STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Nursing Home	123 Baken Street Thief River Falls, MN 56701

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to inform the physician of a burn for 1 of 1 resident (R15) reviewed for burns; and failed to inform the physician of a resident fall with significant bruising 1 of 1 resident (R29) reviewed for falls. Findings include: R15: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate asssistance to roll her body left and right and was at risk for pressure ulcers. R15's care plan dated 10/16/24, identified R15 was at risk for pain related to spinal stenosis, osteoporosis, weakness, impaired mobility, shoulder pain, spondylolisthesis osteoarthritis, chronic gout, low back pain, and amputation of the second toe of the right foot. Non-pharmacological pain interventions may include: rest, reposition, distraction, elevation and ice/warm pack. The care plan directed to update R15's physician with changes. R15's nursing progress notes identified the following: - 10/19/24 at 8:49 a.m., a voicemail was left for family member (FM)-A. R15 was complaining of right hip pain, would note rate pain. As needed (PRN) Tylenol and heat pack applied. - 10/19/24 at 12:05 p.m., a (nursing assistant) NA noted a blister measuring 4 centimeter (cm) x 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did have fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. Blister left open to air. FM-A informed and stated R15's skin was very thin and likely why it blistered easily. The note failed to identify if R15's physician had been notified. - 10/20/24 at 11:31 a.m., R15's blistered area was leaking clear fluid. The area was cleansed, and an ABD pad placed. The note failed to provide a description including measurements or if R15's physician had been notified. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/23/24 at 11:42 a.m., R15's routine skin check performed this shift. No new skin concerns noted. Dressing to right hip/thigh changed. Scant amount of serous fluid noted on old dressing. Cleansed and new dressing applied. Tolerated well. Area has no odor or signs/symptoms of infection. The note failed to identify if R15's physician was notified. - 10/23/24 at 9:51 p.m., R15's dressing to right thigh changed due to previous dressing being soiled. Moderate amount of serous fluid noted on old dressing. No odor noted. Area cleansed with normal saline, and dressing changed per treatment record order. Tolerated well. The note failed to identify if R15's physician was notified. - 10/26/24 at 3:00 p.m., R15 had a bath. Telfa (a non-absorbent and non-adhering dressing) and an ABD applied to right outer hip blister/wound. The outer edges of area were red in color and measure 7.5 cm x 4.5 cm, this was area on entire wound. Blister was intact and fluid filled. Resident had no complaints of pain within that area and tolerated dressing change well. However, the note failed to identify if R15's physician was notified. - 11/4/24 at 3:27 p.m., R15's skin assessment was completed: 8 cm x 5.5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remained intact. Peri wound was reddened. No warmth noted. Wound edges are smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. No drainage to area. Area covered with xeroform and ABD, secured with tape. R15 had no complaints of pain to area. Will change dressing to area daily. - 11/5/24 at 11:22 a.m., a new dressing was applied to right thigh due to old dressing falling off. No drainage noted coming from area, no odor noted. Peri wound reddened; no warmth noted. Area where blister was dark in color. Dressing changed per orders. Resident tolerated well. However, the note failed to identify if R15's physician was notified. - 11/7/24 at 7:56 a.m., a 7 cm x 5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remains intact. Peri wound was reddened. No warmth noted. Wound edges were smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. Slight brown drainage on previous dressing. Area covered with xeroform and ABD, secured with tape. Resident had slight pain to area while cleansing and changing dressing. R15's physician updated. - 11/7/24 at 9:35 a.m., R15's physician ordered R15 to be evaluated in urgent care for R15's right hip wound. FM-A updated and in agreement. R15's MD/Nursing communication dated 11/7/24, identified a nursing concern related to a wound right hip 10/19/24. Hot pack. An order was received for Medi pore tape (hypoallergenic tape that is soft and breathable to reduce the risk for skin sensitivity), xeroform non-occlusive (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a water-in-oil emulsion blend), ABD pad (a large wound dressing). R15's nursing progress note dated 11/7/24 at 11:46 a.m., identified R15 seen in urgent care due to wound to right hip. Orders as follows: Medi pore tape, xeroform nonocclusive, ABD pad; if dressing starts to become saturated then increase dressing change to twice a day. Orders updated in Treatment Administration Record (TAR). Resident referred to wound clinic for further care of wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's physician progress note dated 11/8/24, identified R15's Wound #1 Right Hip was a chronic Full Thickness Burn, thermal (3rd degree) acquired on 10/19/2024 and had received a status of Not Healed. Initial wound encounter measurements are 4.18 cm length x 3.68cm width x 0.01 cm depth. Necrotic adipose (a condition that occurs when fatty tissue is damaged, leading to the death of the fat cells) was exposed. No tunneling has been noted. No sinus tract was noted. No undermining was noted. There was a moderate amount of serosanguineous drainage noted which had a Strong odor. R15 reported a wound pain of level 4/10. The wound margin was attached Wound bed has no granulation (a sign of wound healing) (new connective tissue), no slough (dead tissue within the wound that can impede healing), no epithelialization (new cells) but had eschar (dead tissue that sheds or falls off from the skin). During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she notified R15's physician by making a note in the rounding book. However, RN-A stated she was unaware of when R15's physician would have been rounding at the facility. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing (DON) on 10/19/24 when R15 received a burn to R15's right hip. RN-B was notified of the burn on 10/21/24, but she did not notify R15's physician until 11/7/24 when there was concern about a potential infection. A joint interview was conducted with the DON and RN-D on 1/28/25 at 4:20 p.m. The DON and RN-D stated R15's physician should have been notified immediately to ensure appropriate care and treatment of the burn to prevent worsening and to promote healing. During a telephone interview on 1/29/25 at 3:06 p.m., physician (DR)-A stated, typically for injuries, DR-A would expect to be notified in a day or two. For a burn, DR-A would more than likely have ordered a Silvadene (Silver sulfadiazine is an antibiotic. It fights bacteria and yeast on the skin. Silvadene (for the skin) is used to treat or prevent serious infection on areas of skin with second- or third-degree burns.) dressing and instruct to continue to monitor the wound. R15's delay of evaluation and treatment did not ease the healing process; however, DR-A would not say if it worsened the wound because DR-A did not evaluate the wound prior to 11/7/24. 41575 R29: R29's quarterly MDS dated [DATE], identified R29 had intact cognition. R29 required moderate assistance to dress lower body and with grooming. R29 was independent with transfer and ambulation. R29 had experienced one fall with injury since her last assessement period. Diagnoses included fibromyalgia, chronic pain syndrome, age related osteoporosis, moderate stage rheumatoid arthritis of multiple sites, and intervertebral disc degeneration, lumbar region with back pain. R29's care plan with revision date 11/6/24, identified R29 was at risk for falls related to weakness, and impaired mobility. R29 was independent with ambulation with a walker. R29 receivied anticoagualant therapy with a goal to be free from discomfort or adverse reactions related to anticoagulant use. R29's progress notes were reviewed and identified the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/29/24, R29 fell when trying to hang up a shirt in her closet. Her walker started to roll away and she became weak and fell , hitting her right side of her body on the floor. A physical assessment was completed, and family was notified. However, failed to identify if the physician was notified. -11/30/24, a large, swollen area and bruise 25 cm by 28 cm was noted on R29's right hip as a result of her fall the previous day. Ice packs were applied. - 12/2/24, R29 complained of not feeling well and questioned if she had a sinus infection. R29 agreed to be seen in urgent care the following day. R29 also complained of pain in right hip and was given an ice pack -12/3/24, R29 returned from urgent care. R29 had been assessed for complaints of respiratory illness. A hip X-ray had also been completed which was negative. A Office Visit report dated 12/3/24, identified R29 was seen in clinic for symptoms of cough, nasal congestions and sinus pressure. R29 reported a fall 11/29/24, in which she landed on her right side. R29 complained of pain and reported a large lump on her right hip. On assessment the right hip had large swelling and a large hematoma with pain over the lateral hip. R29 was able to bear weight. A hip Xray was completed with negative findings. R29 was to use heat or ice in 20-minute intervals and return if symptoms worsened. When interviewed on 1/29/25, at 10:44 a.m. R29 stated she had fallen on around the beginning of December in front of her closet. R29 was reaching up for something in the closet and fell . R29 had a bruise that went from her hip to her bruise and still had the lump over the right hip. Pointed to a small, elevated area over her right hip, visible through her pants and stated it still hurt in her groin area. She went to the clinic because she had not been feeling well and they had noticed the bruise and took and Xray which turned out to be ok. When interviewed on 1/30/25, at 3:16 p.m. DON stated she was unable to find an investigation related to the fall with injury. R29's bruise and injury had been monitored on the treatment administration record and/or on her care plan, however, R29's physician had not been notified of the incident, nor was R29 evaluated by the provider. The DON stated it was the facility's general practice to notify the provider of all resident falls. The DON was unable to find documentation R29's primary provider had been notified of her fall with injury on 11/29/24. The facility policy Incidents and Accidents dated 1/2025, identified it was the facility's policy to utilize point click care to report, investigate and review any accidents or incidents that occurred. The nurse would contact the resident's provider to inform them of the incident/accident and report any injuries or other findings, and obtain orders, if indicated.