STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renvilla Health Center	205 Southeast Elm Avenue Renville, MN 56284

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34083 Based on observation, interview and document review the facility failed to appropriately administer and accurately reconcile 1 of 1 resident's (R35) medication (lisinopril) (used for high blood pressure) when the order was changed and prior to administering any medication. Findings include: Observation, interview, and Medication Administration Record (MAR) review on 8/27/24 at 9:14 a.m., with trained medication aid (TMA)-A as she prepared to administer morning medications to R35 identified TMA-A removed R35's medication cards from the medication cart and placed them on top of the cart. She accessed the electronic medical record (EMR) which Displayed R35's current medication orders. TMA- A picked up a card, looked at the order on the screen, and popped the medication into a waiting medication cup. When TMA-A picked up the card containing the lisinopril she looked at the card, glanced at the screen, and prepared to place the lisinopril into the medication cup with the meds to be administered. TMA-A was asked what the order was for the lisinopril and looking at the EMR responded, the order listed 5 milligrams (mg) by mouth (PO) daily (QD). She was then asked what the medication label on the card containing lisinopril for R35 and responded it contained 10 mg tablets. Review of the printed Physician Order Review identified an order dated 6/24/24 for lisinopril 10 mg PO QD. The bubble packaged medication card had no label, or identification of a change in order, and had been stored in the cart with his other current medications. Interview on 8/27/24 at 9:19 a.m. with TMA-A reported she had been administering 10 mg of lisinopril to R35 QD and she had not been informed of a change in his dose. TMA-A confirmed she would have administered the 10 mg tablet to R35 if she had not been questioned. She reported the medication card should have been pulled from the cart, given to the charge nurse and the pharmacy contacted to provide the correct dose of medication. TMA-A reported this type of incident had occurred intermittently with other medications, she had informed the charge nurses, but the issues had not been clarified or acted upon. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/27/24 at 9:23 a.m. with licensed practical nurse (LPN)-A (charge nurse) identified the order on the EMAR and the bubble packaged medication card did not match, and she was not aware of when the order had changed. LPN-A reported the procedure that staff were to follow was when a medication dose was changed, the medication card should have been pulled out of the medication cart, the pharmacy notified of the change and a card with the correct dose provided. She confirmed staff were supposed to be checking to ensure the orders and medication cards matched, but the old card should not have been left in the cart and it would have been possible for an error to occur. Interview on 8/27/24 at 9:53 a.m. with the director of nursing (DON) reported R35's lisinopril order had changed on 8/26/24 and the medication card should have been pulled from the cart, the pharmacy notified and a card with the correct dose provided. She reported staff were supposed to follow the checks for each medication administered, but the process had not been followed, and the order had been entered into the EMR, but the process was not completed when the card with the incorrect Lisinopril dose should have been removed from the cart, to avoid an error. The DON did provide a new Physician Order Review document which contained an order dated 8/26/24 with a start date of 8/26/24 for Lisinopril 5 mg PO QD. She confirmed the procedure for a medication order change had not been followed and R35 should have received 5 mg of Lisinopril on 8/26/24 instead of the 10 mg tablet. Review of the Nursing Policies and Procedures Transcribing MD/NP orders identified the nurse who received an orders was responsible to transcribe and follow the process for any orders received. Medication orders: 1. Were to be entered into the EMR. 2. The new medication or dose change was to be ordered from the pharmacy by either phone or fax. 3. Document the order and/or changes in the progress notes. 4. Make care plan changes if indicated. 5. Apply a label change sticker the medication card if appropriate.

