STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Nursing Home	308 Sherman Avenue Ellsworth, MN 56129

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49336 Based on observation, interview, and document review, the facility failed to ensure all 25 nurse aides ((NA)-A, NA-B, NA-C, NA-D, NA-E, NA-F, NA-G, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-N, NA-O, NA-P, NA-Q, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y and NA-Z), who bathed or had the potential to bathe residents were appropriately trained and deemed competent to manufacturer's instructions for the cleaning and disinfection of 1 of 1 whirlpool tub. Findings include: Observation and interview on 6/25/24 at 9:04 a.m., with NA-B on the north unit shower room identified she retrieved a spray bottle labeled Clorox Fuzion cleaner/disinfectant. She then sprayed the inside of the whirlpool tub and had reached for a white long handled brush and scrubbed the inside of the tub. NA-B waited 1 minute and pressed the FILL button. When pressed water came out of the jet and was flushed to the floor of the whirlpool tub down to the drain. She pressed and held the DISINFECT button for 30 seconds. When pressed, a small amount of clear water came from the jet to the floor of the whirlpool down to the drain. She grabbed the brush and scrubbed the interior whirlpool with the water from the floor of the whirlpool tub. She pressed the RINSE button and used the water sprayer to rinse the solution inside the whirlpool for 3 minutes. NA-B was unaware how long the disinfecting the whirlpool would take or if there was any disinfecting solution coming out of the jets at all. NA-B was shown to perform the procedure as noted, however, she felt the spray solution was actually disinfecting the tub. NA-B wore no PPE while performing that task. Review of the posted Cascade Aqua-Aire Tube Operation System guidelines identified staff were to: 1) Close and lock the door. 2) Remove any viable tissue, residue, or fluids from the tub by pressing the SHOWER button and rinsing the inside tub surfaces with the shower sprayer. 3) Press the FILL button and turn the TEMPERATURE control knob to the left to its warmest level to heat the disinfectant solution. 4) Press the FILL button again to turn off the water. 5) Place drain plug over the drain. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6) Press and hold the DISINFECT button. While the disinfect button was held down, the cleaning solution would run through the air injection system and out the air jets. 7) Release the button after seeing solution coming out of all the air jets. 8) Solution that remained in the foot well of the tub should be cleaned with long-handled brush to scrub all interior surfaces of the tub. Staff were to scrub around the door seal area and temperature probe area and allow the disinfectant to stay on surface for 10 minutes. 9) Remove plug from the drain. 10) Finish rinsing the interior surfaces of the tub with the shower sprayer. 11) Press the Aqua-Aire button to start the air blower and run it for 30 seconds and then turn off the air blower. Observation and interview on 6/25/24 at 12:37 p.m., with NA-C identified she pressed the FILL button on the whirlpool tub and sprayed the inside of the whirlpool for 30 seconds. She reached for the Triforce (bleach) solution spray bottle and sprayed the inside of the whirlpool walls and seat. NA-C noted the solution was to sit on the interior surface with a wet contact time of 5 minutes. The smell of the solution permeated the shower room and was overpowering. She pressed the FILL button and rinsed the whirlpool with shower sprayer for 30 seconds. She stated she would use the brush to scrub the inside of the door when spraying the interior of the tub. She stated the Triforce had an irritating smell. She pressed the DISINFECT knob for 30 seconds. She then stated she would rinse the whirlpool and use the shower sprayer for another 30 seconds. She stated cleaning the whirlpool took 10 minutes total time after each resident bath. She was unaware if the spray cleaner was an appropriate cleaner and sisinfectant to use with the whirlpool tub. Interview on 6/26/24 on 9:26 a.m., with NA-C stated she received training for cleaning and disinfecting the whirlpool during her orientation from a colleague who no longer works at the facility. She was unsure if the facility had a training checklist or competencies for the whirlpool and had not seen it implemented for new employees at the facility. Interview on 6/26/24 at 9:30 a.m., with NA-D she stated she had attended facility in-services for resident care and infection control procedures. She was unsure of training specified for whirlpool cleaning had been implemented in the facility. Interview 6/26/24 at 9:47 a.m., with NA-E stated she received training on whirlpool tub cleaning and disinfection from a coworker when hired. She received annual education on the Healthcare academy (online continuing education program). She stated one of the online courses had discussed procedures for bathing residents and tub cleaning but they were not specific to the tub the facility used. She stated the course did not explain procedures for the disinfectant and cleaning of whirlpool. During her orientation, she hand hands-on training from a co-worker but had none since. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 6/26/24 at 11:15 a.m., with DON stated the facility had no formal checklist that would include nurse aide staff being trained on whirlpool cleaning and disinfection. She had no copies of employee training accessible on file at the facility to identify training or competencies had been completed. NA'ss and would be trained on the job alongside other colleagues. DON stated she was unaware of in-services held at the facility that was directed at whirlpool use and cleaning. Review of 2020, Training policy identified initial orientation would be given to all employees and the online Healthcare Academy would be provided yearly for employee training. The facility would monitor completion of training and would send the completed training to the administrator. There was no indication training was specific to the facility and not generalized overall training.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39988 Based on observation, interview and document review the facility failed to ensure staff followed the facility protocols to verify controlled medication count to prevent potential diversion. Findings include: Observation and interview on 6/25/24 at 2:01 p.m., with registered nurse (RN)-A of the locked box within the medication cart that contained the controlled medications. There was a bound narcotic book that listed the residents-controlled medications with a count of that medication and all resident medications were reconciled by 2 licensed nurses. The locked box also contained the emergency kit (Ekit) of controlled medication in a small plastic box that had a plastic numbered tag securing the box closed and a list of medications within the box. RN-A was unable to find any documentation that the Ekit controlled medications had been reconciled. She reported that in the past that was documented in the bound narcotic book and 2 licensed nurses would verify the plastic tag number. She confirmed that without reconciling the Ekit controlled medication tag number each shift a person would not know if the Ekit controlled medication had been tampered with. Interview and observation on 6/25/24 at 2:46 p.m., with licensed practical nurse (LPN)-A revealed that the nurses did not reconcile the Ekit controlled medications that were stored in the locked box within the medication cart. If a nurse would take a medication out of the plastic box, they would fill out a form that they documented the plastic tag number removed, what medication was removed, and the new plastic tag number they applied. The form was then faxed to the pharmacy to notify the pharmacy that a medication had been removed from the Ekit. She reported the forms were kept in the locked box on the medication cart. When she opened the medication cart there were only blank forms in the locked box. She was unable to verify that the Ekit controlled medication plastic box had not been tampered with as she was unsure what the tag number was supposed to be on the Ekit controlled medication box. She agreed there would be no way to know if someone had opened the box and taken something out unless she went back through the old forms that had been faxed to the pharmacy. Interview and observation on 6/25/24 at 2:52 p.m., with the director of nursing (DON) identified the Ekit controlled medication tag on the box should be monitored and documented each shift. The documentation should be located in the front of the bound narcotic book. After examination of the bound narcotic book the DON was unable to find any documentation of the Ekit controlled medication. She retrieved the prior bound narcotic book and that book Identified on page 2 a date of 6/11/23, the Ekit tag number had been transferred from the narcotic book to the new non-narcotic book in the medication room with a line across the entire page, and no signature of who made the note or the change. The DON reported she had no idea who made this change and stated it should have never been changed. Her expectation was that staff reconciled the plastic tag number of the Ekit controlled medication box each shift with the narcotic count completed by 2 licensed staff. She agreed that there would have been no way to identify diversion without monitoring the tag number each shift. She verified the contents of the medication in the Ekit controlled medication box. The DON revealed that the tag numbers for the Ekit controlled medication had not been monitored and documented in the non-narcotic book in the medication room either. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Ekit controlled medication list affixed to the Ekit controlled medication plastic box identified the following medications: morphine sulfate oral solution 20 mg/ml quantity of 30 ml, hydroco/APAP 5-325 mg quantity 6,lLorazepam 0.5 mg quantity 6, tramadol 50 mg quantity 6. Review of the Emergency Kit Replacement Slip documents located in the Ekit book in the medication room identified the last time the Ekit controlled medication box had been opened was on 1/2/24, and lorazepam 0. 5 mg 1 tablet had been removed at 5:00 p.m. Forms had also been filled out for removal of medications on 12/13/23, 12/7/23 twice, 9/5/23, 94/23, 8/14/23 twice, and 8/7/23 twice. A policy on controlled medications was requested but not provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 39988 Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. Refer to F726 Findings include: Interview on 6/24/24 at 2:56 p.m., with administrator identified he had spoken to the director of nursing (DON) about the facility assessment just this morning as they were unsure when it had been last updated. She revealed he had just finished working on the facility assessment about a half hour ago and he would provide what they had at this time. He reported he was unable to find the old facility assessment and he started a new one. Interview on 6/25/24 at 4:18 p.m., with nursing assistant (NA)-A identified there was no review of skills or competencies where someone watched them however, they did complete training on-line. Interview on 6/26/24 at 7:46 a.m. with director of nursing (DON) identified department heads had not been completing annual evaluations however, the previous administrator completed evaluations on all the department heads. She identified that was something the facility would be working on. She further revealed she had not completed any skills training or competencies with staff other than the lift company that came in once a year to cover proper use of the mechanical lifts. She also identified she had not completed any competencies with any nursing staff but wished she had more time to do get those types of things. Review of the 6/24/24, facility assessment tool identified staff education and competencies were necessary to support the care needed for the residents, including certifications as applicable. The facility assessment identified a list of training and competencies which was not all inclusive that included communication, resident's rights, abuse, neglect, and exploitation, culture change, and infection control which included procedures for infection control. The infection control competencies included hand hygiene, standard precautions, isolation, use of personal protective equipment, and environmental cleaning.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 38687 Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 28 residents. Findings include: Review of QAPI minutes from 6/14/24 identified QAPI was lacking documentation of facility goals and analysis. There was also no response for how facility would meet goals, or that previous goals were evaluated to identify if current measures were met or new processes had been identified. Interview on 6/25/24 at 3:10 p.m., with the director of nursing (DON identified she was agreed there was no analysis of the data brought forth to QAPI, measurable goals set, or if goals were not met, or what actions the facility was going to take to meet their goals. There was no formal process for staff or residents and/or their families to provide feedback to improve areas identified in QAPI. Review of the undated, QAPI Plan policy identified the plan provided guidance for overall quality improvement. The administrator was to assure the plan was reviewed annually by the QAPI committee. QAPI was to review data from areas it believed it needed to monitor on a quarterly basis to ensure systems were being monitored and maintained. The meeting minutes were to be kept with the administrator and shared with residents and resident council and available for staff, residents and family to read. There was no mention of measurable goals, or analysis of data to ensure new areas were identified or if older area benchmarks would be achieved or how compliance would be identified. There was also no evidence the plan had been reviewed to ensure it included all required elements set forth in the regulation.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38687 Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas identified thorough and appropriate data collection and analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 28 residents. Findings include: Review of QAPI minutes from 6/14/24 identified No PIP projects were noted. Interview on 6/25/24 at 3:10 p.m., with the director of nursing (DON) identified the facility had not done a PIP project, as their new administrator had opted not to participate in that project. She agreed PIP projects were crucial in identifying high level areas of concern to provide the highest care possible to residents. Review of the undated, QAPI Plan policy identified the plan provided guidance for overall quality improvement. The administrator was to assure the plan was reviewed annually by the QAPI committee. QAPI was to review data from areas