping), transient ischemic attack (TIA-brief stroke like event), depression, shortness of breath, and dizziness. R44's orders dated 3/11/24, indicated a fluid restriction of 2000 ml's and was not changed per physician order upon R44's return to the facility. R44's Interagency Transfer Orders dated 3/29/24 indicted R44 was hospitalized from 3/22/24 through 3/29/24 for acute chronic systolic congestive heart failure and returned to the facility with an order for a 1500 ml fluid restriction dated to begin 3/29/24. On 5/30/24 at 8:16 a.m., registered nurse (RN)-A stated R44 was on a fluid restriction of 2000 ml' s' and confirmed it had been 2000 ml since RN-A could remember, and it had not been changed following the March hospitalization . ON 5/30/24 at 8:49 a.m., the director of nursing (DON) stated their expectation was upon a residents return from a hospitalization the discharge orders were entered by the health unit coordinator (HUC) and then verified by and RN or an RN would enter it and then it would be verified by a second nurse. DON stated they assumed they had missed the order and it was not entered appropriately. On 5/31/24 at 11:45 a.m., the DON confirmed the hospital discharge orders were not followed and stated it should have been completed and was important to prevent any further exacerbations (worsening of conditions). The facility Admission Criteria policy last revised March 2019, indicated prior to time of admission the residents physician provides the facility with information needed for immediate care of the resident including orders covering at least: type of diet, medication orders, and routine care orders to maintain or improve the residents function.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview, and document review, the facility failed to prevent an avoidable pressure injury related to improper placement and use of a mechanical lift sling for 1 of 1 residents (R19) reviewed for pressure injuries. This deficient practice resulted in actual harm for R19 who developed pressure and shearing related injury to his groin, thighs, and buttocks. Findings include: R19's admission minimum data set (MDS) dated [DATE], showed R19 had a brief interview for mental status (BIMS) score of 15/15 indicating cognitively intact, self-care deficit requiring substantial/maximal assistance for toileting hygiene, upper and lower dressing, positioning and transfers. R19's diagnoses included but were not limited to hemiplegia (weakness or paralysis of one side of the body), bipolar disease (a mental health condition that causes mood swings), and hypertension (high blood pressure). R19's care plan dated 2/14/24 indicated performance of activities of daily living (ADL's) had deteriorated related to a diagnosis of hemiplegia and required extensive staff assistance of one to two staff for toileting, dressing, bathing, grooming and bed mobility. Total dependence with Hoyer lift (a device designed to assist caregivers in safely transferring patients with limited mobility) for all transfers. Risk for pressure ulcers related to need for assist with bed mobility, transfers, and incontinence. Interventions included avoid shearing residents' skin during positioning, transferring, and turning; conduct a systematic skin inspection weekly; keep clean and dry as possible; keep linens clean, dry and wrinkle free; provide incontinence care after each incontinent episode and avoid friction to skin. R19's care plan lacked evidence of the size or color of sling required. EZ Way Smart Lift manufacturer operator instructions indicate the following: -Log roll the patient on his/her side away from you. -Position the sling so the handles on the back of the sling are facing the mattress. -Tuck half of the sling underneath the patient. -Using the center handle as a guide, center the sling on the patient's spine with the base of the sling approximately two inches below the base of the tailbone. -Logroll patient in opposite direction and pull rest of sling out the other side. -Lay patient on their back. Make sure the sling is centered beneath the patient. -Lift patient's left thigh and pull the left sling leg of the sling under patient's thigh. Then place excess sling left over the top of the patient's left thigh. -Repeat steps for the right thigh. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Move the EZ Way Smart lift until the tip of the boom (green nose cone) is centered of the patient's torso. -Take the sling leg lying over the left leg, cross it over and attach it on the hook of the hanger bar located on the right side of the patient. Take the sling lying over the right leg, cross it over and attach it on the hook of the hangar bar on the left side of the patient using the same length and color of loop strap on both sides. -This procedure will ensure the sling is under the patient's tailbone and behind his/her back, with the patient's weight evenly distributed on the sling. -Gently lift the patient's left knee, pulling the sling legs our from underneath the patient's thigh. Continue to right knee. -Lean patient slightly forward and grasp the side handles or the center handle, pulling the sling of from behind the patient. During observation on 5/28/24 at 03:13 p.m., R19 requested nursing assistants (CNA)-G and CNA-H assist him to change incontinent product and clothing. R19 stated the shorts he was wearing were wet with urine. CNA-H crossed the lift sling straps between R19's legs approximately one inch from his groin, connected all four mechanical sling straps to Hoyer lift while CNA-G ran the controls. When