| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245548 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Tuff Memorial Home | 505 East 4th Street<br>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.

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interview and document review, the facility failed to have evidence of measurable goals and documentation of an analysis and evaluation of the data, submitted to the QAPI committee to ensure Performance Improvement Projects (PIPS) areas identified had oversight and a documented action plan. This had the potential to affect all 40 residents living in the facility.Findings include: Review of the QAPI meetings identified in: March 13, 2025, QAPI minutes identified the Restorative program was identified as a PIP, but no measurable goals or action plan was discussed or put in place. April 9, 2025, contained a blank table with labels of Action Plan; Person's Responsible, Target Date, Outcome; and Notes. The QAPI meeting minutes listed a summary from the director of nursing (DON) of days of Restorative therapy provided, and list of residents who did not go to the therapy, but there was no Action plan or measurable goals developed to move forward with the project. July 23, 2025, QAPI meeting minutes, again had a blank table for Action items, Person's Responsible, Target Date, Outcome; and Notes to be followed up at the next QAA meeting, and the area for Restorative Program notes was blank. Interview on 8/27/25 at 11:23 a.m., with the administrator and the social services designee (SSD) identified they acknowledged they had failed to develop a measurable goal and associated Action Plan for the identified PIP of the Restorative Program. They reported there had been discussion but no documentation as to a measurable goal with the identified Action Plan included. Review of the February 2024, Quality Assurance and Performance Improvement Policy identified the committee was to meet at least quarterly to evaluate and coordinate activities including PIP projects under the QAPI program. The facility was to act toward performance improvement with actions monitored and documented in subcommittee and committee meetings. |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to establish criteria for employee illness and appropriate return to work for 3 of 3 sampled staff (nurse aide (NA)-A and NA-B, and trained medication aide (TMA)-A). In addition, the facility failed to ensure staff performed appropriate hand hygiene while assisting 5 of 5 residents (R2, R11, R16, R21, and R35) with meals in the dining room. The facility also failed to ensure staff were following manufacturer's instructions by rinsing and air-drying nebulizer administration sets following treatment and between use for 1 of 1 (R27) resident observed.Findings include:<br><br>Employee Illness<br><br>Review of sampled employee illness forms and timecards from February 2025 through May 2025 identified:<br><br>TMA-A’s Paid Time Off (PTO) Request/Overtime Approval Form sheet identified TMA-A called in to work with symptoms of diarrhea and nausea on 2/22/25. There was no mention on the log of when TMA-A had returned to work. TMA-A’s timecards revealed TMA-A had worked on 2/22/25 from 6:29 a.m. to 9:10 a.m., for a total of 2.68 hours and returned to work on 2/23/25.<br><br>NA-A’s PTO Request/Overtime Approval Form identified NA-A called in to work with respiratory symptoms and fever, myalgia (pain in the muscles), body aches and a productive cough on 5/20/25. NA-A timesheet identified NA-A had worked on 5/19/25 from 10:10 p.m. to 05:48 a.m. the next day, for a total of 7. 14 hours. C.N.A-A had returned to work on 5/22/25.<br><br>NA-B’s Request/Overtime Approval Form identified, NA-B called in to work with dizziness, nausea, and a fever on 5/29/25. NA-B had symptoms of diarrhea, nausea and fever. NA-B’s timesheet identified NA-B last worked on 5/29/25 and returned to work on 5/30/25.<br><br>There was no mention of any criteria used to identify the appropriateness of the above-mentioned staff’s return to work, if their symptoms had resolved, or if they had come into contact with other staff or residents that may put them at risk for transmission of illness and require heightened surveillance.<br><br>Interview on 8/27/25 at 8:47 a.m., with the infection preventionist (IP) identified employees who called out for work related to an illness would have a call-out sheet filled out on their behalf by nursing staff on the units. The sheet was placed on her desk to review when she arrived to the office. The IP was to determine when the employee would to return to work, dependent upon their symptoms and communicated it to the employee after reviewing the facility policy related to employee illnesses. When she was out of the office, the director of nursing (DON) was to provide oversight of employee illnesses tracking. On several occasions, the IP identified employees who called out sick had returned to work the following day. Management had not ensured employees who had returned to work were either symptom free or free from infection using criteria. The IP agreed the logs lacked adequate surveillance and monitoring of employee illnesses and appropriate return to work.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 8/27/25 at 11:14 a.m., with DON identified the facility recorded all employee illnesses, but did not have a process in place to ensure consistency when determining if employee symptoms had improved or resolved or before returning to work that would potentially cause an increased risk of exposure to residents or other staff in the facility.<br><br>Review of July 2025 Employee Work Restriction-Infectious Diseases Policy identified the employee or contract staff was to report communicable or infectious disease to his or her supervisor. It was the responsibility of the employee’s supervisor to make determinations regarding work-restrictions. The designated Infection Preventionist (IP) was to be consulted to provide guidance when the employee was to return to work and the employee was to stay away from the facility until the employee was no longer contagious or cleared by a medical provider. In addition, the facility was to follow Centers for Disease Control and Prevention (CDC) guidelines, as well as, state and local regulations, if absent, to determine work restrictions.