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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. 34083 Based on observation, interview, and document review, the facility failed to ensure an accurate labeling of three medication for two residents (R35 and R38), who had medication package labels and orders that did not match or give clear direction, to avoid the potential medication errors. Findings included: R35's current 8/26/24 physician order for lisinopril (a blood pressure medication) listed 5 milligrams (mg) by mouth (PO) daily (QD). The medication card located with R35's active medications contained 10 mg tablets. The bubble packaged medication card had no label, or identification of a change in order, or dosage. R38's current Physician Order Summary contained a 6/18/24 order for Gabapentin (used to treat neuropathic pain) oral capsule 100 mg, 3 capsules PO twice daily (BID) (7:00 a.m.-10:00 a.m. and 7:00 p.m. - 10:00 p.m.) and 100 mg PO QD (12:00 p.m.-2:30 p.m.). The current medication card contained 300 mg capsules and directed staff to administer one capsule PO BID. The card failed to contain any label or notation to draw attention to the dosage of the medication in the active card, and the orders. R35 also had a 8/13/24 order for Lidoderm External Patch 5% 1 patch QD on (7:00 a.m. - 11:00 a.m.) off at bedtime (HS). The current pharmacy package label directed to apply 1-3 patches to skin QD. Leave on for up to 12 hours in a 24 hour period. Interview on 8/27/24 at 9:19 a.m. with trained medication aid (TMA)-A confirmed the order listed in the electronic medical record (EMR) listed Lisinopril 5 mg PO QD, and the current medication card contained 10 mg tablets with directions to administer 1 tablet PO QD. She reported she had been administering the 10 mg daily and confirmed she had not been notified of a change in the dosage. TMA-A reported when an order was changed the process was to pull the card and request a new card from pharmacy. She reported she would not have attempted to break the 10 mg tablet, but would have waited for a new correct dose medication to be sent from the pharmacy. She identified she would have administered the 10 mg tablet, as that was the dose R35 had been receiving. Interview on 8/27/24 at 9:23 a.m. with licensed practical nurse (LPN)-A (charge nurse), confirmed R35's active Lisinopril medication card contained 10 mg tablets and the order had been changed in the EMR, but she was not aware of a change in dosage. LPN-A reported the order change should have been communicated, the card pulled from the medication cart, and a new card requested from the pharmacy. She identified the process for medication changes, had not been followed and could have resulted in a medication error. Interview on 8/27/24 at 9:53 a.m. with the director of nursing (DON) reported R35's Lisinopril order had changed on 8/26/24 to Lisinopril 5 mg PO QD and the medication card should have been pulled from the cart, the pharmacy notified and a card with the correct dose provided. The change in order should have also been communicated during shirt report to avoid a potential error. (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 Nursing Policies and Procedures Transcribing MD/NP orders identified the nurse who received an orders was responsible to transcribe and follow the process for any orders received. Medication orders: 1. Were to be entered into the EMR. 2. The new medication or dose change was to be ordered from the pharmacy by either phone or fax. 3. Document the order and/or changes in the progress notes. 4. Make care plan changes if indicated. 5. Apply a label change sticker the medication card if appropriate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47497 Based on observation, interview, and record review, the facility failed to prepare food under sanitary conditions, discard food that had been expired, ensure all foods were labeled and dated, and ensure the freezer door had been shit to prevent potential spoiling of food. This had the potential to affect all 39 residents. During observation and interview with cook-A and later joined by the dietary manager on [DATE] at 11:30 a. m., the following was observed during the initial tour of the kitchen: 1. Mrs. Gerry's Parmesan Pepper Corn Pasta Salad had been previously opened with an expiration date of [DATE]. 2. Mustard with a use by date of [DATE] 3. Bag of California Sun Dried Raisins, best before [DATE]. 4. Minced garlic in a squeeze bottle with no visible expiration date, bottle had a dark brown substance on the inside of the lid and around the opening and a black substance on the outside of the bottle. 5. A second bottle of minced garlic with a use by date printed on the bottom of [DATE] 6. A bottle of [NAME] Lynch Dressing with a use before [DATE] 7. A plastic container of strawberry smoothie mix with no expiration date and no open date. 8. Boursin Cheese with a use by date of [DATE]. 9. a zip lock bag of pepperoni with an expiration date of [DATE]. The following items were observed in the walk-in cooler with no date or label. 1. A Bowl containing a white creamy substance loosely wrapped with plastic Cook-A was unsure what the bowl contained; however, she thought it may be ranch dressing. 2. A plastic squeeze bottle with a solid white substance Cook-A was unsure what the bowl contained; however, she thought it may be sour cream 3. A plastic squeeze bottle, the contents had separated, an oily substance on top, a solid yellow substance in the middle, and a brown liquid on the bottom. 