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review the facility failed to report a burn that resulted from the inappropriate use of a hot pack to the state agency (SA) for 1 of 1 resident (R15) reviewed for wound care. Findings include: The Rester's Choice Gel Pack undated manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reached and evenly distributed, that's the heating time that should be used at the current microwave oven. - Caution/Warnings: Individuals with circulatory or diabetes issues should consult a physician before use. Do NOT lean or sit on pack. Unattended use of gel pack by elderly or incapacitated individuals is dangerous; monitor for insensitivities to product temperature. R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and was at risk for pressure ulcers. R15's nursing progress note dated 10/19/24 at 12:05 p.m., identified a nursing assistant (NA) noted a blister measuring 4 centimeters (cm) by 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. The blister was left open to air. Family member (FM)-A was informed and stated R15's skin was very thin and likely blistered easily. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's physician progress note dated 11/8/24, identified R15's wound on R15's right hip was a chronic Full Thickness Burn (also called a third-degree burn. This type of burn involved all of the layers of skin and sometimes the fat and muscle tissue under the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, so there may be little or no pain) that was acquired on 10/19/24 and had not healed. Initial wound encounter measurements are 4.18 cm length by 3. 68cm width by 0.01 cm depth. Necrotic adipose (Fat necrosis is a condition that occurs when fatty tissue is damaged, leading to the death of fat cells (also known as adipose cells)) was exposed. No tunneling was noted. The patient reports a wound pain of level 4/10. The wound margin was attached, and the wound bed had no granulation (new connective tissue), slough (yellowish or tan colored material) or epithelization (wound closure) but did exhibit eschar (a hardened, dry, black or brown dead tissue, forms a scab-like covering over deep wounds, such as severe burns or ulcers). An investigation into causative factors and analysis of R15's burn was requested and was not received. During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for maybe 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the reddened area that resulted in a burn on R15's right hip. However, RN-A stated she did not report the burn to the state agency (SA) because she wasn't sure if the reddened area wouldn't go away. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was informed of R15's burn on 10/21/24, however, a report to the SA was not discussed nor completed. I just didn't think of it. During an interview on 1/28/25 at 4:20 p.m., with the director of nursing (DON) and the RN-D, the DON stated she started her role on 11/25/24 and was unaware of the circumstances of R15's right hip burn. The report to the SA should have been filed. RN-D stated she was also unaware of the circumstances of R15's burn was a serious concern that showed lack of assessment and follow through to prevent a burn from happening again. The facility policy Abuse Prevention and Reporting revised 1/2025, identified all cases of suspected abuse/neglect/exploitation must be reported to authorities immediately, after forming a suspicion if cause of suspicion did not result in serious bodily injury, to the Administrator, Department Manager, or the Administrator's designee. The definition of immediately, means as soon as possible, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A person (including an employee, volunteer or other person) associated with the facility, who reasonably believes or who knows of information that would cause a person to believe that the health or welfare of a resident of the facility has been, is or will be adversely affected by abuse or neglect by any person shall, as soon as possible, report the information supporting the belief to the Minnesota Department of Health, or the appropriate healthcare regulatory agency, by telephone, in writing, or by personal visit. Reports of abuse, neglect, misappropriation of property, and exploitation should be made immediately to the Administrator or his/her designee. During normal business hours, notify the Administrator or Director of Nursing. During non-normal business hours, notify the on-call RN (responsible to submit reports to MDH during non-normal business hours) and notify the administrator and director of nursing (this may be done by phone, answering machine, voicemail, or text message).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review the facility failed to investigate a burn that resulted from the inappropriate use of a hot pack for 1 of 1 resident (R15) who was reviewed for wound care. Findings include: Rester's Choice Gel Pack manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reached and evenly distributed, that's the heating time that should be used at the current microwave oven. - Caution/Warnings: Individuals with circulatory or diabetes issues should consult a physician before use. Do NOT lean or sit on pack. Unattended use of gel pack by elderly or incapacitated individuals is dangerous; monitor for insensitivities to product temperature. R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and was at risk for pressure ulcers. R15's nursing progress note dated 10/19/24 at 12:05 p.m., identified a nursing assistant identified a blister measuring 4 centimeters (cm) by 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. The blister was left open to air. Family member (FM)-A was informed and stated R15's skin was very thin and likely blistered easily. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's physician progress note dated 11/8/24, identified R15's wound on R15's right hip was a chronic Full Thickness Burn (also called a third-degree burn. This type of burn involved all of the layers of skin and sometimes the fat and muscle tissue under the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, so there may be little or no pain) that was acquired on 10/08/24 and had not healed. Initial wound encounter measurements are 4.18 cm length by 3. 68cm width by 0.01 cm depth. Necrotic adipose (Fat necrosis is a condition that occurs when fatty tissue is damaged, leading to the death of fat cells (also known as adipose cells)) was exposed. No tunneling was noted. The patient reports a wound pain of level 4/10. The wound margin was attached, and the wound bed had no granulation (new connective tissue), slough (yellowish or tan colored material) or epithelization (wound closure) but did exhibit eschar (a hardened, dry, black or brown dead tissue, forms a scab-like covering over deep wounds, such as severe burns or ulcers). During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for maybe 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the reddened area that resulted in a burn on R15's right hip. RN-A disposed of the gel packs because she believed R15's was caused by a defective gel pack; however, RN-A did not review the manufacturer's instructions to verify the gel pack had been used correctly. RN-A provided verbal direction to the other nursing staff; however, no documentation of that direction was done. Additionally, RN-A did not report the incident to RN-B (who was acting director of nursing at the time) until 10/21/24. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing on 10/19/24 when R15 received a burn to R15's right hip. RN-B stated R15 had fallen and staff had applied a hot pack to R15's right hip for comfort. R15 was laying directly on the hot pack and R15's skin was burned. RN-B stated she wasn't notified of the burn until 10/21/24. The burn was discussed in the morning interdisciplinary meeting (IDT) and it was decided the facility would obtain new gel packs because RN-A had thrown the gel packs away because RN-A believed the gel packs to be defective. RN-B stated no investigation to determine if the gel pack was used appropriately, if the gel pack should have been used for R15 who was a diabetic, if the nursing staff were aware of the gel pack heating instructions, and/or any other resident who had received a burn from the gel packs. RN-B stated a thorough investigation should have been conducted to prevent further harm to R15 or harm to any other resident. The facility's IDT (interdisciplinary team) minutes dated 10/22/24, identified Order new ice/hot pack but failed to identify and investigation into the causeative factors of R15's burn. The facility's IDT minutes dated 10/23/24, identified new hot packs/cold packs purchased but failed to identify R15's burn. The facility's purchasing order dated 10/22/24, identified microwavable heating pads were orders (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's purchasing order dated 12/19/24, identified the purchase of 2 boxes of [NAME] Hot Compress. During an interview on 1/28/25 at 4:20 p.m., with the director of nursing (DON) and RN-D, the DON stated she started her role on 11/25/24 and was unaware of the circumstances of R15's right hip burn. A thorough investigation should have been conducted to ensure the safety of the residents. RN-D stated she was also unaware of the circumstances but R15's burn was a serious concern that showed lack of assessment and follow through to prevent a burn from happening again. The facility policy Abuse Prevention and Reporting revised 1/2025, identified at the administrator or his/her designee will then begin the investigation. As part of the investigation, the affected resident(s) will be interviewed, staff and other witnesses will be interviewed, circumstances leading up to the incident will be evaluated, employees/persons accused of abuse will be investigated, and policies and procedures will be reviewed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Nursing Home	123 Baken Street Thief River Falls, MN 56701