<br><br>NEBULIZER<br><br>R27 was admitted on [DATE] with hospice services in place due to a terminal diagnosis of chronic obstructive pulmonary disease (COPD). R27 had physician orders for budesonide inhalation (bronchodilator used to open airways of the lungs)1 unit, to be inhaled orally 2 times a day for COPD at 8:00 a.m. and again at 5:00 p.m R27 also had an order for ipratropium-albuterol, 1 unit to be inhaled every 4 hours as needed for COPD.<br><br>Observations, document review, and subsequent interview on:<br><br>8/25/25 at 1:00 p.m. and again at 6:30 p.m. with R27, noted a nebulizer was placed on this bedside table, with a face mask and medication container attached that had been connected during the last administration, hanging on the side of the machine by the mask strap.<br><br>8/26/25 at 8:30 a.m., noted the face mask with medication container attached was hanging on the nebulizer machine with oxygen tubing attached and not rinsed following administration. Review of the Treatment Administration Record (TAR) identified R27 had received his most recent nebulized medication at 8:00 a.m.<br><br>8/26/25 at 11:29 a.m. identified registered nurse (RN)-A prepared to administer R27's albuterol medication. She obtained the medication from the medication cart, went to R27's room, applied gloves, picked up the mask with the medication container attached, removed the medication container from the mask, and placed the liquid medication into the container. She then reattached the medication container to the mask and placed the mask on R27's face as she switched on the machine.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8/26/25 at 11:45 a.m. RN-A returned to R27's room, removed the face mask with medication container attached and returned it to hang on the machine without disconnecting the nebulizer and rinsing the medication cup. She reported the mask, and nebulizer was changed weekly. She then hung by the mask strap on the nebulizer machine without first rinsing disassembling the mask and cup and rinsing the medication cup. When asked about the nebulizer, she fshe noted when she went to administer a nebulizer treatment, she usually found the mask with the medication container attached. RN-A then exited the room. When asked about the lack of rinsing of the medication cup, she reported she would return to R27's room and disassemble the nebulizer equipment and rinse the cup. She took the nebulizer mask, medication cup and mouth piece to the bathroom and applied gloves, took the pieces apart, rinsed them at the sink, and placed on a paper towel on the shelf located above the sink to air dry the parts. RN-A noted she had not been rinsing the nebulizer set following each use and was not certain what the policy directed, and stated she was not certain if other staff knew to perform this procedure after administration either.<br><br>Interview on 8/26/25 at 11:53 a.m. with the DON, identified the nebulizer mask, medication container and mouthpiece were reusable and changed weekly, but the compressor surface was wiped daily with Sani-Cloths. She was not aware of any necessary cleaning/rinsing of the equipment following use, other than the weekly change. She would need to review the facility policy to determine if the reusable set up equipment was to be handled differently. Subsequent interview on 8/26/25 at 1:15 p.m. with the DON following review of both the policy and manufacturer’s instructions identified the mask and medication container were to be rinsed and allowed to air dry following each use. The DON confirmed the facility policy failed to include this information and would need to be updated to follow the direction in the manufacturer’s instructions for cleaning.<br><br>Interview on 8/27/25 at 7:15 a.m. with the IP identified she was aware the setup used for administration of nebulized medication was to be rinsed following each use and allowed to air dry. She was unaware of what the policy stated or that staff were not rinsing the nebulizer setup following each use. The IP expected nebulizer equipment including the mouthpiece, mask, and medication container to be rinsed and placed on a paper towel following each use and allowed to air dry. Information regarding staff training was requested but not received.<br><br>Review of the July 10, 25 Nebulizer Treatment Procedure of the Tuff Memorial Home failed to include instructions for cleansing of the nebulizer reusable mask, mouthpiece and medication container after each use.<br><br>Review of the DeVilbiss Pulmo-Aide Compact Compressor/Nebulizer Instruction Guide - Nebulizer cleaning listed all parts of the nebulizer, except tubing should be cleaned according to the instructions. A warning identified to prevent possible risk of infection from contaminated medication, cleaning of the nebulizer is recommended after each treatment. Disinfecting was recommended once a day. Instructions noted were to clean after every use. Instructions listed were: 1. With power switch in the “Off” position, unplug power cord from wall outlet.2. Disconnect tubing from the air-inlet connector and set aside.3. Disassemble mouthpiece or mask from cap. Open nebulizer by turning capcounterclockwise and removing baffle.4. Wash all items, except tubing, in a warm water/dishwashing detergent solution. Rinseunder warm tap water for 30 seconds to remove detergent residue. Allow to air dry.<br><br>DINING<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 8/26/25 at 11:24 a.m., in the dining room identified NA-C was assisting 5 residents with eating dinner. NA-C had gloves on and was sitting between R2 and R16. A kitchen staff person delivered food to the table and placed it in front of each resident. The table had 4 residents and another table off to the side had 1 resident seated awaiting their meals. NA-C offered R2 a bite to eat. She then turned to her left and using her right hand again she offered a bite of food to R16. She then rolled on her chair to the other side of the table next to R35. Using her same gloved hand, she rubbed R35's chest and arm to arouse her. She offered R35 a bite of food using a fork and picked up R35’s glass to give her a drink. She then turned toward R16 and gave her a bite of her food. NA-C then rolled her chair across the floor to another table where R11 was seated and asked him if he was doing okay. She then rolled her chair back between R2 and R16. Without removing her gloves and performing hand hygiene, she wiped R2’s mouth using R2’s clothing. NA-C failed to change gloves or perform hand hygiene during the meal service between tasks for residents.