CNA-G began to lift R19 the bottom edge of the tan lift sling was noted to be just below R19's coccyx. The lower half of the sling was darker in color from the area under R19's buttocks extending up towards mid back. A strong odor of urine was noted. CNA-G turned the lift and pushed it towards R19's bed. CNA-G lowered R19 to his bed. CNA-H disconnected the sling straps CNA-G moved the lift away and walked to the opposite side of the bed from CNA-H and assisted with product and clothing change. CNA-H stated the sling was wet, however, continued to apply the device. CNA-G crossed straps of tan sling between R19's legs, pulled the straps together to the right side of R19's groin, and instructed CNA-H to move the lift to R19's bed. Both lower sling straps were positioned nearest to R19's right leg. CNA-G connected the lower sling straps to the lift. CNA-H again stated the sling was wet, however, continued to connect the wet sling straps to the lift. R19 asked CNA-H to wipe off the wheelchair cushion stating it had urine on it. CNA-G lifted R19 off the bed while CNA-H kept her hands on R19's back. R19's abdomen was not fully supported. His weight was not evenly distributed during the transfer due to the lower straps positioning. R19 stated ouch and it's pinching me. Neither staff addressed R19's concerns of pain. On 5/31/24 during continuous observation from 11:58 a.m. through 01:00 p.m., R19 was seated in his wheelchair with a green sling beneath him and lower straps noted to be aligned with his hips. Approximately 8 inches of green sling was folded and bunched behind R19 where his wheelchair back met the seat. CNA-E, and CNA-D connected the lift sling straps and raised R19 from his wheelchair. CNA-E was on R19's left side and stated the sling was not under R19 very well and instructed CNA-D to lower R19. CNA-D lowered R19, forcefully pulled the sling under R19's buttocks by grabbing the loop of the sling strap and pulling hard towards the mechanical lift. -At 12:08 p.m., two additional staff entered the room. Registered nurse RN-D attempted to pull the sling under R19 by pulling the lower left strap towards the mechanical lift and instructed staff to do the same on the lower right side. RN-D instructed staff to raise the sling. She again pulled the sling towards the mechanical lift by yanking on the straps. (continued on next page)

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	245546	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	3401 East Medicine Lake Boulevard Plymouth, MN 55441

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:13 p.m., R19 stated I feel like I'm going to be pulled out of my chair Staff continued to raise, lower, and readjust sling under R19. At 12:16 p.m., CNA-F entered room, instructed staff, and stated the sling was not under R19 correctly. CNA-F instructed staff to connect the sling straps to the lift using the yellow loop on the lower portion of sling and green loop on the upper portion of the sling. As staff began raising the lift R19 stated Ouch. RN-D and CNA-F completed transfer and left the room. Assistant director of nursing (ADON) entered the room. -During skin inspection ADON stated R19 had two reddish purple lines approximately 8 centimeters on lower inner thigh extending into groin and going up R19's right buttock. There was an abrasion approximately 3 centimeters by 3 centimeters on right buttock and another 2 centimeters by 3 centimeter to the front lower scrotum with scant blood. Further, there were three small abrasions to the back of scrotum and a reddish purple line approximately 10 centimeters on front of left upper thigh extending into groin. -During interview on 05/30/24, at 10:51 a.m., CNA-C stated residents had slings in their room. Further, slings that had to be crossed at the legs must always be removed from under the resident after transfer. -During interview on 05/30/24, at 10:26 a.m., registered nurse (RN)-A stated the sling normally used for R19, who weighed 298 lbs, went up to 200 lbs., and he did not know who determined what sling to use. Additionally, he stated slings were routinely left under residents and the care plan would include this information. Review of R19's careplan lacked evidence of type or color of sling to be used. During interview on 5/31/24, at 03:04 p.m., with ADON and DON, ADON stated the abrasions and reddish-purple lines on R19's groin were from improper sling use and improper transfer techniques. ADON stated by leaving a wet sling under a resident and forcefully tugging on the sling straps would cause increased pressure to R19's skin and cause tearing of the skin. ADON stated the injuries to R19's groin were consistent with friction or shearing, and that she had notified R19's physician and requested orders for management. DON stated she expected all staff to immediately report any alterations in a resident's skin to the nursing staff. DON stated this was important so nursing staff can investigate the root cause of the skin alteration and monitor the resident's skin for signs of infection or worsening wounds. Facility procedure titled Lifting Machine, using a Mechanical with a revised date of July 2017 indicated lift design and operation varied across manufacturers and staff must be trained and demonstrate competency using the specific machines or devices utilized by the facility. Measure the resident for proper sling size and purpose, according to manufacturer's instructions. Double check the sling and machine's weight limits against the resident's weight. Visually check the size to ensure it is