STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Halstad Living Center	133 Fourth Avenue East Halstad, MN 56548

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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 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** 45844 Based on interview and document review, the facility failed to obtain informed consent and provide education to the resident representative on the risks and benefits regarding the use of psychotropic medications for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 had severe cognitive impairment and diagnoses which included: non traumatic brain dysfunction, dementia with behavior disturbance and paranoid personality disorder. Indicated R33 received antipsychotic medication. R33's care plan dated 7/28/23, identified R33 used antipsychotic medication related to dementia. Care plan directed staff to discuss with R33's family and MD regarding ongoing need for psychotropic medication and to educate family and caregivers regarding risks and benefits of medication. R33's Order Summary Report dated 4/17/24, identified orders for the psychotropic medications Seroquel (an antipsychotic) for dementia with behavioral disturbance and paranoid personality disorder with a start date of 10/16/23, and Paxil (an antidepressant) for anxiety with a start date of 11/16/23. R33's medical record lacked evidence of consent from R33's representative for the psychotropic medication. In addition, the medical record lacked evidence of education to R33's representative regarding the risks and benefits of the psychotropic medication. During an interview on 4/17/24 at 11:27 a.m., registered nurse (RN)-A confirmed R33 was receiving the psychotropic medication and the facility had not received consent from R33's representative for the psychotropic medication. In addition, R33 confirmed the facility had not provided R33's representative education regarding the potential side effects of the psychotropic medication. RN-A stated the usual process was to provide resident or representative with education regarding risks and benefits and obtain consent before the psychotropic medication was started. During an interview on 4/17/24 at 11:33 a.m., director of nursing (DON) stated her expectation was the facility would have provided education on risks and benefits and received consent from R33's representative prior to R33 starting the psychotropic medication. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Use of Psychotropic Medications dated 1/24, indicated Residents and/or representatives would be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. Review psychotropic medication consent form with resident and/or representative. .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 3 of 3 residents (R3, R4, R2) observed. In addition, the facility failed to ensure PPE was readily available for use for 1 of 2 residents (R24) observed for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Further, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for 2 of 4 hallways observed for linen transportation. In addition, the facility failed to ensure catheter drainage bags were properly placed to prevent the risk for cross contamination for 1 of 2 residents (R34) reviewed for catheter care. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. Review of CDC guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. LAUNDRY/ HAND HYGIENE During an observation on 5/15/24 at 12:47 p.m., housekeeper aide (HA)-A pushed an uncovered laundry cart down the 400 hallway to R11's room, removed clothing from the uncovered laundry cart, placed clothing into R11's closet, removed hangers from R11's closet and returned the hangers to the uncovered laundry cart. HA-A returned to the uncovered laundry cart, removed clothing and delivered the clothing to R 38's room as a visitor walked by the uncovered laundry cart. HA-A returned to the uncovered laundry cart, removed clothing and delivered the clothing to R 29's closet, removed hangers from R29's closet and returned hangers to the uncovered laundry cart. HA-A returned to the uncovered laundry cart, removed clothing and delivered the clothing to R 6's closet as a staff member walked by the uncovered laundry cart. HA-A returned to the laundry cart, placed the cover over the laundry cart and pushed the laundry cart to the 100 wing. HA-A uncovered the laundry cart, removed clothing and placed the clothing in R5's closet. HA-A returned to the uncovered laundry cart, removed clothing and delivered the clothing to R22's room as a resident in a scooter drove past the uncovered laundry cart. At no time during the above observation did HA-A perform hand hygiene. During an interview on 4/15/24 at 12:59 p.m., HA-A confirmed the laundry cart had been uncovered when she distributed laundry and stated she should have covered the laundry cart while delivering the