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure the medications section of the Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R15) reviewed for MDS accuracy. Findings include: R15's significant change Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included Type 2 Diabetes. R15 received an insulin injection weekly. R15's Order Summary Report dated 6/20/23, identified R15 received Trulicity (an antihyperglycemic - glucagon-like peptide-1 (GLP-1) receptor agonists) (used with a proper diet and exercise program to control high blood sugar in people with type 2 diabetes) subcutaneous solution pen-injector 3 milligram (mg)/0.5 milliliter (ml). Inject 3 mg subcutaneously in the morning every Thursday related to type 2 diabetes. During an interview with the registered nurse (RN)-D on 1/29/25 at 11:32 a.m., RN-D stated she was assisting with completing resident MDS while the facility's MDS nurse was out of the facility on medical leave. RN-D stated Trulicity was not an insulin but a GLP-1 medication to assist in the treatment of type 2 diabetes and, because of that, should be identified as an insulin on the MDS. RN-D stated the MDS was a tool to assist in the resident's individualized plan of care and R15 received an injectable mediation to treat type 2 diabetes once a week. Because of this, RN-D stated R15's MDS was coded correctly. The facility policy Resident Assessment (Minimum Data Set (MDS)) revised 1/2025, identified it was the policy of the facility to conduct initial and periodic standardized assessments of each resident's functional capacity. This will include assessment and evaluation of a resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) as specified by CMS. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, identified the steps for assessment included: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure manufacturer's instructions were followed for the use of a microwave heating of a gel pack, complete a comprehensive assessment of the burn and implement timely interventions to promote the healing of a burn for 1 of 1 resident (R15) reviewed for burns. This resulted in actual harm to R15 who sustained a 3rd degree burn (destroys your first three layers of skin and fatty tissue) from a gel pack. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and currently had no wounds. R15's care plan dated 10/16/24, identified R15 was at risk for pain related to spinal stenosis, osteoporosis, weakness, impaired mobility, shoulder pain, spondylolisthesis osteoarthritis, chronic gout, low back pain, and amputation of the second toe of the right foot. Non-pharmacological pain interventions may include rest, reposition, distraction, elevation and ice/warm pack. The care plan directed to update R15's physician with changes. R15's nursing progress notes identified the following: - 10/19/24 at 8:49 a.m., a voicemail was left for family member (FM)-A. R15 was complaining of right hip pain, would note rate pain. As needed (PRN) Tylenol and heat pack applied - 10/19/24 at 12:05 p.m., a nursing assistant (NA) noted a blister measuring 4-centimeter (cm) x 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did have fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. Blister left open to air. FM-A informed and stated R15's skin was very thin and likely why it blistered easily. - 10/20/24 at 11:31 a.m., R15's blistered area was leaking clear fluid. The area was cleansed, and an ABD pad placed. The note failed to provide a description including measurements. - 10/23/24 at 11:42 a.m., R15's routine skin check performed this shift. No new skin concerns noted. Dressing to right hip/thigh changed. Scant amount of serous (clear to light yellow) fluid noted on old dressing. Cleansed and new dressing applied. Tolerated well. Area has no odor or signs/symptoms of infection. - 10/23/24 at 9:51 p.m., R15's dressing to right thigh changed due to previous dressing being soiled. Moderate amount of serous fluid noted on old dressing. No odor noted. Area cleansed with normal saline, and dressing changed per treatment record order. Tolerated well. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- 10/26/24 at 3:00 p.m., Telfa (a non-absorbent and non-adhering dressing) and an ABD applied to right outer hip blister/wound. The outer edges of area were red in color and measure 7.5 cm x 4.5 cm, this was area on entire wound. Blister was intact and fluid filled. Resident had no complaints of pain within that area and tolerated dressing change well. - 11/4/24 at 3:27 p.m., R15's skin assessment was completed: 8 cm x 5.5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remained intact. Peri wound was reddened. No warmth noted. Wound edges are smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. No drainage to area. Area covered with Xeroform and ABD, secured with tape. R15 had no complaints of pain to area. Will change dressing to area daily. - 11/5/24 at 11:22 a.m., a new dressing applied to right thigh due to old dressing falling off. No drainage noted coming from area, no odor noted. Peri wound reddened; no warmth noted. Area where blister was dark in color. Dressing changed per orders. R14 tolerated well. - 11/7/24 at 7:56 a.m., a 7 cm x 5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remains intact. Peri wound was reddened. No warmth noted. Wound edges were smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. Slight brown drainage on previous dressing. Area covered with Xeroform and ABD, secured with tape. R14 had slight pain to area while cleansing and changing dressing. R15's physician updated. - 11/7/24 at 9:35 a.m., R15's physician ordered R15 to be evaluated in urgent care for R15's right hip wound. FM-A updated and in agreement. - 11/7/24 at 11:46 a.m., R15 was seen in urgent care due to wound to right hip. Orders as follows: Medi pore tape, Xeroform nonocclusive, ABD pad; if dressing starts to become saturated then increase dressing change to twice a day. Orders updated in Treatment Administration Record (TAR). Resident referred to wound clinic for further care of wound. R15's medical record lacked a comprehensive assessment for R15's burn along with interventions implemented. R15's MD/Nursing communication dated 11/7/24, identified a nursing concern related to a wound right hip 10/19/24. Hot pack. An order was received for Medi pore tape (hypoallergenic tape that is soft and breathable to reduce the risk for skin sensitivity), xeroform non-occlusive (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a water-in-oil emulsion blend), ABD pad (a large wound dressing). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R15's physician progress note dated 11/8/24, identified R15's wound was a chronic Full Thickness Burn, thermal (3rd degree) acquired on 10/19/24 and had received a status of not healed. Initial wound encounter measurements were 4.18 centimeters (cm) length x 3.68 cm width x 0.01 cm depth. Necrotic adipose (a condition that occurs when fatty tissue is damaged, leading to the death of the fat cells) was exposed. No tunneling was noted. No sinus tract was noted. No undermining was noted. There was a moderate amount of serosanguineous (light pink, watery fluid) drainage noted which had a strong odor. R15 reported a wound pain of level 4/10. The wound margin was attached. Wound bed has no granulation (a sign of wound healing) (new connective tissue), no slough (dead tissue within the wound that can impede healing), no epithelialization (new cells) but had eschar (dead tissue that sheds or falls off from the skin). R15's Order Summary Report identified the following: -10/19/24, Nursing order to monitor 4 cm x 1 .5 cm blister to right hip two times a day. Use ice pack if causing discomfort. - 10/24/24, Nursing order to monitor 4 cm x 1 .5 cm blister to right hip. Change dressing every 3 days two times a day and as needed (PRN). Cleanse with saline and apply ABD (a large wound dressing) with tape - 11/7/24, Physician order to dressing to right hip - cleanse with saline, pat dry, apply Xeroform (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a water-in-oil emulsion blend) and cover with ABD, secure with Medi pore (soft cloth surgical tape, this is a breathable, gentle, conformable tape that comes in easy tear, perforated rolls) tape one time a day. R15's significant change Minimum Data Set (MDS) dated [DATE], identified R15 had a burn. R15's wound clinic notes dated 11/8/24 - 1/28/25, identified R15 had received consistent wound care since the referral and R15's wound was in the process of healing. During a telephone interview on 1/28/25 at 9:48 a.m., FM-A stated R15 had a fall back in October 2024 and received no injuries, but did receive a burn to R15's right hip from a hot pack. FM-A stated nursing did tell FM-A right away and said either the hot pack was faulty or they left it on too long. Nursing made it sound like it wasn't really a big deal and FM-A spoke with R15 every evening and R15 didn't say anything about it. Then, a few weeks later, FM-A was told R15 needed to be seen by a wound specialist. Nursing told FM-A they disposed of all the hot packs. FM-A stated she didn't know if nursing didn't think it was a big deal, but FM-A would have liked to be updated before being told about the wound specialist. Maybe we could have done something sooner and it wouldn't have gotten so bad. During a telephone interview on 1/28/25 at 10:43 a.m., registered nurse (RN)-C stated she was aware of the burn but was not working when it occurred. RN-C could not say what first aid was provided to R15, but R15 was being followed by wound care. RN-C stated she was told to not use the hot packs because they were unaware of the feature that would make gel packs so hot. RN-C believed the gel packs were discontinued. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/28/25 at 1:30 p.m., RN-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for maybe 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the reddened area that resulted in a burn on R15's right hip. RN-A did not apply ice or cool water and left R15's burn open to air. RN-A stated she was unaware of when R15's physician would have been rounding at the facility but did not seek medical attention for R15 because I thought it might go away. The undated Rester's Choice Gel Pack manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reach and evenly distributed, that's the heating time that should be used at the current microwave oven. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing (DON) on 10/19/24, when R15 received a burn to R15's right hip. RN-B stated R15 had fallen, and staff applied a hot pack to R15's right hip for comfort. R15 was lying directly on the hot pack and R15's skin was burned. RN-B stated she was notified of the burn on 10/21/24, during the morning IDT meeting, but she did not notify R15's physician until 11/7/24, when there was concern about potential infection. RN-B stated she did not assess R15's wound until 11/7/24, because nursing staff had completed skin assessments. RN-B stated she did not evaluate nor analyze R15's burn to determine if the gel pack was used according to manufacturer's instructions and/or if any other diabetic residents had used the gel packs During an interview on 1/28/25 at 4:04 p.m., licensed practical nurse (LPN)-F stated R15's burn was caused by a hot pack, and LPN-F wasn't working when it happened. LPN-F stated she had used the hot packs many times. It's always a resident's choice if they want to use a hot or cold pack and LPN-F thought they could be left on for 30 minutes to an hour. If a burn happened when LPN-F was working, LPN-F would immediately try to cool off the burn with ice to try to lessen the burn; then would call the RN on-call for further direction. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A joint interview was conducted with RN-D, who was the facility's corporate nurse, and director of nursing (DON) on 1/28/25 at 4:20 p.m. The DON and RN-D both stated they were not aware of the circumstances surrounding R15's burn. The DON stated she overheard nurses talking about microwaving gel packs. The DON stated she told the nurses microwaving gel packs was not advisable and ordered the [NAME] Hot Compresses on 12/19/24. However, the DON stated she did not question the nurses further and was unaware R15's wound was caused by a gel pack. We were talking about Best Practice. The DON stated she verbally educated the nurses regarding the [NAME] Hot Compress during report at shift changes but had done no formal education. The DON stated staff that worked casually would need to rely on other staff to tell them. DON stated staff were expected to assess, monitor, treat and document wounds to promote healing. RN-D stated the incident was a serious concern that showed lack of assessment and lack of follow through to prevent this from occurring again. During a telephone interview on 1/29/25 at 3:06 p.m., physician (DR)-A stated, typically for injuries, DR-A would expect to be notified in a day or two. For a burn, DR-A would more than likely have ordered a Silvadene dressing ((Silver sulfadiazine) is an antibiotic. It fights bacteria and yeast on the skin. Silvadene (for the skin) is used to treat or prevent serious infection on areas of skin with second- or third-degree burns) and instruct to continue to monitor the wound. R15's delay of evaluation and treatment did not ease the healing process; however, DR-A would not say if it worsened the wound because DR-A did not evaluate the wound prior to 11/7/24. During an interview on 1/30/25 at 8:49 a.m., the DON and RN-D stated R15's burn should have been thoroughly investigated to ensure equipment was used according to manufacturer's instructions, if staff were aware of how to use the gel pack and to determine which residents with circulatory problems or diabetes were involved to ensure no other residents were or could be harmed. A facility first aid policy was requested but not received. A facility wound monitoring policy was requested but not received A facility policy/procedure regarding the Rester's Choice gel pack was requested but not received. The American Burn Association's First Aid for Minor Burns direction dated 2020, identified the following: Stop the burning process: - cool with burn with running cool (not cold) water for at least 5 minutes. Sterile water not necessary. - Remove all jewelry, watches, rings, and clothing around the burned area as soon as possible. - Administer an over-the-counter pain reliver such as ibuprofen or acetaminophen for pain control. Follow the directions on the label. Consult a physician or health care provider if pain is not relieved. - Cover the burn with a sterile gauge bandage or clean cloth. Wrap the burned area loosely to avoid putting too much pressure on the burn tissue. - Minor burns will usually heal without further treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- For a small area burn (less than 1% or the size of the person's hand), apply soothing lotions that contain aloe vera to a burned area to help relieve the pain and discomfort. - Seek medical attention if there is a persistent fever not relieved by medication or redness that may extend beyond the border of the burn or pain is not controlled by ibuprofen or acetaminophen. - Drink plenty of fluids (electrolyte-containing solutions such as Gatorade) if the person appears to be dehydrated. Do not apply ice - this may further damage to the skin. Do not over cool! If victim starts to shiver, stop the cooling process. Do not use any butter, ointments, or other home remedies on the burn. Such substances may trap the heat in the tissue and makes the burn worse. Do not break any blisters - leave intact. Blisters may rupture over time - this is normal. Do not delay seeking medical attention if the burn is larger than the size of the victim's hand.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed comprehensively assess a pressure ulcer and implement interventions to promote healing for 1 of 2 residents (R14) reviewed for wound care. Findings include: R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had a severe cognitive impairment and diagnoses that included dementia, anorexia, and chronic kidney disease. R14 was at risk for pressure ulcers but had no current pressure ulcers. R14's Braden Scale for Predicting Pressure Sore Risk dated 1/7/25, identified R14 was at risk for pressure ulcers. R14's care plan revised 1/13/25, identified R14 was a risk for skin breakdown related to impaired mobility, incontinence, low adipose tissue and impaired cognition. Staff were directed to perform the following: assist R14 to turn/reposition at least every 2-3 hours when up in her wheelchair and all-night rounds, barrier cream will be applied as needed, Braden scale to be completed per facility policy, bruises would be observed at least weekly until healed, pressure relieving mattress and wheelchair cushion, skin tears would be observed at least daily until healed, skin would be observed during cares, staff to report any areas of concern to nurse immediately and weekly skin checks to be completed by licensed staff on bath day. The care plan failed to identify R4's right great toe pressure ulcer or interventions to prevent worsening and/or promote healing. The Paradise resident care sheet dated 1/22/25, failed to identify R14 had a pressure ulcer. R14's nursing progress note(s) identified the following: - 10/22/24 at 11:10 a.m., a nursing assistant (NA) was undressing resident for a shower. While taking socks off R14's feet R14 complained of pain on her right great toe. The NA noticed R14 had an area on the outer side of R14's toe that was bleeding. The NA notified nurse. R14 stated I don't know what happened. She was taking my socks off and it hurt. Area appears to look like R14 had dry skin stuck to her sock and skin was pulled off when CNA removed her socks. Area measured 1 centimeter (cm) in diameter. Area cleaned and band aide applied. R14's physician notified via rounding book, left voicemail for son. - 11/11/24 at 12:35 p.m., identified a disposable adhesive bandage was changed to R14's right great toe. Two small scabs approximately measuring 0.1 cm x 0.1 cm and 0.2 cm x 0.2 cm. Blanchable redness surrounding. No complaints of pain or discomfort. No drainage. A disposable adhesive bandage applied to area. Lotion applied to feet. Shoes removed while R14 lying in bed at this time. - 12/17/24 at 2:57 p.m., R14's skin check completed this shift. A pinpoint small scab to side of R14's right big toe. No other skin concerns. Denies pain. No SOB noted. Lotion to extremities. R14 refused nail care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/24/24 at 1:57 p.m., R14's shower and skin check completed this shift. Skin warm, dry, and intact. Nails trimmed. Lotion applied. No new skin concerns currently. - 1/7/25 at 10:30 a.m., R14's skin assessment was completed. Noted to have open area to great toe under nail. Area measuring 0.5 cm x 0.6 cm. Area was darkened blood tinged. Area around toe was inflamed, reddened. Was not warm to touch. Foot was dry and flaky. R14 offered pain upon assessment. Area cleansed and protective dressing applied. - 1/12/25 at 12:24 p.m., identified R14's skin assessment was completed. Previously open area to under right great toenail has now scabbed over. Scabbed area measuring 0.5 cm x 0.6 cm. Area was dry and intact. Toe was no longer inflamed. Was not reddened, warm to touch, no swelling noted. R14 denied having any pain to area. Area cleansed and protective dressing applied. Will encourage R14 to remove footwear while in bed. Will continue with current plan of care. - 1/17/25 at 11:29 a.m., identified R14 continued with scabbed area to right great toe measuring 0.5 cm x 0.4 cm. Area was dry and intact. No redness, inflammation, or swelling noted to area. R14 had no complaints of pain or discomfort. Area cleansed and protective dressing applied. Will continue with encouraging R14 to remove shoes while in bed and apply dressing every other day and as needed (PRN). - 1/22/25 at 11:21a.m., identified R14 continued with scabbed area to right great toe measuring 0.5 cm x 0.4 cm. Area was dry and intact. No redness, inflammation, or swelling noted to area. R14 had no complaints of pain or discomfort. Area cleansed and protective dressing applied. Will continue with encouraging resident to remove shoes while in bed and apply dressing every other day and PRN. - 1/28/25 at 2:03 p.m., identified R14's routine skin check performed this shift. No new skin concerns noted. Dressing to right great toe changed per order. No drainage noted to previous dressing. No odor or signs or symptoms of infection. Tolerated well. R14's wound dressing order dated 1/12/25 through 1/14/25, directed staff to apply a right great toe dressing daily: cleanse area with wound wash, pat dry, apply foam dressing, wrap with kerlix and secure with tape R14's wound dressing order dated 1/15/25, directed staff to apply a right great toe dressing every other day and as needed: cleanse area with wound wash, pat dry, apply foam dressing, wrap with kerlix and secure with tape R14's medical record lacked a comprehensive assessment along with new interventions to promote healing of the pressure area on the right toe. During an interview on 1/29/25 at 2:06 p.m., NA-A stated R14 did have a sore on her toe but R14 liked to keep her socks on all the time, even when in bed. The nurse put the dressing on the toe, so NA-A did not really know what the wound looked like. I really don't know more than that. During an interview on 1/29/25 at 3:22 p.m., NA-B stated R14 did have a little sore on her right great toe. NA-B hadn't really seen the wound but it's just a little thing. NA-B did not know what they nurses were doing for the would other than a dressing. (continued on next page)

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	245592	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Nursing Home	123 Baken Street Thief River Falls, MN 56701