<br><br>R2’s 4/15/25, quarterly Minimum Data Set assessment identified she was dependent on staff (Staff does all the effort) with eating and drinking and has diagnosis of Alzheimer’s Disease, arthritis, and degenerative joint disease. R2’s undated, current care plan identified staff were to assist with intake as needed. R2’s level of ability with eating may vary from day to day.<br><br>R16’s 6/24/25, significant change Minimum Data Set assessment identified she required substantial (staff does more than half the effort) assistance with eating and diagnoses of dementia, anxiety, depression, and COPD. R16’s undated, current care plan identified her ability to feed herself varies from day to day. She at times can eat independently and at times is dependent on staff to eat.<br><br>R35’s 6/17/25, quarterly Minimum Data Set assessment identified she required substantial assistance from staff while eating and had a diagnosis of a neurological condition. R35’s undated current care plan identified she was able to eat independently after set-up.<br><br>R21’s 4/15/25, annual Minimum Data Set assessment identified he required supervision or touching with meals. Helper provides verbal cues or steadying assistance. R21 had diagnoses of traumatic brain dysfunction, arthritis, and depression. R21’s undated, current care plan identified staff were to assist R21 with using utensils and finger foods. R21 could drink independently after staff placed the glass in his hand.<br><br>R11’s 6/24/25, quarterly Minimum Data Set assessment identified he required supervision or touching assistance with meals and had a diagnosis of non-traumatic brain dysfunction and dementia.<br><br>Interview on 8/26/25, at 1:03 p.m., with NA-C identified the facility normally had 2 staff ithe dining room to assist residents with eating but they didn’t come in today so I just did it on my own”. She was unable to recall the last time she had infection control training.<br><br>Interview on 8/27/25 at 8:55 a.m. with the IP identified staff have been trained to use hand sanitizer and change their gloves between residents when feeding. The IP noted NA-C should not be feeding 2 residents with the same gloved hand without first performing hand hygiene. The IP agreed the lack of appropriate infection control practices can put residents at risk for cross contamination, especially gastrointestinal (stomach) infections. Staff were required to complete online infection control training. She had done some in-person training with hand washing and PPE use. It had been about a year since the last time she audited the dining room for appropriate staff hand hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the July 2025, Promoting/Maintaining Resident Dignity During Mealtimes policy identified staff were to only assist 1 resident at a time. The policy made no mention of how to safely maintain infection control while assisting multiple residents with meals. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, and document review, the facility failed to maintain 1 of 13 ceiling vents in a sanitary manner.Findings include: Observation on 8/25/2025 at 12:19 p.m., of the facility beauty salon vent identified to have an appearance of black spotted substances, appeared to look like mold and rust scattered throughout the inside and outside of the vent. Observation and interview on 8/25/2025 at 3:32 p.m., with both the administrator and the maintenance director in the beauty salon room to observe the vent identified the maintenance director had scraped the vent with a paper towel and stated the black substance was removable from the vent and had voiced that this room received humidity and high temperatures of heat throughout the summer, possibly contributing to buildup of the black substance on the vents. Maintenance stated the vents in the facility were cleaned every two months on a routine basis. Both the administrator and maintenance director voiced the vent had the appearance of a black mold-like substance. Observation on 8/25/2025 at 3:59 p.m., of the other facility 12 vents throughout the facility halls and corridors appeared to be clean and free of debris. Review of 7/07/25, Maintenance log for 10-inch(in) BI fan/all air vents check was last completed 7/07/25. Further interview on 8/27/2025 at 9:27 a.m., with maintenance director identified the vent should have been addressed during monthly maintenance checks. He agreed the condition of the beauty salon vent appeared to be dirty and unkempt and should have been cleaned when checked on rounds. There was no record for August 2025. Interview on 8/27/2025 9:46 a.m., with salon technician identified she was made aware (unknown date) by an (unknown) resident, who had pointed to the ceiling and stated the ceiling appeared to need repairs. The salon technician had not informed the administration of the concern brought up from the resident and was not aware of the of the condition of the vent before being identified by a resident of the vent when she worked in the salon. Review of August 2025, Preventative Maintenance Program policy identified the facility was to ensure a safe functional and sanitary environment for residents, staff, and visitors. The maintenance director was responsible for developing and maintaining service to assess the physical plant to determine if maintenance was required, decide on tasks that needed to be completed and how often, and develop a calendar to assist with keeping track of all tasks. Request of August salon fan cleaning record was requested and not received during survey period. |