not too large or too small. Make sure the sling is attached to the clips and that it is properly balanced. Lift the resident 2 inches from the surface to check stability of the attachments, the fit of the sling and the weight distribution. Check the resident's comfort level by asking or observing for signs of pinching or pulling of the skin. Carefully remove the sling from under the resident. Document the reason for the transfer, the type of lift used, equipment size and condition, names, and titles of staff assisting, resident's physical and mental condition before and after the procedure and how the resident tolerated the procedure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Surveyor: [NAME], [NAME] M. Based on observation, interview, and document review, the facility failed to perform mechanical lift and lift sling assessments for 1 of 1 residents (R19) to ensure appropriate use and proper size. Further the facility failed to adequately train staff on manufacturers guidelines for use of mechanical lift. This deficient practice had the potential to effect all residents requiring assist with a mechanical lift. Findings include: R19's admission minimum data set (MDS) dated [DATE], showed R19 had a brief interview for mental status (BIMS) score of 15/15, cognitively intact, self-care deficit requiring substantial/maximal assistance for toileting hygiene, upper and lower dressing, positioning and transfers. R19's diagnoses included hemiplegia (weakness or paralysis of one side of the body) and muscle weakness. R19's care plan dated 2/14/24 indicated R19's ability to perform activities of daily living (ADL's) had deteriorated related to a diagnosis of hemiplegia and required extensive staff assistance of one to two staff for toileting, dressing, bathing, grooming and bed mobility. Total dependence with Hoyer lift (EZ Way Smart Lift- a device designed to assist caregivers in safely transferring patients with limited mobility) for all transfers. R19's care plan lacked evidence of the size or color of sling required. R19's record lacked evidence of a comprehensive safe transfer assessment to determine the appropriate sling to use with the mechanical lift. During observation on 5/29/24, at 03:04 p.m., R19 was driving an electric wheelchair in hallway outside his room and through doorway into his room. [NAME] mechanical lift sling noted under resident with sling straps hanging loose. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 5/28/24 at 03:13 p.m., R19 requested certified nursing assistants (CNA)-G and CNA-H assist him to change his incontinent product and clothing. CNA-H crossed the lift sling straps between R19's legs approximately one inch from his groin, connected all four mechanical sling straps to EZ Way Smart lift while CNA-G ran the controls. CNA-H kept her hand on R19 while CNA-G turned the lift and pushed it towards R19's bed. When R19 was situated above his bed CNA-G began lowering R19 to his bed. CNA-H disconnected the sling straps when R19 was completely lowered to the bed. CNA-G then moved the lift machine away from the bed but walked around to the opposite side of the bed from (CNA)H to assist with the incontinent product and clothing change. Upon completion of changing of clothing and incontinent product, (CNA)H stated the sling was wet but did not retrieve a clean sling. CNA-G crossed straps of tan sling between R19s legs and pulled both straps to the right side of R19's groin. They instructed CNA-H to move the mechanical lift to R19's bed and began to connect the sling straps to the lift. CNA-H again stated the sling was wet while holding the upper sling strap but continued to connect the sling straps to the lift. R19 asked CNA-H to wipe off his wheelchair cushion stating it had urine on it. CNA-G began to lift R19 off the bed while CNA-H kept her hands on R19's back. R19's abdomen was not fully supported, and weight was unevenly distributed during the transfer due to the lower straps positioning. R19 stated ouch and it's pinching me throughout the transfer to his wheelchair. On 5/31/24 during continuous observation from 11:58 a.m. through 01:00 p.m., R19 was seated in his wheelchair with a green sling beneath him with lower straps/loops noted to be aligned with his hips. Approximately 8 inches of green sling was folded and bunched behind R19 where his wheelchair back met the seat. CNA-E, and CNA-D connected the mechanical lift sling straps and began to raise R19 from his wheelchair approximately one inch when CNA-E, who was on R19's left side, stated the sling was not under R19 very well and instructed CNA-D to lower R19 back to the wheelchair. CNA-D lowered R19 to the wheelchair and attempted to pull the sling under R19's buttocks by grabbing the loop of the sling strap and pulling hard towards the mechanical lift. At 12:08 p.m., two additional staff, registered nurse RN-D and RN-E entered the room. RN-D attempted to pull the sling under R19 by pulling the lower left strap towards the mechanical lift and instructed staff to do the same on the lower right side. RN-D instructed staff to raise the sling and then she again attempted to pull the sling towards the mechanical lift. At 12:13 p.m., R19 stated I feel like I'm going to be pulled out of my chair. CNA-E had his hands on R19 while CNA-D continued to raise, lower, and attempt to readjust sling under R19. At 12:16 p.m., CNA-F entered room and stated the sling was not under R19. CNA-F instructed staff to connect the sling straps to the mechanical lift using the yellow loop on the lower portion of sling and green loop on the upper portion of the sling. As staff began raising the lift R19 state Ow. Staff continued transfer to R19's bed. When R19 was lowered onto his bed RN-D, RN-E, and CNA-F left the room. ADON entered the room. Staff completed incontinent cares and began the process of placing sling under R19 to transfer back to his wheelchair. At 12:55 p.m., CNA-D and CNA-F attached sling straps to the lift. ADON stated R19 was positioned to far to one side and told staff he could not be lifted in that position. Staff readjusted R19 to the center of the sling and reattached the sling to the mechanical lift. Staff began raising the lift when ADON asked if R19 had used the current sling before. CNA-D stated it was the only one in the room and continued the transfer of R19. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/30/24, at 10:37 a.m., CNA-B stated two staff were needed to transfer with a mechanical lift. Additionally, he stated the case managers, or the doctors decided what sling size to use and usually the slings were in the room and staff would use whatever was in the resident's room. He went on to say the slings were typically left under a resident unless the doctor said not to. During interview on 5/30/24, at 10:51 a.m., CNA-C stated slings were left in a resident's room or found downstairs. Additionally, he stated staff made sure slings were not bunched up under a resident and the sling that required the straps to be crossed always had to be removed from beneath a resident. During interview on 5/30/24, at 10:26 a.m., RN-A stated he did not know how the sling size was determined and staff regularly left the sling under a resident after transfer. Furthermore, this information was found on a resident care plan. During interview on 5/30/24, at 10:57 a.m., DON stated all lifts required two staff. DON stated all residents had the slings kept in their rooms and it should be on the CNA care sheets. OT assessed sling size and to determine the appropriate way to transfer. DON stated she expected staff to removed the slings from under a resident unless there was a doctor's order instructing otherwise, or in the case of resident preference. DON also stated her expectation of staff included removing a soiled or wet sling from a resident's room and replacing it with a clean one. During interview on 5/30/24, at 11:08 a.m., licensed practical nurse and staff development coordinator (LPN-SDC) stated staff training was completed with an online education program. Additionally, staff were provided instruction during orientation on the floor by thier peers. During interview on 5/31/24, at 01:01 p.m., assistant director of nursing (ADON) stated upon admission occupational therapy (OT) would do an assessment for the appropriate mechanical lift. ADON stated the sling type and size was also determined at that time by OT. Additionally, ADON stated all nursing staff were trained upon hire on how to safely and appropriately operate the facility used mechanical lifts. ADON went on to say, It's obvious they need more training to do safe transfers. During interview on 5/31/24, at 02:28 p.m., certified occupational therapy assistant (COTA) stated therapy performed therapy evaluation upon admission if the resident had a physician order. COTA went on to state therapy made recommendations on the type of device or lift depending on the level of assistance required but did not make recommendations on the appropriate sling sizes or styles to be used. Furthermore, COTA stated nursing had the education on lift transfers and should be able to make a judgement on sling selections. During interview on 5/31/24, at 03:04 p.m., DON and ADON both stated they did not participate in new staff orientation and could not describe the methods used to educate staff on facility used mechanical lifts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EZ Way Smart Lift manufacturer operator instructions indicate the following: Log roll the patient on his/her side away from you. Position the sling so the handles on the back of the sling are facing the mattress. Tuck half of the sling underneath the patient. Using the center handle as a guide, center the sling on the patient's spine with the base of the sling approximately two inches below the base of the tailbone. Logroll patient in opposite direction and pull rest of sling out the other side. Lay patient on their back. Make sure the sling is centered beneath the patient. Lift patient's left thigh and pull the left sling leg of the sling under patient's thigh. Then place excess sling left over the top of the patient's left thigh. Repeat steps for the right thigh. Move the EZ Way Smart lift until the tip of the boom (green nose cone) is centered of the patient's torso. Take the sling leg lying over the left leg, cross it over and attach it on the hook of the hanger bar located on the right side of the patient. Take the sling lying over the right leg, cross it over and attach it on the hook of the hangar bar on the left side of the patient using the same length and color of loop strap on both sides. This procedure will ensure the sling is under the patient's tailbone and behind his/her back, with the patient's weight evenly distributed on the sling.