STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuff Memorial Home	505 East 4th Street Hills, MN 56138

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49336 Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R32) reviewed for prosthetics. Findings include: R32's, Face sheet identified he had a diagnoses of Transient Ischemic Attack (stroke), absence of left leg below knee amputation, anxiety and depression. R32's, 5/14/24 Significant change Minimum Data Set (MDS) identified R32 was cognitively intact, had used substantial/maximal assistance with activities of daily living and was dependent with mobility and transfers. R32's MDS, section GG, did not identify R32 had a left leg below the knee prosthetic. R32's, undated, current care plan identified he had a self-care performance deficit related to his left leg below knee amputation. The goal was for R32 to maintain current level of function. Interventions were for staff to apply the left leg stump shrinker sleeve and prosthetic to his left lower extremity for transfers, standing and/or pivoting with his hemi-walker, and to remove the left leg prosthetic when R32's request. Observation and interview on 7/28/24 at 6:56 p.m., identified R32 had a left leg prosthetic along with his left stump shrinker sleeve stored next to his recliner. He stated he had received his first below the knee prosthetic approximately 2 years ago from Sioux Falls Orthopedic Institute and had recently received a newer left leg prosthetic that would assist him with ambulation and transfers. Interview on 7/30/24 at 10:58 a.m., with registered nurse (RN)-A stated she did not code R32's prosthetic accurately on his current MDS. She stated she would make a modification on R32's MDS. Interview on 07/30/24 03:53 p.m., with director of nursing (DON) would expect accurate coding on the MDS and plan to implement a verification process to prevent MDS errors from reoccurring. Review of 7/29/24, MDS policy identified MDS would be completed within the time frame guidelines and would refer to RAI (Resident assessment instrument) manual for updates. The policy lacked direction on how to correct and/or identify changes to the MDS when an error would occur.

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 47497 Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance for 1 of 5 resident (R12) who had an order for an antibiotic with no end date. Findings include: R12's 6/4/24, Significant Change Minimum Data Set (MDS) assessment identified her cognition was intact, she used a walker for mobility, and was independent with activities of daily living (ADL's). Review of R12's current diagnosis list identified a diagnosis of chronic cystitis without hematuria (inflammation of the bladder that can predispose patient to bladder infections). R12's current medication administration record identified she has been taking cephalexin (antibiotic) 250 milligrams (mg) daily for a diagnosis of chronic cystitis starting upon admission in January of 2024. Review of R12's current care plan identified she was on antibiotic therapy related to chronic bladder infections. Staff were to monitor adverse reactions or signs and symptoms of secondary infections related to antibiotic therapy. The care plan made no mention that staff should monitor for effectiveness, or review to ensure the long-term antibiotic therapy remained appropriate. There was no documentation to support other methods of prevention, such as cranberry juice or diet changes had been attempted, nor that it was being overseen by a specialist or medical provider routinely. Review of the June 2024 Quality Assurance and Performance Improvement (QAPI) minutes identified that 2 residents R6 and R15 had received antibiotic therapy, the minutes included the type of antibiotic, duration, and the indication for use. The minutes made no mention of R12's use of chronic antibiotics. Review of the facilities infection surveillance monthly report identified they had been tracking infections and antibiotic use in the facility; however, the report did not include any tracking for R12's use of a prophylactic antibiotic cephalexin oral capsule 250 mg daily for a diagnosis of chronic cystitis without hematuria (bladder infection). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/30/24, at 10:02 a.m., with the infection preventionist (IP) identified R12 had an order for antibiotics in place when she was admitted to the facility in January of 2024. The order did not include an end date, and she had not followed up to obtain one. She thought the order came from a previous doctor but was not certain and did not have a copy of the original order. They had no documentation that the antibiotic had been monitored for effectiveness, had not completed a time out, and had not followed up with the primary physician to see if the medication should be reviewed by a urologist to ensure it remained an appropriate treatment. She identified that they did not have an end date because it was used prophylactically to prevent infection. She had not included it in her monthly infection report or the QAPI facility antibiotic use report because although R12 is taking an antibiotic, she does not have an active infection. She identified that R12 has not had any complaints of pain or discomfort and has had no recent infections. R12 is seen by her primary doctor every 60 days at the facility, however, she was unable to provide any documentation that the physician had reviewed the long term antibiotic or any documented rationale for the continued use of the antibiotic. R12's primary physician was not available for interview during the survey period. Review of the 11/14/23, Antibiotic Stewardship Program policy identified that all prescriptions for antibiotics shall specify the dose, duration, and indication for use. Staff will monitor the response to antibiotics, and laboratory results when available, and consult with the physician to determine if the antibiotic is still indicated or adjustments should be made. Antibiotics upon admission weather a new admission or a re-admission to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.