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 3:24 p.m., licensed practical nurse (LPN)-A stated R14 did have a wound on her right great toe and LPN-A needed to change R14's dressing that evening when R14 was ready for bed. LPN-A stated she really didn't know anything about the wound other than the dressing order, what it was caused from or what the staff were doing to promote healing or prevention worsening. During an observation on 1/29/25 at 4:22 p.m., registered nurse (RN)-B changed R14's dressing. RN-B wore gloves but did not put on a gown. R14 had two open areas at the base of her right great toenail. The measurements for the first area were 0.5 cm x 0.4 cm and the second measured 0.3 cm x 0.1 cm. The areas were dry and scabbed. During an interview on 1/29/25 at 4:40 p.m., RN-B stated the wound to R14's right great toe was the same wound that began on 10/22/24. Staff have been doing dressing changes and encouraging R14 to take off her shoes and wear gripper slippers but R14 would refuse the slippers. RN-B stated the wound was caused by R14's toe rubbing on the inside of R14's shoe causing pressure. RN-B stated R14's wound interventions were passed on to staff verbally during report, but no interventions had been documented besides dressing orders. RN-B stated prior to 1/12/25, staff were using their nursing judgement to apply a dressing but because there was concern for infection on 1/7/25, an official dressing order was entered on 1/12/25. RN-B stated consistent weekly documentation had been completed to ensure R14's wound was healing. During an interview on 1/29/25 at 4:44 p.m., the director of nursing stated staff were expected to follow the facility's pressure ulcer protocol. The facility's policy for pressure ulcer was requested but not received. The facility's policy for wound dressing was requested but not received.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure as needed pain medications were available to treat acute break through pain for 1 of 2 residents (R27); and failed to respond to request for pain medications for 1 of 2 residents (R29) reviewed for pain management. Findings include: R27: R27's quarterly Minimum Data Set (MDS) dated [DATE], identified R27 had severe cognitive impairment and had impaired range of motion in both upper and lower extremities. R27 received both scheduled and as needed pain medications. There were nonverbal sounds and facial expressions of pain observed three to four days per week. R27's Quarterly Pain assessment dated [DATE], identified R27 received scheduled pain medication and PRN pain medication, and having received no non-medication interventions for pain. R27 was unable to answer pain interview questions so a staff assessment for pain was completed. Pain was observed with non-verbal sounds such as crying, whining, gasping or moaning and facial expressions of grimaces, winces, wrinkled forehead, furrowed brow or clenched teeth or jaw and the indicators of pain was noted daily. The quarterly pain assessment failed identify underlying causes or patterns to R27's pain, determine if R27's pain had increased, responses to interventions to prevent or reduce pain, or whether current approaches needed to be reconsiders, revised or supplemented. R27's care plan, with last revision date 12/14/24, identified R27 was at increased risk for pain related to fibromyalgia, polymyalgia rheumatic, osteoarthritis and impaired mobility. A goal was listed R27 would show signs and symptoms of adequate pain relief. Interventions included administer pain medications as ordered, encourage adequate rest periods, non-pharmacological pain interventions to include distraction, reposition, rest, elevation, ice/warm pack and staff were directed to observe for pain at least every shift, using the non-verbal pain scale. R27's Physician Order Summary report dated 1/29/25, identified R27 was ordered acetaminophen 1000 milligrams (mg) three times a day with start date of 1/25/24, as well as acetaminophen 650 mg every four hours as needed with start date 10/31/21. Oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. During interview on 1/28/25, at 8:14 a.m. family member (FM)-A stated the facility's idea of pain management was to give R27 an as needed pain pill. Staff told FM-A R27 was not getting the PRN pain medication every 12 hours and so it did not need to be scheduled. FM-A felt the staff needed to watch for R27's cues that she was in pain. FM-A had been asking the facility to stop applying R27's splints for a long time. R27 had torn ligaments in her joints that made the splints more painful. FM-A stated the facility ran out of R27's as needed pain medication at one point and R27 had to wait a long time for her pain medication, FM-A thought it had taken into late the next day. FM-A removed the hand splints from the facility and the physician did finally order them to be stopped. Once R27 was placed on hospice her pain was managed with a patch and removing the splints. R27 had since passed away. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's progress notes identified the following: - 11/27/24, staff noted R27 had two doses of her pain medication remaining. Pharmacy was contacted and staff were notified the provider would need to be contacted for refill request, as R27 was out of refills for the oxycodone. Staff also called R27's provider's office to update on need for medication. - 11/28/24, FM-A visited and assisted staff with R27's tub bath. R27 was hollering out during the transfer and bathing process. FM-A was upset R27 did not have her pain medication available and requested a provider be contacted to request an injection for pain relief. Review of available emergency kit medications identified oxycodone with Tylenol was available, however, R27's oxycodone order did not include Tylenol, and the hospitalist would need to be contacted to approve. R27 was laid down in bed and shoulders and knees were rubbed with Voltaren cream (an analgesic). R27 then fell asleep. FM-A took R27's hand splints home with her and notified staff she would return the hand splints to the facility when R27 had her pain medication available. - 11/29/24, at 10:17 a.m. pharmacy was contacted regarding R27's oxycodone refill. Pharmacy was still waiting refill authorization from the provider. Call placed to provider to notify R27 was out of her pain medication. - 11/29/24, at 3:29 p.m. call was placed to pharmacy for update on R27's need for refill of oxycodone. Pharmacy indicated medication would be delivered this evening. Family updated. R27's November Medication Administration Record 2024, identified acetaminophen 1000 mg was administered three times per day, and PRN oxycodone was administered 20 times during the month of November with pain noted in range from 4 to 10 on a 0 to 10 scale. PRN Tylenol was administered two times on 11/29/24 for pain rated at 5 on a 0 to 10 scale. The PRN oxycodone had been administered on 11/28/24, at 2:58 a.m. and was next administered 11/29/24, at 7:53 p.m. When interviewed on 1/28/25, at 4:12 p.m. registered nurse (RN)-B stated R27 had scheduled Tylenol for pain and staff would allow her to rest in bed when in pain. The oxycodone was effective for R27's pain and the family wanted the medication increased. RN-B instructed staff to assess and use the PRN medication more frequently. RN-B faxed R27's primary provider with request to increase the frequency of R27's oxycodone, but the provider was out of office that week, so the family took R27 into the clinic to be seen. Pain assessments scales were completed on the resident's TAR, staff rated a resident's pain using the PAINAD scale and documented the pain number on the TAR each shift. A joint interview was conducted with RN consultant (RN)-D and the director of nursing (DON) on 1/28/25, at 4:47 p.m. The nurses were really good to offer the PRN pain medication and repositioning as far as interventions and RN-B was working with R27's provider for different options as well. The DON became aware R27 had run out of her PRN oxycodone on 11/28/24, when she came into work the next day and had asked staff to pull pain medications from the facility's emergency kit but was told R27 could not tolerate the doses in the kit. Staff actively worked on trying to get R27's pain medication refilled as quickly as they could. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/29/25, at 8:00 a.m. the DON stated when a resident needed refill of medication after hours or holidays, the process was for staff to contact the on-call doctor as well as utilize the facility's emergency medications kit (E-kit). R27 could not utilize the medications in the facility's E-Kit because she was already receiving the maximum allowed dose of Tylenol and all the pain medications in the E-kit contained Tylenol, as well as allergies. The facility should never run out of anything, as they were a nursing home. The DON did not know why the on-call doctor was not utilized. The DON would have expected resident's pain to be managed and all resources to be utilized to ensure resident's pain was under control at all times. When interviewed on 1/29/25, at 9:53 a.m. RN-B stated she called the pharmacy to have R27's pain medication refilled and was told the pharmacy had to wait for authorization from the provider. RN-B called the physician's office a couple times regarding the need for refill. RN-B stated she supposed the facility could have contacted the medical director for the refill, but she had not thought of that at the time. R27 was not always hollering out in pain, and they had put nonpharmacological interventions in place such as lying R27 down in bed and utilizing her Tylenol and Voltaren cream. RN-B had not thought of holding the Tylenol to give R27 the oxycodone with Tylenol from the facility's E-kit. During telephone interview on 1/30/25, at 12:48 p.m. TMA-B stated staff usually gauged when R27 was having pain when R27 started hollering out and say OW. The facility had re-ordered R27's oxycodone but were waiting for the provider to sign off on the refill, so there was a time when there was no oxycodone available to give R27. R27 did seem to be having more pain during the time the medication was not available, as she was hollering out OW or would do a thing where she would just yell out ahhh, ahh. TMA-B was upset because the only thing she could give R27 on 11/29/24 was Tylenol because there was no oxycodone available. It had happened a couple of times when staff had to wait for R27's oxycodone to come in, it would not arrive from pharmacy until 5:00 p.m. and so at times would have to wait from the beginning of her shift at 2:00 p.m. until the medication arrived at 5:00 p.m., and then was told to give it to R27 immediately when it came in and so she had done so. The facility's policy Pain Management and assessment dated ,d+[DATE], identified if pain relief/reduction was not achieved, staff were to report to RN as soon as possible. The RN would complete a pain assessment when next available and then report to the resident's attending physician any problems with pain control. Assessments would include at minimum: diagnosis, medical status, recognizing when a resident was experiencing pain, identification of times pain could be anticipated, identifying the cause of pain, and evaluation of existing pain. R29: R29's quarterly MDS dated [DATE], identified R29 had intact cognition. R29 received a scheduled and PRN pain medication for frequent pain that occasionally interfered with day-to-day activities. R29's pain was rated 6 on a 0 to 10 scale. Diagnoses included fibromyalgia, chronic pain syndrome, age related osteoporosis, moderate stage rheumatoid arthritis of multiple sites, and intervertebral disc degeneration, lumbar region with back pain. R29's care plan dated 11/6/24, identified R29 was at increased risk for pain with a goal R29 would verbalize adequate pain relief. Interventions included to administer pain medications as ordered, encourage adequate rest periods, observe for pain at least every shift and use of non-pharmacological pain interventions including rest, distraction, ice/warm pack, elevation, and reposition. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's Physician Order Summary Report dated 12/27/24, identified staff were to monitor and document pain level every shift and included and order for staff to apply Lidocaine external patch 5% to R29's back every morning. When interviewed on 1/29/25, at 10:44 a.m. R29 stated she hurt so badly during the night, she needed help to get to the bathroom. Her pain was all over, and thought it was related to her arthritis. Staff had given her a pain pill at bedtime and Tylenol when she awoke. Sometimes she had to ask for her Lidocaine patch to be applied. Most of the time the nurses came in when the aides were helping her to dress for breakfast and put it on first thing. A couple of days ago, she had not gotten her pain patch at the usual time. She wheeled out in the hall to visit her spouse around 10:00 a.m. and noticed RN-E in the hall visiting with another staff. R29 told RN-E she would like her pain patch and RN-E told her it was not due until 11:00 a.m. and she would have to wait as it was not time yet. So R29 did not get the patch applied until later and she usually had it when she washed up for the day. RN-E said it did not come up on the medication cart until 11:00 a.m., it was R29's patch and if it was needed, it was needed because she had pain. R29 was not sure exactly which day the late administration of the pain patch had occurred. During subsequent interview on 1/30/25, at 8:54 a.m. R29 stated when going down to visit her spouse in his room around 10:00 a.m. and saw RN-E in the hall, she asked RN-E for her pain patch and was told it did not come up on the computer until 11:00 a.m. so she would have to wait. No one had ever told R29 that before and she had always gotten the pain patch applied right away in the morning when she was getting dressed. The pain patch was for her fibromyalgia. It was her pain patch, and it was the only thing that helped her pain, other than the Tylenol. After RN-E told her she would have to wait, R29 just sat down by her spouse and talked with him and did not say anything more. R29 could not remember if her pain had worsened that day due to receiving the pain patch later than usual as she was in pain all the time. R29 stated that patch was everything, as it helped with everything. When RN-E finally came to her room and applied the patch, later in the morning, all RN-E did say was here is your patch and applied it to her lower back. R29's Treatment Administration Record (TAR) for January 2025, identified an order for Lidocaine External Patch 5%. Apply to back topically in the morning for chronic pain syndrome. RN-E had signed off administration of R29's Lidocaine patch on 1/4/25, at 10:42 a.m., and on 1/27/25, at 10:43 a.m. During interview on 1/30/25, at 10:29 a.m. TMA-A stated the nurses applied R29's Lidocaine patch in the mornings. TMA-A knew they usually did it around breakfast when R29 was getting ready for the day. The aides would walkie for someone to come down and apply it when they were in there assisting her to get dressed. The Lidocaine patch was ordered every am, so it could be applied anytime R29 asked for it in the morning. When interviewed on 1/30/25, at 2:55 p.m. the DON stated she received a complaint regarding a staff member not responding to a resident's request for pain medication. The complaint identified the pain patch was administered late and caused increase pain to the resident. The facility was in the process of investigating the incident. The DON had conducted a number of interviews and felt the way the nurse interacted with residents may be perceived a little blunt or off-putting at times. The DON had discussed R29's preferences for the time patch and planned to adjust the medication administration time to be more specific. RN-E had been sent home until the investigation was completed. The plan was to have RN-E return to work after receiving education. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Medication Administration Times dated 5/2017, identified AM medications were to be given between 6:00 a.m. and 10:00 a.m. The facility policy Pain Management and Assessment date 5/2015, identified it was the facility's policy residents remain comfortable and as free from pain as possible. Residents would be monitored for pain on an ongoing basis per regularly scheduled pain assessments, daily observation, administration of analgesic as ordered and follow-up monitoring of medication effectiveness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure a medication allergy was clarified prior to administering medication and failed to ensure as needed (PRN) medication was administered under the recommended daily dose for 1 of 1 resident (R27) reviewed for pain. Findings include: R27's significant change Minimum Data Set (MDS) dated [DATE], identified R27 had severely impaired cognition. R27 received both scheduled and as needed pain medications. R27 had daily non verbal sounds and facial expressions of pain. R27's Physician Order Summary report dated 1/29/25, identified R27 was ordered acetaminophen 1000 milligrams (mg) three times a day with start date of 1/25/24, as well as acetaminophen 650 mg every four hours as needed with start date 10/31/21. Oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. R27's November Medication Administration Record (MAR) 2024, identified acetaminophen 1000 mg was administered three time on 11/29/24, along with administering 650mg of Tylenol for break through pain. The PRN oxycodone had been administered on 11/28/24, at 2:58 a.m. and was next administered 11/29/24, at 7:53 p.m. R27's MAR for September 2024 through December 2024 identified allergies on each MAR and included an allergy to oxycodone. The MAR's identified the following: - September 2024, PRN oxycodone was administered to R27 five times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - October 2024, PRN oxycodone was administered to R27 20 times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - November 2024, R27 PRN oxycodone was administered to R27 20 times during the month of November, despite oxycodone was listed as an allergy in R27's medical record. - December 2024, PRN oxycodone was administered 45 times during the month of December, despite oxycodone was listed as an allergy in R27's medical record. R27's Consultant Pharmacy Monthly Reviews were reviewed from January 2024 through December 2024 and identified the consultant pharmacist reviewed R27's medical record every month; however, failed to identify there was a discrepancy regarding the oxycodone order dated 2/9/2024 and the listed allergy. R27's medical record lacked documentation the potential drug interaction had been identified and brought to the providers or nurses' attention to be addressed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's medical record lacked any evidence R27 experienced and allergic reaction from receiving the oxycodone.' During subsequent interview on 1/29/25, at 8:00 a.m. the director of nursing (DON) stated she noticed R27 was administered her scheduled 3000 mg and then had also received PRN Tylenol 650 mg two times on 11/29/24. The DON stated the acceptable dose for the elderly would be the 3000 mg of Tylenol in a day and the Tylenol R27 had received on 11/29/24, would have exceeded that threshold. During telephone interview on 1/29/25, at 11:00 a.m. consultant pharmacist (CP)-H stated she had not completed R27's monthly medication reviews, as they had been completed by a recent retired pharmacist. CP-H would review the record and answer what questions she was able. CP-H stated it was common practice to review a residents allergy list when reviewing their medications monthly. If a medication had been given that was listed as an allergy, the pharmacist would typically look back in the notes to see if any adverse reaction had occurred. If no reaction occurred would wonder they would question if was a true allergy was or not. They would talk with the nurses and possibly make a recommendation to remove the medication from the allergy list or consider a different pain medication. The medication would not always be removed from the allergy list, as would want to keep an eye on the administration of the medication, because of a possible adverse reaction to the medication in the past. CP-H reviewed R27's record and could tell through the filling pharmacy's records that R27 did not have a true allergy but rather some adverse reactions and it was ok to fill the medication. CP-H was unable to identify if the previous pharmacist had identified this as there was no notes identifying the potential allergy was reviewed. Further, R27 was receiving the medication without any documented problems, and it would just be alert to keep in mind R27 had had a problem with oxycodone in the past and not a true allergy. During telephone interview on 1/29/25, at 2:49 p.m. CP-H stated she was unable to find documentation the reviewing CP had identified the discrepancy of the ordered medication with R27's allergy list. When interviewed on 1/29/25, at 3:10 p.m. the DON stated she reviewed R27's clinic medical record and was able to find R27's provider had over-ridden the allergy alert when he first ordered the oxycodone, so the provider was aware of the listed allergy. The information was just found when she searched R27's clinic record now and there was no evidence the allergy had been questioned by the facility staff or discussed with the provider when it was ordered. The DON would have expected the consultant pharmacist to have identified the irregularity and to have completed an irregularity report for the provider to review and clarify. During telephone interview on 1/30/25, at 12:48 p.m. trained medication assistant (TMA)-B stated they administered the PRN Tylenol on 11/29/24. TMA-B was not aware R27 was over the maximum limit of 4000 mg. Normally TMA-B usually just gave R27 her scheduled Tylenol but had been told by the nurse on 11/29/24 to give R27 her PRN Tylenol as well because she was having increased pain and her PRN oxycodone was awaiting a provider refill prescription. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Drugs.Com manufacturers guidance dated 6/10/24, identified acetaminophen can cause acute liver failure, sometimes resulting in liver transplantation and death, can occur. Liver injury usually is associated with doses that exceed the maximum recommended daily dosage and often involves use of more than one acetaminophen-containing preparation. In adults the current limit is 4 g daily (4000mg). Some experts recommend a maximum dosage of 3 g (3000mg) daily when used for long-term therapy (e.g., =2 weeks). FDA is evaluating whether data exist to support establishing a lower (i.e., <4 g daily) maximum daily dosage for certain patients (e.g., those who chronically ingest alcohol). Some manufacturers (e.g., [NAME], Tylenol) voluntarily revised their labeling and currently recommend a maximum dosage of 3 g (3000mg) daily.