laundry. HA-A indicated she should have sanitized hands before starting to deliver laundry and after she exited each room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/24 at 9:25 a.m., housekeeping director (HD) stated her expectation was staff would have kept the laundry cart covered during transport and HA-A would have performed hand hygiene when entering and exiting residents rooms while delivering the laundry. During an observation on 4/17/24 at 8:03 a.m., nursing assistant (NA)-E came out of R3's room carrying soiled bed linen with her bare hands against her clothing and placed it in a cart in the soiled utility room. NA-E proceeded to remove a clean blanket from the clean utility room and delivered it to R3's room. At no time during the above observation did NA-E perform hand hygiene. During an interview on 4/17/24 at 8:05 a.m., NA-E confirmed she had carried soiled bed linen with her bare hands against her clothing from R3's room,removed a clean blanket from the clean utility room, delivered it to R3's room and had not performed hand hygiene at any time. NA-E stated she should have worn gloves, placed soiled linen in a bag before bringing into the hallway. NA-E indicated she should have performed hand hygiene before touching the clean blanket. ENHANCED BARRIER PRECAUTIONS AND PPE USE R24's quarterly minimum data set (MDS) dated [DATE], identified R24 had moderate cognitive impairment and diagnoses which included stroke, peripheral artery disease (PAD), and depression. Identified R24 required moderate assistance for activities of daily living (ADL's) which included toileting, transfer, and dressing. Indicated R24 had a venous ulcer. R24's care plan revised 7/7/23, indicated R24 had a non- pressure chronic ulcer on his left calf. Care plan directed staff to follow facility policies/protocols for prevention and treatment of skin breakdown and to monitor dressing to ensure it was intact and report loose dressing to the nurse. During an observation on 4/15/24 at 12:25 p.m., there was no PPE located near R24's room for staff to wear while providing care for R24 (who was on enhanced barrier precautions). R2's MDS dated [DATE] identified R2 had intact cognition and diagnoses which included MRDO, hypertension (elevated blood pressure) and obesity. Identified R2 required extensive assistance with activities of daily living (ADL's) which included toileting, transfer, and dressing. R2's care plan revised 4/13/24, identified R2 had a history of open wounds on his legs and directed staff to follow facility protocols regarding wounds. During an observation on 4/15/24 at 12:30 p.m., hanging behind R2's door was an organizer that contained gowns, gloves, masks, and a sign that said Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer gown, and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/17/24 at 7:30 a.m., NA-C brought a hoyer lift into R2's room. NA-C and NA-D were wearing no PPE. NA-C and NA-D proceeded to hook R2 up to a hoyer lift sheet which was placed under R2. NA-C and NA-D were standing within an inch of R2 during the hoyer lift transfer. NA-C proceeded to place deodorant under R2's armpits and assisted R2 with putting his shirt on. NA-C then sanitized the lift and his hands while NA-D sanitized her hands and wheeled R2 out of the room to breakfast. During a joint interview on 4/17/24 at 7:39 a.m., NA-C and NA-D verified they had not worn any PPE when transferring R2 into his wheelchair and assisting R2 to put his shirt on. NA-C and NA-D indicated they understood PPE was only required when providing personal cares for R2 and that they had removed the PPE after providing his personal cares and prior to transferring R2 into the wheelchair and assisting R2 with putting his shirt on. 48740 HAND HYGIENE/PPE: R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was severely cognitively impaired and had diagnoses which included dementia, neurogenic bladder and paraplegia. Indicated R4 required total assistance from staff with all activities of daily living (ADLs). Identified R4 was incontinent of bowel and had a suprapubic urinary catheter. R4's care plan dated 11/21/23 indicated possible Methicillin-resistant Staphylococcus aureus (MRSA, an infection caused by a type of staph bacteria) to open areas and blisters on the back and was on contact isolation. During an observation on 4/15/24 at 7:40 p.m., NA-A and NA-B sanitized hands and donned the appropriate PPE for contact isolation precautions. NA-A and NA-B knocked on the door and went into R4's room. NA-A explained to R4 that they were going to change his brief. NA-B placed the head of the bed down and took the wedge out from R4's right side used for positioning. NA-A removed the blanket off of his legs and wedge under the legs used for positioning. NA-A and NA-B unhooked the tabs of R4's brief. NA-A and NA-B rolled R4 on his right side and tucked the brief under