4. A glass jar with a screw top cap, the contents were a yellow creamy like consistency. The jar had no label and was not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. A partial head of lettuce loosely wrapped in plastic with one side exposed. The lettuce appeared brown and wilted. There was no label or date. 4. A zip lock bag containing lettuce with no label or date. 5. A plastic lidded container with a white solid block of unknown product, with no label or date. The walk-in freezer had copious amounts of frost build up on the first 2 shelving units closest to the door and did not contain an internal thermometer. The stove top had a piece of long hair and food particles, the front of the stove had dried brownish drip marks, the side of both stoves also had a brownish/yellow substance that had dried in a drip pattern. The wall behind the griddle had a yellow and brown substance that had dried. Interview [DATE] at 11:30 a.m., with Cook-A identified she was not certain of the contents of any of the unlabeled bottles but said most of the items were used for resident Happy Hour. She identified that the kitchen has had a lot of staff turnover and they have not had time to get their cleaning done or check for expired foods. Follow up interview on [DATE] at 8:20 a.m., with Cook-A identified when she came in for her shift on Friday morning on [DATE], the walk-in freezer door was open, the frost was much worse then it is now. She identified that she did not notify anyone that morning of the incident, she did not check the temperature of the freezer, and did not check to ensure the foods had not thawed. She had told the dietary manager later that day, however, nothing was ever directed to staff to check the food to ensure it had not thawed out overnight. Review of the [DATE] through [DATE], daily cleaning schedule sign off sheets provided by the dietary manager identified the following tasks: 1. Wipe up spills in oven. 2. Wash off stove tops. 3. Wipe out convection oven. 4. Wash out microwave. 5. Wipe off shelves below cook's station. 6. Wash can opener. 7. Wash food processor/Robot Coupe. 8. Clean and Sanitize work surfaces. 9. Scrub 3 compartment sink. 10. Clean and sanitize work counters. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. Take out garbage. At the bottom of the sheet were notes to Make sure all tasks listed are completed before you leave your shift. All cooks watch for outdated foods and discard. None of the listed kitchen cleaning tasks had been signed off as completed for the following days: Week of [DATE], Monday, Tuesday, Wednesday, or Saturday. Week of [DATE], Sunday, Monday, Friday, or Saturday. Week of [DATE], Sunday, Tuesday, Wednesday, Thursday. Week of [DATE], Monday, Friday, or Saturday. Week of [DATE], Sunday, Monday, Tuesday, Wednesday, Thursday. Week of [DATE], Monday, Friday, or Saturday. Week of [DATE] Sunday, Monday, Tuesday, Wednesday, Thursday. Week of [DATE], Monday, Thursday, Friday, or Saturday. Week of [DATE], Sunday, Monday, Wednesday, Thursday. Week of [DATE], Monday, Friday, or Saturday. Week of [DATE], Sunday, Tuesday, Wednesday, Thursday. Week of [DATE], Monday, Wednesday, Friday, Saturday. Week of [DATE], Friday. Review of monthly cleaning schedule form January of 2024 through August of 2024, identified a task to wipe out walk in cooler. The task had not been signed off as completed on any of the months provided. Interview on [DATE] at 12:06 p.m., with the dietary manager identified she agrees with the above findings. Cooks are supposed to keep an eye expiration dates and should throw them away and order new if needed. We do not have any system to ensure staff are checking for expired foods, we discussed doing audits and competencies with staff, but we have never completed any. We wipe the cooler down monthly and once a year we pull the racks out and clean them. We have sign off sheets for cleaning the cooler, but I have not been checking them. The frost in the freezer was caused by the freezer door being left open over-night last week. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 3:30 p.m., with the director of dietary services identified she had been in this position for about 15 months, she oversees 14 facilities for this corporation and most of her work is done remotely. She reviews weights monthly and assesses high risk residents like people on dialysis The dietary manager does most of the nutritional assessments on site. She had been at the facility in May and had done a tour of the kitchen, she had a conversation with the dietary manager about completing audits and competencies with staff but had not heard if she had completed them yet. Interview on [DATE] at 2:56 p.m., with the administrator identified she would expect the dietary manager would have a system in place to ensure staff were completing all kitchen duties including cleaning, removal of expired foods and appropriate labeling to prevent harm to residents. Review of the [DATE], Labeling of Foods/Grocies facility policy identified all foods need to have a label and date to indcate what is in the package and when it expires and when it was opened. The policy lacked any indication of what system the facility should use to ensure the policy is being followed. Review of the [DATE], Using Sanitary Practices to Prepare, Serve, and Store Food facility policy identified staff were to follow cleaning list to ensure all equipment is cleaned regularly, and employees will label, and date all opened food and items pulled out to be thawed. The policy lacked any indication what system (such as audits or competencies) should be used to ensure staff were following the policy.