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation, interview and document review the facility failed to ensure ongoing monitoring of weight was completed as directed for 1 of 3 residents (R45) reviewed for nutrition. Findings include: R45's quarterly minimum data set (MDS) dated [DATE], indicated R45 was cognitively intact, had poor appetite or overeating, and was independent with eating. The MDS also included diagnoses of hypertension (high blood pressure), hyperlipidemia (too much fat in a patient's blood), and paraplegia (partial or complete paralysis of the lower half of the body. Additionally, the MDS indicated R45 was at risk for pressure ulcers and had at least one stage two, partial thickness pressure ulcer, at least one stage three, full thickness pressure ulcer, one stage four, full thickness pressure ulcer with exposed bone, tendon, or muscle, and at least one unstageable pressure ulcer. R45's care plan dated 1/24/24 indicated R45 had a nutritional risk due to diagnoses of paraplegia, hypertension and hyperlipidemia, weight fluctuations with unplanned weight loss then significant weight gain, skin status/wounds, variable oral intake patterns, and high body mass index (BMI). Interventions included obtain weight as ordered and per facility protocol. R45's full nutritional assessment dated [DATE] indicated R45 had a BMI of <19 or >27, skipped meals, and nutritional risk indicator score of 11 indicating high risk. R45's signed physician order report dated 5/1/24, indicated R45 received Arginaid (a nutritional supplement) twice daily, received a regular diet with regular texture and thin liquids, and was ordered to be weighed monthly on bath days with special instructions to include weight be completed even if bath/shower was declined. R45's electronic medical record (EMR) indicated the following recorded weights: 4/3/24- 268.2lbs, 11/27/23-265.6lbs, 11/16/23- 263.1lbs, 10/5/23-245.7lbs, 7/12/23-244.7lbs, 6/22/23-248.8lbs, 5/23/23-237.1lbs. Progress note dated 12/27/23 at 09:19 a.m., signed by registered dietician (RD)-I indicated R45 was followed monthly due to skin status and noted weight gain; RD to continue to monitor, make changes/recommendations prn and follow monthly due to skin status and weight changes. Progress note dated 01/29/24 at 09:52 a.m., RD-H indicated no new nutritional changes; most recent weight noted of 265.6# 11/27/23; BMI: 36.0. RD will recommend an updated weight; RD to continue to monitor weights. Progress note dated 02/05/24 at 04:13 p.m., RD-H indicated no updated weight since 11/27/23 of 265.6# BMI: 36.02; significant weight gain noted at 30 days (+19.9#, +8%) and 180 days (+28.5#, +12%); elevated BMI, noted weight gain based on most recent weight over past year; RD will continue to monitor weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 3/19/24 at 10:40 a.m., signed by RD-H indicated most recent weight noted of 265.6# on 11/27/23; BMI: 36.0. RD will recommend an updated weight; Res has increased needs to promote wound healing. Resident continues to be provided Ariginad BID for extra nutritional support to aid in wound healing; RD will continue to monitor weights. Progress note dated 4/16/24 at 10:31 a.m., signed by RD-H indicated weight (4/3/24): 268.2#; no 30 days or 90 days weight; 180 days (10/5/23): 245.7; RD will continue to monitor weights. Progress note dated 4/30/24 at 10:55 a.m., signed by RD-H indicated weight (4/3/24): 268.2#; BMI: 36.3; elevated BMI, noted weight gain based on most recent weight over past year, use of supplements to aid in meeting nutritional needs. RD will continue to monitor weights. Progress note dated 5/15/24 at 08:34 a.m., signed by RD-H indicated weight (4/3/24): 268.2#; no 30 days or 90 days weight; 180 days (10/5/23): 245.7# (+22.5, +9.1%); BMI: 36.3; RD will continue to monitor weights. Review of R45's EMR did not reveal any notification to physician of lapse in recorded weights. During interview on 5/29/24, at 09:28 a.m., RD-H stated the dietary manager attended care conferences and RD reviewed at risk residents. RD-H stated weights were done monthly for RD to review, however, if they were not completed RD would sent a request to DON to address. During interview on 5/30/24 at 11:06 a.m., DON stated weights were routinely done monthly for most residents, however, could be scheduled at a greater frequency with physician orders. After reviewing R45's EMR, DON confirmed R45 had not been getting weights done as ordered. DON stated her expectation was all staff followed the care plans and weighed residents per physician's orders, and, if residents refused it should be clearly documented and physician updated. DON went on to say weight monitoring and weight documentation was essential to accurately monitor residents' nutritional status, skin integrity and wound healing. Facility policy, Weighting and measuring the resident, indicated the purpose was to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. Further, the policy indicated if the resident refused the procedure, the reason why, the intervention taken, and notification of the nursing supervisor was to be documented.