R4 partially. NA-B took the urinary catheter and moved it to the left side of the bed. NA-A and NA-B then rolled R4 to his left side. NA-B removed the dirty brief and placed it in a trash can next to the bed. On the left gluteal region, there were three open areas approximately with no drainage noted. NA-B performed peri care to the coccyx region with a wet wipe and placed the used wipe in the trash can. NA-B grabbed a clean brief with the same gloved hands that she used to perform peri-cares. The clean brief was tucked under R4. NA-A and NA-B rolled R4 to his right side to adjust the brief into place. The brief was pulled between legs and NA-A and NA-B hooked the tabs of the brief on the left and right side. NA-A and NA-B then explained to R4 that he needed to be moved up in bed. NA-A and NA-B grabbed the lift sheet and then lifted R4 in bed so that his head was about two inches from the headboard. NA-A repositioned the pillow behind R4's head and replaced the wedge under the legs. NA-A placed the blanket over R4's legs. NA-B took R4's urinary catheter drainage bag and placed it on the right sided bed frame. NA-B placed the side table next to the bed. NA-A and NA-B went into the bathroom to remove PPE and performed hand hygiene. NA-B picked up the trash bag with the dirty brief and exited the room. During an interview on 4/15/24 at 7:52 p.m., NA-B stated soiled gloves should have been removed between touching the soiled brief and clean brief to prevent contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/24 at 2:08 p.m., LPN-B stated R4 had a history of MRSA and infections to the blisters on the thigh area. CATHETER CARE: R34 quarterly MDS dated [DATE], indicated R34 was severely cognitively impaired and had a diagnoses which included cerebrovascular accident (CVA), and transient ischemic attack (TIA or stroke). Identified R4 required total assistance from staff with all ADL's. Indicated R34 was always incontinent of bowel and had a urinary catheter. During an observation on 4/15/24 at 2:22 p.m., R34 was lying in bed, which was in the lowest position. A urinary drainage bag was hanging on the right bed frame. The urinary drainage bag lacked a privacy covering. The urinary catheter bag had about 100 milliliters (cc) of cloudy urine. The bottom of the urinary catheter bag was touching the floor. During an observation on 4/15/24 at 3:47 p.m., R34 was lying in bed. The bed was in the lowest position. The urinary drainage bag was on the right side of the bed frame. No privacy bag covering was used on the urinary drainage bag. The urinary drainage bag had approximately 150 cc of yellow urine. The bottom of the urinary bag continued to be touching the floor. During an observation on 4/16/24 at 1:15 p.m., R34 was lying in a low bed. The urinary drainage bag was attached to the right side of the bed frame. No privacy bag covering was over the drainage bag. The urinary drainage bag had approximately had 100 cc of yellow urine and was touching the floor. During an interview on 4/16/24 at 1:35 p.m., LPN-C, entered R34's room and verified the urinary drainage bag was touching the floor. LPN-C confirmed the urinary drainage bag should not have been touching the floor due to the potential for the spread of bacteria. During an interview on 4/16/24 at 2:05 p.m., LPN-A stated catheter bags should not touch the floor due to the potential of cross contamination. Catheter bags should have a privacy bag on them to prevent the catheter drainage bag from touching the floor. During an interview on 4/17/24 at 7:54 a.m., RN-A indicated the facility used privacy bags and a bucket under the catheter bag to keep the catheter drainage bag off the floor. During a joint interview on 4/17/24 at 8:40 a.m., infection preventionist (IP) confirmed R2 and R24 were on Enhanced Barrier Precautions and R4 was on Contact precautions. IP stated her expectations were PPE would have been readily available to care for any residents in EBP and staff would wear PPE when indicated. In addition,IP expected clean laundry would have been covered when delivered and dirty linen would have been transported appropriately. IP further stated her expectation was for staff to perform hand hygiene, change gloves when appropriate and ensure that catheter bags were not touching the floor. DON further stated her expectations were the same as above and that staff would receive training on infection control and prevention. According to the Center for Disease Control and Prevention (CDC) on Catheter-Associated Urinary Tract Infections dated 11/5/2015, section 111.B.2, indicated staff were to keep the collection bag below the level of the bladder at all times. Do not rest the bag on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Enhanced Barrier Precautions revised 3/24, identified It was the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.(EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. Indicated the facility would make gowns and gloves available immediately near or outside of the resident's room; PPE for enhanced barrier precautions was necessary when performing high-contact care activities. Review of a facility policy titled Hand Hygiene revised 4/24, identified all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Alcohol-based hand rub with 60 to 95% alcohol was the preferred method for cleaning hands in most clinical situations. Indicated the use of gloves did not replace hand hygiene. If your task required gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. In addition, directed staff to use hand hygiene during resident care, moving from a contaminated body site to a clean body site. Review of a facility policy titled Handling clean linen revised 4/24, identified it was the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which could lead to infection. Clean linens must be transported by methods that ensured cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that could be secured to the cart. Review of a facility policy titled Handling Soiled Linen revised 4/24, identified linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons. Indicated used or soiled linen should be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated lined receptacle. When the task was complete, the bag should be closed securely and placed in the soiled utility room. A review of the facility policy titled Personal Protective Equipment dated 4/24, directed staff to change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn. A policy titled Catheter Care dated 4/24, indicated privacy bags would be available and catheter drainage bags would be covered at all times while in use. The policy lacked information regarding keeping urinary catheter drainage bags off of the floor.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to ensure 4 of 5 residents (R5, R8, R16 and R32) were offered or received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations Findings include: Review of the current CDC recommendations 3/15/2023, revealed The CDC identified Adults [AGE] years of age or older received the (PPSV23) or (PCV13) at any age and who have not received the Pneumo 20-valent conjugate Vaccine (PCV20) should receive a dose of the PCV 20 at least one year after the most recent PPSV23 or PCV13 vaccine. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 was received at age 65 and older, based on shared clinical decision-making with the patient and the provider one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R5's facesheet identified R5, age 88 was admitted to the facility on [DATE]. Review of R5's Minnesota Immunization Information Connection (MIIC) undated, identified R5 received the PPSV23 on 2/2/2005, and the PCV13 on 10/21/20016. R 5's medical record lacked documentation R5 had been offered or received the PCV20 based on shared clinical decision-making. Review of R8's facesheet identified R8, age 81 was admitted to the facility on [DATE]. Review of R8's MIIC record undated, identified R8 received the PPSV23 on 9/9/2010, and the PCV13 on 2/29/2016. R8's medical record lacked evidence R8 had been offered the PCV20 based on shared clinical-decision making. Review of R16's facesheet identified R16, age 75 was admitted to the facility on [DATE]. Review of R16's MIIC record undated, identified R16 received the PPSV23 on 3/11/2009, and the PCV13 on 8/27/2020. R16's medical record lacked evidence R16 had been offered the PCV20 at least one year after the most current dose of the PPSV23 or the PCV13. Review of R32's facesheet identified R32, age 94 was admitted to the facility on [DATE]. Review of R32's MIIC record undated, identified R32 had received the PPSV on 1/2/1997, and the PCV13 on 7/29/2015. R32's medical record lacked evidence R32 had been offered or received the PCV20 based on shared clinical decision- making. During an interview on 4/17/24 at 8:50 a.m., infection preventionist (IP) confirmed R5, R8, R16, and R32 had not been offered or received the pneumococcal vaccines as recommended by the CDC. IP stated her expectation was the facility would offer and administer all vaccine per CDC recommendation. During an interview on 4/17/24 at 8:58 a.m., director of nursing (DON) confirmed R5,R8, R16, and R32 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. DON stated her expectation would have been that all residents were offered and received all pneumococcal vaccines per CDC recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Pneumococcal Vaccine (Series) revised 4/24, identified the facility was to offer residents immunizations against pneumococcal disease in accordance with current CDC guideline and recommendation. Identified each resident would have been offered a pneumococcal immunization unless it was medically contraindicated or the resident had already been immunized.