it believed it needed to monitor on a quarterly basis to ensure systems were being monitored and maintained. The meeting minutes were to be kept with the administrator and shared with residents and resident council and available for staff, residents and family to read. There was no indication how QAPI would identify PIP projects or how that information would be educated to staff and residents and their families so input could be achieved and PIP measured to see if goals would be accomplished or how compliance would be achieved. There was also no evidence the plan had been reviewed to ensure it included all required elements set forth in the regulation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on observation, interview, and document review, the facility failed to ensure 2 of 2 observed nurse aides (NA) (NA-B and NA-C) appropriately cleaned and disinfected 1 of 1 whirlpool tub according to manufacturer's guidelines and use personal protective equipment (gown an gloves) (PPE) while cleaning and disinfecting the whirlpool tub. This affected 2 of 2 current residents (R3 and R11) who utilized the whirlpool tub for bathing. Findings include: Observation and interview on [DATE] at 9:04 a.m., with NA-B on the north unit shower room identified she retrieved a spray bottle labeled Clorox Fuzion cleaner/disinfectant. She then sprayed the inside of the whirlpool tub and had reached for a white long handled brush and scrubbed the inside of the tub. NA-B waited 1 minute and pressed the FILL button. When pressed water came out of the jet and was flushed to the floor of the whirlpool tub down to the drain. She pressed and held the DISINFECT button for 30 seconds. When pressed, a small amount of clear water came from the jet to the floor of the whirlpool down to the drain. She grabbed the brush and scrubbed the interior whirlpool with the water from the floor of the whirlpool tub. She pressed the RINSE button and used the water sprayer to rinse the solution inside the whirlpool for 3 minutes. NA-B was unaware how long the disinfecting the whirlpool would take or if there was any disinfecting solution coming out of the jets at all. NA-B was shown to perform the procedure as noted, however, she felt the spray solution was actually disinfecting the tub. NA-B wore no PPE while performing that task. Review of the posted Cascade Aqua-Aire Tube Operation System guidelines identified staff were to: 1) Close and lock the door. 2) Remove any viable tissue, residue, or fluids from the tub by pressing the SHOWER button and rinsing the inside tub surfaces with the shower sprayer. 3) Press the FILL button and turn the TEMPERATURE control knob to the left to its warmest level to heat the disinfectant solution. 4) Press the FILL button again to turn off the water. 5) Place drain plug over the drain. 6) Press and hold the DISINFECT button. While the disinfect button was held down, the cleaning solution would run through the air injection system and out the air jets. 7) Release the button after seeing solution coming out of all the air jets. 8) Solution that remained in the foot well of the tub should be cleaned with long-handled brush to scrub all interior surfaces of the tub. Staff were to scrub around the door seal area and temperature probe area and allow the disinfectant to stay on surface for 10 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9) Remove plug from the drain. 10) Finish rinsing the interior surfaces of the tub with the shower sprayer. 11) Press the Aqua-Aire button to start the air blower and run it for 30 seconds and then turn off the air blower. Interview on [DATE] at 9:17 a.m., with housekeeping supervisor stated staff were to be using the Triforce spray bottle solution for cleaning and disinfecting of the whirlpool tub. The whirlpool tub manufacturer identified [NAME] Classic cleaning and disinfecting solution was to be used for the air jet whirlpool tub, but the facility no longer used that product. The facility now used Triforce spray or the Clorox Fuzion spray. The reason the [NAME] products from the manufacturer were not used any longer was staff had no access to the door to where the solution was to be added to the compartment due to a water heater that had been placed near the whirlpool preventing access to the compartment. The compartment was what held the disinfecting solution where a specific amount would have been pumped via automated design, into the tub per manufacturer's instructions. Observation and interview on [DATE] at 12:37 p.m., with NA-C identified she pressed the FILL button on the whirlpool tub and sprayed the inside of the whirlpool for 30 seconds. She reached for the Triforce (bleach) solution spray bottle and sprayed the inside of the whirlpool walls and seat. NA-C noted the solution was to sit on the interior surface with a wet contact time of 5 minutes. The smell of the solution permeated the shower room and was overpowering. She pressed the FILL button and rinsed the whirlpool with shower sprayer for 30 seconds. She stated she would use the brush to