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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. The facility assessment protocol further failed to solicit input from staff, residents, representatives, or family members. Refer to F812 Findings include: Review of the 8/8/24, facility assessment identified changes which were highlighted in yellow that went into effect on 8/8/24. The changes included solicitation of feedback: questionnaire to resident/representative related to staffing, suggestion boxes throughout facility, annual notices to residents/representative prior to annual review, review during resident/family council meeting, departmental/all staff meetings. Accepting residents not on the assessment-add prior to admission. Competencies-knowledge and skills able to prove (demonstration) for hired staff, temporary staff, volunteers, and vendors. On the page identified as authorizations and resident profile listed persons assisting in completing assessment, including QAA/QAPI review and approval to include the administrator, director of nursing, SFHS regional director/governing body representative, medical director, and pharmacist. Highlighted in yellow was additional people including infection preventionist, licensed nurse, nursing assistant, resident/family council, and other. With identification that the facility assessment had been reviewed on 4/15/24 at QAA/QAPI and the next review would be October. The facility assessment further identified that staff competencies had been completed for licensed nurses, nursing assistants, dietary staff, and other staff. Review of a sample of staff competencies for licensed nurses, nursing assistants, and dietary staff identified the nursing staff had their competencies completed. The dietary staff sampled for competencies on sanitation and modified diets revealed that cook-A and cook-B had no competencies completed. Interview on 8/27/24 at 2:31 p.m., with dietary manager identified the dietary staff complete their training on educare. She stated competencies were only completed annually and she did not have any for the two staff requested. She reported the one staff went to part time and the other staff she would be completing soon. Interview on 8/27/24 at 4:31 p.m., with the administrator identified that the facility had not yet implemented input from residents or representatives as the regulation had just went into effect. She revealed that the facility had discussed the changes that went into effect during their leadership call with the corporate office. She reported that the facility would be adding residents, vendors, and staff input on next year's facility assessment. She confirmed that there had been no questionnaires sent out, no notices to residents/representatives had been sent, and the facility had not had a resident/family council yet to discuss the changes. She identified the area's highlighted in yellow on the facility assessment were the changes that the facility would be implementing by the next review.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 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 areas identified had oversight for their perspective outcomes brought forth for 1 of 1 Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the 2/14/24, monthly QAPI meeting minutes identified the facility departments were submitting data to be reviewed by the committee. 2 examples of failure to document a measurable goal and/or analyze the data identified: 1) Quality improvement Incentive Program (QIIP) Bowel incontinence with toileting plan identified residents with bowel incontinence triggering would be reviewed for toileting habits and interviews with staff would be completed. The individualized toileting plans would be reviewed. The director of nursing (DON), assistant director of nursing (ADON) and the MDS coordinator would be assigned the review. Completion date was ongoing. Follow up area identified to assess toileting plan if effective and meeting goals. Information on QIIP by breakroom for all staff to review. There was no documentation of a measurable goal, no documentation to support the QAPI committee analyzed the data brought forward, how they were going to achieve their compliance, if further education was needed, or if the action plan required revision. 