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49035 Based on observation, interview and document review, the facility failed to ensure post-dialysis assessment and monitoring was completed for 1 of 2 residents (R42) reviewed for dialysis. Findings include: R42's Resident Face Sheet dated 5/31/24, included diagnosis of end stage renal disease (ESDR), hypotension of hemodialysis (low blood pressure), anemia in chronic kidney disease (low red blood cells), and dependence on renal dialysis. R42's physician order report dated 5/31/24, included an order to prepare a PRN dose of midodrine 10 mg (a medication to treat low blood pressure) to send with resident to dialysis Tuesday, Thursday and Saturday. Physician order report failed to include orders to monitor AV fistula for a thrill (a specific feeling over the dialysis graft) and a bruit (a whooshing sound heard with a stethoscope over the dialysis graft site) daily. R42's treatments administration history for May 2024 printed 5/30/24, included an order to avoid taking blood pressure or lab draws on left arm and to remind/encourage R42 to keep the pressure dressing intact after dialysis and monitor for bleeding once the pressure dressing was removed. Treatment administration history failed to include post dialysis monitoring including blood pressure, assessment of resident's overall condition or monitoring of the fistula site. R42's Care Plan, revised 4/24/24, included R42 had an AV fistula on right forearm. This was inconsistent with documentation to avoid blood pressure and lab draws on left arm due to fistula on resident's left arm. R42's care plan included he attended dialysis at HCMC Dialysis in Minneapolis and included a phone numbers for the location. R42's treatment details report was from DaVita dialysis center, not HCMC, dated 5/11/24 listed an access site of left upper arm. During interview on 5/30/24 at 12:26 p.m., dialysis center registered nurse stated it was best practice to monitor blood pressure and make sure the resident is not lightheaded or dizzy. The resident should not leave the pressure dressing on overnight but should be on for at least 3 hours and dialysis site should have been monitored. During interview on 5/31/24 at 10:38 a.m., director of nursing (DON) stated the facility did not have a policy for dialysis care. DON confirmed the facility had not completed post dialysis assessments when a resident returned from dialysis and had not monitored the fistula daily. DON stated this would have been important to have a policy to have formal expectations and standard care provided to every dialysis resident.

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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** 49657 Based on record review and interview the facility failed to ensure a clinical rationale for the extended use of an as needed (PRN) antianxiety medication (Ativan) beyond 14 days was documented for 1 of 1 resident (R25) reviewed for hospice services. Findings include: R25's quarterly minimum data set (MDS) dated [DATE], indicated R25 had a brief interview for mental status (BIMS) of 11 and was a substantial to maximum assist for dressing and cares and dependent for bathing. R25's MDS indicated diagnoses of hypertension (high blood pressure), diabetes mellitus, dementia (loss of cognitive functioning), hemiparesis (loss of ability to move part of one's body) and anxiety disorder. R25's current physician orders signed 5/1/24, indicated an order for lorazepam (Ativan) 1mg by mouth (PO) every 2 hours as needed (PRN). The start date was 3/13/24 and end date of 9/13/24. R25's medical record lacked clinical rationale for the extended use beyond 14 days. R25's electronic medical record (EMAR) reviewed 5/31/24, indicated R25 had last received a dose of Ativan on 5/19/24. R25's consultant pharmacist's medication review dated 3/5/24, indicated the following recommendations from the pharmacist: This patient's PRN Ativan order was updated on 2/9/24, however there was no stop date/duration listed for this medication on the medication administration record (MAR). Per updated CMS (Center for Medicaid Services) regulations, all new prn psychotropic medications orders must be re-evaluated within 14 days of initiation, and then at routine intervals thereafter. Additionally, when renewing the PRN psychotropic orders, clinical rationale for continuing the medication must be provided. NOTE: CMS had specified that hospice was not an exception to the rule. The physician response dated 3/13/24 did not provide a clinical rationale for use beyond 14 days. On 5/30/24 at 08:49 a.m., the director of nursing (DON) stated their expectation for a PRN psychotropic medication was the order would last 14 days or have a clinical indication for why the order was extended. On 5/31/24 at 11:22 a.m., the pharmacist (O)-C stated a PRN psychotropic medication order such as Ativan needed to have rational for use, duration, and clinical reasoning as to why the physician was extending the order past the 14 days. O-C confirmed the facility failed to provide a clinical rational for extending the order. Furthermore, O-C stated they had addressed this issue in the monthly pharmacy review from December, March and planned to address again in June. (continued on next page)

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	245546	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	3401 East Medicine Lake Boulevard Plymouth, MN 55441

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Psychotropics Policy and Procedure last reviewed 2/2024, indicated PRN medication orders were to be for 14 days then set to be renewed or discontinued depending on use and need.