scrub the inside of the door when spraying the interior of the tub. She stated the Triforce had an irritating smell. She pressed the DISINFECT knob for 30 seconds. She then stated she would rinse the whirlpool and use the shower sprayer for another 30 seconds. She stated cleaning the whirlpool took 10 minutes total time after each resident bath. She was unaware if the spray cleaner Interview on [DATE] at 5:37 p.m., with director of nursing (DON) stated the maintenance director had planned to relocate the water [NAME] to another area of the facility so staff could access and utilize the correct whirlpool disinfectant solutions as indicated on the whirlpool manufacturer instructions. She stated staff would have to continue to use the available disinfectant spray solution the facility had in place for cleaning and disinfecting the whirlpool until the water heater could be relocated. The DON was unaware if staff were utilizing the correct product or if the products were appropriate to clean and disinfect the whirlpool tubs. The DON agreed staff should wear PPE while performing that task. Interview on [DATE] at 7:35 a.m., with BETCO specialist identified stated the Triforce solution would have a contact time of 3 minutes when wet and should be sprayed on a dry surface. Gloves and eye mask should be worn when using the spray solution and surfaces should be wiped down not rinsed with water after solution had been applied to the surface. The BETCO specialist stated the product was designed for overall cleaning and disinfection of surfaces, but agreed it was not made for the whirlpool tub specifically and could not verify it would reach all surfaces of the tub or around the jets when sprayed on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on [DATE] at 8:04 a.m., with maintenance director identified the facility installed a water heater in the east unit shower room and confirmed the water heater had been installed in the year 2016. He demonstrated as he faced the whirlpool, that to the left of the tub, there is a locked compartment that was to have disinfectant solutions connected to the whirlpool tub tubing. He stated the right side of the tub had another locked compartment and when opened, he could not access the solutions that were originally stationed to the left of the whirlpool. He stated the water heater had blocked access to the left compartment and was aware that had been an issue for staff to replace the disinfectant solution as it was impossible to reach. Further interview on [DATE] at 9:35 a.m., with the maintenance director identified the facility had extra whirlpool tub solution stored in the maintenance director's office that was not in use. He confirmed the solution expired July of 2023 and would not be safe to use for cleaning or disinfection. He stated he was sure the disinfectant cleaner solution connected to the whirlpool had ran dry and therefore when staff pressed the DISINFECT button, only water would have come out of the jet. Further interview on [DATE] at 11:15 a.m., with the DON identified the facility had no formal checklist that would include staff being trained on whirlpool use and cleaning, nor had there been documentation of competencies. She had no copies of employee training accessible on file at the facility to prove that training had been completed. NA's and would be trained on the job alongside other colleagues. Review of the current, Triforce Disinfectant Directions for Use identified staff were to use ,d+[DATE] ounce per gallon of water and apply to surfaces allowing them to be wet for 3 minutes. For heavily soiled areas, cleaning prior to disinfection was required. The product was not to be used for areas that may come into contact with any mucous membranes of a body. Review of the undated, hand-typed Whirlpool Cleaning policy identified the whirlpool bath was to be routinely disinfected to ensure appropriate infection control. When a bath was completed, the entire whirlpool was to be swabbed with the whirlpool disinfectant. Staff were to then use a small white hand mop with whirlpool cleaner in a small bottle. The instructions then noted staff were to rinse thoroughly with clear water. When whirlpools were done for the day, staff were to fill a white bucket to the mark FILL TO HERE with water and 4 ounces of whirlpool cleanser and submerge the agitator mechanism in the bucket and let it run for 10 minutes. Staff would then swab the entire tub and chair with whirlpool cleanser and rinse with clear water. There was no indication how old the policy was, what tub the instructions were for, or if the solution or whirlpool tub were the same as when the policy was created. Review of 2020, Training policy identified initial orientation would be given to all employees and the online Healthcare Academy would be provided yearly for employee training. The facility would monitor completion of training and would send the completed training to the administrator. There was no indication training was specific to the facility and not generalized overall training.