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	245592	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Nursing Home	123 Baken Street Thief River Falls, MN 56701

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the consulting pharmacist failed to identify and report irregularities related to resident allergies for a prescribed medication for 1 of 1 resident (R27) reviewed for pain. Findings include: R27's significant change Minimum Data Set (MDS) dated [DATE], identified R27 had severely impaired cognition. R27 received both scheduled and as needed pain medications. R27 had daily nonverbal sounds and facial expressions of pain. R27's Physician Order Summary report dated 1/29/25, identified an order for oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. R27's Medication Administration Record (MAR) for September 2024 through December 2024 identified allergies on each MAR and included an allergy to oxycodone. The MAR's identified the following: - September 2024, PRN oxycodone was administered to R27 five times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - October 2024, PRN oxycodone was administered to R27 20 times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - November 2024, R27 PRN oxycodone was administered to R27 20 times during the month of November, despite oxycodone was listed as an allergy in R27's medical record. - December 2024, PRN oxycodone was administered 45 times during the month of December, despite oxycodone was listed as an allergy in R27's medical record. R27's Consultant Pharmacy Monthly Reviews were reviewed from January 2024 through December 2024 and identified the consultant pharmacist reviewed R27's medical record every month; however, failed to identify there was a discrepancy regarding the oxycodone order dated 2/9/2024 and the listed allergy. R27's medical record lacked documentation the potential drug interaction had been identified and brought to the providers or nurses' attention to be addressed. R27's medical record lacked any evidence R27 experienced and allergic reaction from receiving the oxycodone. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on 1/29/25, at 11:00 a.m. consultant pharmacist (CP)-H stated she had not completed R27's monthly medication reviews, as they had been completed by a recent retired pharmacist. CP-H would review the record and answer what questions she was able. CP-H stated it was common practice to review a residents allergy list when reviewing their medications monthly. If a medication had been given that was listed as an allergy, the pharmacist would typically look back in the notes to see if any adverse reaction had occurred. If no reaction occurred would wonder they would question if was a true allergy or not. They would talk with the nurses and possibly make a recommendation to remove the medication from the allergy list or consider a different pain medication. The medication would not always be removed from the allergy list, as would want to keep an eye on the administration of the medication, because of a possible adverse reaction to the medication in the past. CP-H reviewed R27's record and could tell through the filling pharmacy's records that R27 did not have a true allergy but rather some adverse reactions and it was ok to fill the medication. CP-H was unable to identify if the previous pharmacist had identified this as there was no notes identifying the potential allergy was reviewed. Further, R27 was receiving the medication without any documented problems, and it would just be alert to keep in mind R27 had had a problem with oxycodone in the past and not a true allergy. During telephone interview on 1/29/25, at 2:49 p.m. CP-H stated she was unable to find documentation the reviewing CP had identified the discrepancy of the ordered medication with R27's allergy list. When interviewed on 1/29/25, at 3:10 p.m. the DON stated she reviewed R27's clinic medical record and was able to find R27's provider had over-ridden the allergy alert when he first ordered the oxycodone, so the provider was aware of the listed allergy. The information was just found when she searched R27's clinic record now and there was no evidence the allergy had been questioned by the facility staff or discussed with the provider when it was ordered. The DON would have expected the consultant pharmacist to have identified the irregularity and to have completed an irregularity report for the provider to review and clarify. The facility's policy Medication Regimen Review (monthly report) dated 8/2017, identified the consultant pharmacist would complete a comprehensive medication regimen review (MMR) at least monthly. The MMR included evaluating the resident's response to medication therapy to determine the resident maintained the highest practicable level of function and to prevent or minimize adverse consequences related to medication therapy. Findings and recommendations would be reported to the DON for follow up with the attending physician.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40943 Based on interview and document review, the facility failed to ensure licensed nursing staff hours were submitted accurately on the payroll-based journal. This had the potential to affect all 32 residents residing in the facility. Findings include: The PBJ (payroll-based journal) Staffing Report CASPER Report 1705D FY [fiscal year] Quarter 4 2024 (July 1 - September 30) identified the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following days: 7/23/24, 7/24/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, 7/29/24, 7/30/24, 7/31/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24. The facility payroll and working scheduled were reviewed for 7/1/24 through 9/30/24 and there was a licensed nursing staff 24 hours/day consecutively on all 36 days identified on the PBJ report. During an interview on 1/29/25 at 8:49 a.m., registered nurse (RN)-B stated during quarter 4 2024, she was a salaried employee, and she did not use the timeclock even though she worked charge nurse shifts during that time. During an interview on 1/29/25 at 9:34 a.m., registered nurse (RN)-D, who was the corporate nurse, stated the administrator was responsible for submitting the PBJ for the facility, but the administrator was unavailable due to a family emergency. RN-D stated she was aware the administrator was having difficulty submitting the PBJ data and had to hand enter the information. The facility always had licensed staff in the building 24 hours/day, however, salaried employees were not using the timeclock system. A policy/procedure regarding PBJ data submission was requested but not provided.