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46943 Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (quarter one), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings include: Review of the facility Payroll Based Journal Report (PBJ) [NAME] Report 1705 D for quarter one (10/1/23 to 12/31/23) identified a 1-star staffing rating and failure to submit PBJ data. Review of staffing schedules identified the facility had a registered nurse at least 8 hours of every 24 hours and/or a licensed nurse 24 hours seven days a week per requirement for the above-mentioned dates and therefore the data reflected in the PBJ to CMS was inaccurate. When interviewed on 5/31/24 at 3:00 p.m., the payroll manager stated he used to submit the facility PBJ report quarterly but had lost access to the CMS submission site and so then the administrator took over the submissions. When interviewed on 5/31/24 at 3:00 p.m., the administrator stated he started submitting the PBJ report after the payroll manager lost access and acknowledged he had inadvertently failed to submit direct care staffing information for quarter one. There was no policy related to PBJ entries provided by the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49657 Based on interview and document review the facility failed to ensure the infection control program included symptom tracking and ongoing analysis of trending of resident infections to prevent the spread of infections. This deficient practice had the potential to affect all 58 residents in the facility. Findings include: The facility's infection control logs were reviewed for March and April 2024. The logs identified tracking records of residents with infections, cultures, and treatments. However, the facility lacked documentation of analysis and/or trending of patterns identified. The facility utilized a form titled infection control log which had sections for each of the following items: identifying location, date, the patient, admitted , room number, unit, type, site and date of onset of infection, cultures, organisms, antibiotic resistance. Additionally, whether an antibiotic was started, infection definition (type of), classification section to select community or healthcare acquired infections, date resolved and if the resident was isolated or not. Furthermore, the form included sections regarding tracking of infections such as total number of different types of infections, number of new cases with and with out antibiotic resistance organisms, total number of infections, and reporting time period. Four infection control logs were provided by the facility, of those four, two were labeled April of 2024 and two were labeled May of 2024. One of the May of 2024 logs designated 2nd floor as a location, the other three lacked a location. The two infection control logs dated April of 2024, were filled out inconsistently and lacked part or all of the following information for the residents listed there: location of log, symptoms, location of infection, type of infection, cultures or diagnostics and dates taken, classification of infection, date resolved, if isolation was necessary, start dates of antibiotics, and whether or not criteria was met for the infection. Additionally, the form lacked documentation of analysis or tracking of symptoms and infections within the facility. The two infection control logs dated May of 2024, were filled out inconsistently and lacked part or all of the following information for the residents listed there: location of log, symptoms, location of infection, type of infection, cultures or diagnostics and dates taken, classification of infection, date resolved, if isolation was necessary, start dates of antibiotics, and whether or not criteria was met for the infection. Additionally, the form lacked documentation of analysis or tracking of symptoms and infections within the facility. The Quality assurance (QA) meeting minutes dated 4/8/2024, listed infection control: Jan-7, Feb-4, March-10. No additional details were provided. On 5/30/24 at 9:31 a.m., the infection preventionist licensed practical nurse (LPN)-A stated since the previous director of nursing (DON) left the facility near the end of March 2024, the current DON was responsible for symptom tracking and antibiotic stewardship in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/30/24 at 11:45 a.m., the DON stated since the previous DON had left the facility the infection preventionist LPN-A had been completing symptom tracking and antibiotic stewardship. DON had not completed either task. On 5/31/24 at 1:22 p.m., the DON and LPN-A confirmed neither person had been analyzing the data and trends with symptom tracking and antibiotic stewardship in the facility since the exit of the previous DON in late March 2024. On 5/31/24 at 3:30 p.m., the administrator stated they believed the DON had been analyzing and trending symptom tracking and antibiotic stewardship. They were informed the DON had stated it had not been completed. Administrator stated they also discuss them at QA, however deferred to nursing to provide the information discussed. The Infection Control-Surveillance Policy last reviewed 7/2023, indicated the infection preventionist or designated personnel was responsible for gathering and interpreting surveillance data. Interpreting Surveillance data: Analyze the date to identify trends, compare previous timeframes. The infection preventionist and quality assurance committee will review data quarterly to identify predominant pathogens or sites of infection or in particular units by recording month to month and observing trends.