2) Performance-Based Incentive Payment Program (PIIP) identified task 2023 [NAME]-Employee Recruitment and Retention (UKG [NAME] Implementation) Reduce turnover by 2%, increase employee satisfaction, increase applications for open positions, fall grant, facility will continue to work on their fall reduction and prevention. Person assigned would be the HR/Grant Coordinator. Completion date identified as ongoing. Follow up education and communication was ongoing with any concerns noted with UKG. Next step was plans to be advanced scheduling. There was no documentation to support the QAPI committee had data to analyze brought forward, no action plan as how the facility would achieve their compliance, or if revisions were needed. Review of the 3/13/24, QAPI meeting minutes identified the facility departments were submitting data to be reviewed by the committee. 2 examples of failure to document a measurable goal and/or analyze the data identified: 1) Quality improvement Incentive Program (QIIP) Bowel incontinence with toileting plan identified residents with bowel incontinence triggering would be reviewed for toileting habits and interview staff. Individualized toileting plans would be reviewed. The director of nursing (DON), assistant director of nursing (ADON) and the MDS coordinator would be assigned the review. Completion date was ongoing. Follow up identified assess toileting plan if effective and meeting goals. Information on QIIP by breakroom for all staff to review. There was no change from last meeting and no documentation of a measurable goal, no documentation to support the QAPI committee analyzed the data brought forward, how they were going to achieve their compliance, if further education was needed, or if the action plan required revision. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) Performance-Based Incentive Payment Program (PIIP) identified task 2023 [NAME]-Employee Recruitment and Retention (UKG [NAME] Implementation) Reduce turnover by 2%, increase employee satisfaction, increase applications for open positions, fall grant, facility will continue to work on their fall reduction and prevention. Person assigned HR/Grant Coordinator. Completion date identified as ongoing. Follow up education and communication were ongoing with any concerns noted with UKG. Next step was plans to be advanced scheduling. New this meeting was that in March 2024, performance reviews were now in the new UKG to start using. HR was to send managers information and training video. There was no documentation to support the QAPI committee had data to analyze brought forward, no action plan as how the facility would achieve their compliance, or if revisions were needed. Review of the 7/29/24, QAPI meeting minutes identified the facility departments were submitting data to be reviewed by the committee. 2 examples of failure to document a measurable goal and/or analyze the data identified: 1) Problem, April falls: 7 of 9 falls were on a weekend in April. Tasks identified will review staffing and activities. Person assigned was managers, completion date identified as ongoing. The follow up action plan included afternoon snack cart in dining room versus room to room. Get residents out of their room for afternoon snack/socialization. Review activity staffing hours on weekends. Monitor to see if continues as a trend or pattern. The problem had been identified at May meeting, with no documentation of a measurable goal, no documentation to support the QAPI committee analyzed any data brought forward, how they were going to achieve their compliance, if further education was needed, or if the action plan required revision. 2) Problem, dementia. Tasks included education with staff on how to handle residents with dementia. No person was assigned, completion date was ongoing, and there was no follow up or action plan identified. There was no documentation of a measurable goal, no documentation to support the QAPI committee analyzed any data brought forward, how they were going to achieve their compliance, if the action plan required revision. Interview on 8/27/24 at 2:45 p.m., with administrator identified the QAPI documentation was lacking but discussions had taken place about concerns identified. She agreed that there was a lack of measurable goals, and analysis of information brought forward during the meetings. Review of the 10/8/18, Quality Plan policy identified the administrator had the responsibility and was accountable to the Regional Director/VP/CEO and governance Board of Directors of QAPI and ensuring quality of care was delivered. The administrator was to provide staff support to the QAPI program and review recommendations made through that process. The administrator was to oversee each department actively participated in the program with objectives to problem identification, implementation of corrective action, and evaluation of the effectiveness of the program through ongoing monitoring and data collection.