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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** 40943 Based on interview, and document review, the facility failed to develop, monitor, and evaluate their identified performance measures. This had the potential to affect all 46 residents residing in the facility. Findings include: The Facility assessment dated ,d+[DATE], identified the facility was a Medicare and Medicaid certified skilled nursing facility. The facility was licensed for 35 beds with an average daily census in the past year of around 34. The facility provided skilled nursing, unskilled nursing, short- and long-term care. Additional services offered are care for those with dementia or other cognitive deficits, end-of-life care, behavioral health, spiritual care, nutritional services, housekeeping, laundry, wound care, ostomy care, dialysis coordination, care of chronic and acute illnesses, oxygen therapy, physical/occupational/speech therapies, restorative and functional maintenance programs, care coordination with physicians, clinics and specialists. Facility Assessment and QAPI Information from the Facility Assessment was used to inform the Quality Assurance Performance Improvement (QAPI) process as indicated in the QAPI Plan. Improvement projects would focus on high-risk or problem-prone areas that the facility had identified through data collection of various sources as indicated in the facility policy and procedure for Quality Assurance and Performance Improvement. The description of care, services, and resources available at the facility provided both areas for monitoring processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance. The facility held QAPI meetings on a scheduled quarterly basis and more often, if indicated. The QAPI team consisted of representatives from each department along with open invitations to residents and direct care staff. The QAPI process was conducted according to industry standards. The Plan, Do, Study, Act process was used to review and implement and review effectiveness of improvement projects. The Quality and Safety Meeting dated 4/17/24, identified the following: Performance Improvement Projects: Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program - have increased walking for those who tolerate. Currently have ten, last quarter were eight participating. Four walking to all three meals, four walking to at least two meals, and two walking once daily - Restorative program - continuing to work towards getting up and going. Infection Control: focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Ensuring EBP rooms are fully stocked and staff knowledge - Training in new IP nurse The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting dated 7/18/24, identified the following: Performance Improvement Projects: Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program have increased walking for those who tolerate. Currently we have 8, last quarter was 1 participating. 4 walking to all three meals, 2 walking to at least two meals, and 2 walking once daily. - Restorative program - continuing to work towards getting up and going. A full-time therapy aide hired, starting July 22nd, will support restorative programs. Infection Control: focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP have been completed. - Continuing to ensure EBP rooms are fully stocked and staff knowledge. - Ongoing training in new IP nurse. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting dated 10/16/24, identified the following: Performance Improvement Projects Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program -have increased walking for those who tolerate. Currently we have 8 participating. 4 walking to all three meals, 2 walking to at least two meals, and 2 walking once daily. - Restorative program -continuing to work towards getting up and going. Infection Control: Focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP have been completed. - Continuing to ensure EBP rooms are fully stocked and staff knowledge. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Ongoing training in new IP nurse. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The facility QAPI Meeting Minutes dated 1/15/25, identified the following: Performance Improvement Projects - Fall Reduction: Root cause analysis, interventions, and education ongoing. - Walk to dine program expanded. - Restoration program implemented. - Infection Control: Focus on rates, precautions, and audits. - QIPP Project - Nutrition: Snack survey completed, monthly dietician meetings. - Dining room: Audits conducted; access improved. - Weight loss/nutrition: Reports reviewed; bi-monthly weights implemented. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. During an interview on 1/30/25 at 2:13 p.m., with the director of nursing (DON) and registered nurse (RN)-D, RN-D stated the administrator was unavailable for interview. RN-D stated the minutes did identify actions aimed at performance improvement, however, did not identify a measurement of success, and track performance to ensure that improvements were realized and sustained. The facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 6/2018, identified the objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents. 1. The facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: 3. Tracking and measure performance; 4. Establishing goals and thresholds for performance measurement; 5. Identifying and prioritizing quality deficiencies; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Systematically analyzing underlying causes of systemic quality deficiencies; 7. Developing and implementing corrective action or performance improvement activities; and 8. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. 9. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements 10. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 11. The Quality Assessment and Assurance Committee consists at a minimum of: a. The Director of Nursing; b. The Medical Director or his/her designee; c At least three other members of the facility's staff, at least one of who must be the Administrator, owner, a board member or other individual in a leadership role; and d. The infection Preventionist - effective November 28, 2019. 6. The QAPI plan describes the methods to validate and update staff competencies at the time of hire and periodically. 7. The QAPI plan ensures that residents provide input to prioritize the areas to monitor and measure that reflect the resident's preferences, ethnic, cultural, and religious considerations. 8. Contract staff will contribute data and information and collaborate within the QAPI program. 9. QAA meetings will be held at least quarterly and with enough frequency to conduct required QAPI/QAA activities. 10. All facility staff, contracted staff, and volunteers will be educated about the QAPI plan and their role in development and implementation of interventions. 11. A plan will be in place to ensure that agency staff are educated on the facility QAPI plan. 12. The QAPI plan will be reviewed annually and with any significant change at the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40943 Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee held meetings with the required members on a, at minimum, quarterly basis. This had potential to affect all 32 residents residing in the facility at the time of the survey. Findings include: The Quality and Safety Meeting minutes dated 7/18/24, failed to identify the medical director was in attendance or had been provided the information for review and provide opportunity for feedback. The Quality and Safety Meeting dated 10/16/24, identified the director or nursing, consultant pharmacist and medical director were not in attendance or had been provided the information for review provide opportunity for feedback. During an interview on 1/30/25 at 2:13 p.m., with the director of nursing (DON) and registered nurse (RN)-D, RN-D stated the administrator was unavailable for interview. RN-D stated the information in the meeting minutes identified the required members did not attend; however, believed they were available by phone at any time needed. The facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 6/2018, identified the objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high-volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents. 1. The facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: 3. Tracking and measure performance. 4. Establishing goals and thresholds for performance measurement. 5. Identifying and prioritizing quality deficiencies. 6. Systematically analyzing underlying causes of systemic quality deficiencies. 7. Developing and implementing corrective action or performance improvement activities; and 8. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements 10 . The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 11. The Quality Assessment and Assurance Committee consists at a minimum of: a. The Director of Nursing. b. The Medical Director or his/her designee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R14, R15) with wound care and failed to ensure personal protective equipment was used during the sorting of soiled laundry. Findings include: EBP: R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had a severe cognitive impairment and diagnoses included dementia, anorexia, and chronic kidney disease. R14 was at risk for pressure ulcers but had no current pressure ulcers. R14's care plan revised 1/13/25, failed to identify R14's right great toe wound and/or the need for enhanced barrier precautions (EBP) to prevent infection. During an observation on 1/29/25 at 1:57 p.m., NA-A assisted with personal hygiene and pivot transfer from R14's bed to wheelchair. NA-A did wear gloves but failed to wear a gown during high contact activities. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. During an observation on 1/29/25 at 3:16 p.m., nursing assistant (NA)-B assisted R14 to pivot transfer from R14's wheelchair to bed. NA-B did not don a gown or gloves. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. During an observation on 1/29/25 at 4:22 p.m., registered nurse (RN)-B changed R14's dressing. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. RN-B wore gloves but did not put on a gown. R14 had two open areas at the base of her right great toenail. The measurements for the first area were 0.5 cm x 0.4 cm and the second measured 0.3 cm x 0.1 cm. The areas were dry and scabbed. During an interview on 1/29/25 at 4:40 p.m., RN-B stated R14 should have been placed in enhanced barrier precautions (EBP) on 1/7/25 due to a chronic wound and was not. R15 R15's significant change Minimum Data Set (MDS) dated [DATE], identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 was at risk for pressure ulcers and R15 had a burn. R15's care plan revised 12/3/24, identified enhanced barrier precautions for R15 due to R15 was at risk for infection due to right hip wound. Staff were directed to use hand hygiene, gown and glove during care with expected exposure to blood, bodily fluids, skin breakdown, or mucus membranes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 1/28/25 at 9:24 a.m., trained medication aide (TMA)-A assisted R15 to transfer from R15's wheelchair to R15's recliner using a full standing lift. TMA-A did not apply gown or gloves during the transfer. An EBP sign was hanging on the outside of the bathroom door with a plastic 3 tier bin inside R15's bathroom containing disposable gowns and gloves. During an interview on 1/29/25 at 9:13 a.m., TMA-A stated she did not wear a gown or gloves during R15's transfer because that was only if staff were doing cares, like toileting, or dressing changes. During an interview on 1/30/25 at 10:43 a.m., the director of nursing (DON) stated staff were expected to follow the facility's EBP policy to prevent infection. The facility policy Infection Prevention and Control Program revised 1/20/25, identified standard and transmission-based precautions were to be followed to prevent the spread of infections. However, the policy failed to identify EBP and/or when EBP would be used. Laundry During a tour of the laundry department on 1/29/25 at 8:28 a.m., a black fabric apron hung from a hook on the wall in the soiled laundry room. A 6-drawer plastic bin was on the floor underneath the hook, but no other aprons and/or disposable gowns were available. Laundry aide (LA)-A stated the staff wore the same black fabric apron throughout the day to sort soiled laundry because they only had the one because the ties broke on the other one. Each time soiled items needed to be sorted, the laundry staff would put the apron on and hang it back up on the hook when the sorting was done. The apron would be washed at the end of the day. LA-A stated there used to be a box of disposable gowns, however, those disappeared. LA-A stated it was yucky to put the apron on because you could see skin cells and stuff on the apron as the day went on and LA-A could see why the facility wanted laundry staff to wear an apron to protect their clothing. During an interview on 1/29/25 at 11:13 a.m., RN-D stated laundry staff were expected to wear a long sleeve, impermeable gown while sorting soiled laundry to prevent the contamination of their uniforms as well as preventing the contamination of clean laundry during folding. Staff should always wear a gown and gloves and, if a chance of splashing, a face mask/shield and eye protection. A facility policy regarding infection prevention and control during soiled laundry sorting was requested but not received.