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 49657 Based on interview and document review the facility failed to implement a process for antibiotic stewardship to determine appropriate indications, dosage, duration, symptoms, analysis of trends and efficacy of antibiotic use. This had the potential to affect any of the 58 residents in the facility. Findings include: The facility's infection control logs were reviewed for March and April of 2024. The logs identified tracking records of residents with infections, cultures, and antibiotic treatments. However, the facility lacked documentation of analysis, trending of patterns identified or efficacy of antibiotics used. The facility utilized a form titled infection control log which had sections for each of the following items: identifying location, date, the patient, admitted , room number, unit, type, site and date of onset of infection, cultures, organisms, antibiotic resistance. Additionally, whether an antibiotic was started, infection definition (type of), classification section to select community or healthcare acquired infections, date resolved and if the resident was isolated or not. Furthermore, the form included sections regarding tracking of infections such as total number of different types of infections, number of new cases with and with out antibiotic resistance organisms, total number of infections, and reporting time period. Four infection control logs were provided by the facility, of those four, two were labeled April of 2024 and two were labeled May of 2024. One of the May of 2024 logs designated 2nd floor as a location, the other three lacked a location. The two infection control logs dated April of 2024, were filled out inconsistently and lacked part or all of the following information for the residents listed there: location of log, symptoms, location of infection, type of infection, cultures or diagnostics and dates taken, classification of infection, date resolved, if isolation was necessary, start dates of antibiotics, and whether or not criteria was met for the infection. Additionally, the form lacked documentation of analysis of antibiotic usage and efficacy within the facility. The two infection control logs dated May of 2024, were filled out inconsistently and lacked part or all of the following information for the residents listed there: location of log, symptoms, location of infection, type of infection, cultures or diagnostics and dates taken, classification of infection, date resolved, if isolation was necessary, start dates of antibiotics, and whether or not criteria was met for the infection. Additionally, the form lacked documentation of analysis of antibiotic usage and efficacy within the facility. The Quality assurance (QA) meeting minutes dated 4/8/2024, listed infection control: Jan-7, Feb-4, March-10. No additional details were provided. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/30/24 at 9:31 a.m., the infection preventionist licensed practical nurse (LPN)-A stated since the previous director of nursing (DON) left the facility near the end of March 2024, the current DON was responsible for antibiotic stewardship in the facility. On 5/30/24 at 11:45 a.m., the DON stated since the previous DON had left the facility the infection preventionist LPN-A had been completing antibiotic stewardship. DON had not completed antibiotic stewardship. On 5/31/24 at 1:22 p.m., the DON O-B and LPN-A confirmed neither person had been analyzing the data, usage trends and efficacy of antibiotics in the facility since the exit of the previous DON in late March 2024. DON and LPN-A stated each day during their interdisciplinary team meeting they discuss all new orders and why the resident was placed on the antibiotics. Staff were expected to chart in progress notes if the antibiotics were working or any reactions occurred. However, there was no follow up unless completed by the floor nurses. On 5/31/24 at 3:30 p.m., the administrator stated the the DON had been analyzing and trending the antibiotic stewardship program. They were informed the DON had stated it had not been completed. Administrator stated they also discussed them at QA, however deferred to nursing to provide the information discussed. The Antibiotic Stewardship Policy last reviewed in 2024, indicated the purpose of the antibiotic stewardship program was to monitor the use of antibiotics in our residents. Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview and record review the facility failed to ensure 1 of 5 residents (R35) received a pneumococcal vaccine offered by the facility. Findings include: R35's undated face sheet indicated R35 was [AGE] years of age, admitted to the facility on [DATE], and had diagnoses of current smoker, traumatic subdural hemorrhage without loss of consciousness (stroke related to bleeding in the brain), dysphagia (difficulty swallowing), diabetes mellitus, atrial fibrillation (top chambers of the heart beat erratically), congestive heart failure (heart does not beat efficiently), and depression. R35's current physician orders reviewed 5/31/24, indicated a physician's order on 2/29/24 which read may receive pneumococcal vaccinations if indicated. R35's progress note dated 3/15/24, indicated R35 had received education and given consent upon admission to receive a dose of the pneumococcal conjugate vaccine (PCV) 15 or PCV-20. R35's vaccination record dated 5/29/24, lacked evidence a pneumococcal vaccination was received. R35's chart lacked evidence a dose of PCV-15 or PCV-20 was given. On 5/30/24 at 9:31 a.m., the infection preventionist licensed practical nurse (LPN)-A confirmed R35 had not received either a PCV-15 or PCV-20 dose. On 5/30/24 at 10:39 a.m., an electronic mail (e-mail) sent from thrify white pharmacy to the facility, indicated on 3/30/24 the pharmacy faxed an approval form for the vaccine which was not responded to or followed up on by the facility. On 5/31/24 at 3:48 p.m., the director of nursing (DON) expected the staff would go over education, consents and administer vaccinations upon admission to the facility to help reduce the risk of pneumonia. A pneumococcal vaccination policy was requested, and it was not provided.