STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	501 Oak Street Chaska, MN 55318

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation and interview, the facility failed to ensure privacy was maintained for 1 of 2 residents (R146) reviewed for dignity. Findings include: R146's face sheet undated, indicated R146 admitted [DATE] and had diagnoses of nondisplaced intertrochanteric fracture of right femur, unspecified fall, weakness, essential tremor, and depression. R146's baseline care plan observation dated 5/28/24, identified R146 was oriented to person and time and had forgetfulness and intermittent confusion. R146 required assistance of one with bed mobility, toileting, dressing, and grooming/hygiene. R146 transferred with a standing mechanical device with assistance of two and did not walk. R146 had a history of falls with fracture prior to admission and was incontinent of bladder and bowel. R146's paper baseline care plan dated 5/28/24, identified R146 had a foley catheter and occasional, accidental incontinence. During observation on 5/30/24 at 8:59 a.m., nursing assistant (NA)-B uncovered R146, stated R146 had a catheter, and walked out of the room to place on personal protective equipment (PPE). NA-B left R146's personal and shared room door opened, and R146 was seen from the hallway with a shirt, incontinent product, wound dressing on right thigh, and gripper socks. R146 resided on a transitional care unit in which residents were assisted to and from their rooms for meals and therapy. R146 stated they were bare naked and did not like that. During interview on 5/30/24 at 9:25 a.m., NA-B stated they ensured residents' privacy by shutting room doors and keeping residents covered as much as possible throughout cares. NA-B stated some residents were more conservative than others, and they cared for residents based on their preferences to ensure residents were comfortable. NA-B learned about residents and what cares and assistance they required from the care plans and other information on OneNote. NA-B was surprised and stated they should have shut R146's door when they placed on PPE outside the room. During interview on 5/31/24 at 11:03 a.m., NA-G stated they ensured residents' privacy and dignity by closing doors and curtains, giving residents time to complete tasks themselves and assisting with tasks residents needed such as shaving, showering, changing incontinent products. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/31/24 at 11:47 a.m., registered nurse (RN)-A stated they provided residents privacy by knocking on residents' door prior to entering, not giving medication during activities or dining without asking the resident first, and assisting lab to find private space to draw blood. During interview on 5/31/24 at 1:50 p.m., RN-B stated staff closed doors or pulled curtains shut to provide privacy for residents during cares. Staff were not to leave residents uncovered with the door open. During interview on 5/31/24 at 5:12 p.m., the director of nursing (DON) expected staff to keep residents covered or have the door closed when residents exposed. DON stated having a resident uncovered with the door open was a dignity issue and did not respect resident's modesty. The facility policy Resident Rights dated 11/16, directed staff to protect and promote the rights of each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure residents were free from accident hazards for 1 of 1 residents (R13) who used a remote-controlled recliner. In addition the faility failed to comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of falls for 2 of 4 residents (R13, R99) reviewed for falls. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated mild cognitive impairment with no exhibited verbal or physical behaviors, no rejection of care, and no hallucinations or delusions. The MDS also indicated R13 had hemiplegia and hemiparesis (one-sided weakness and immobility) due to a stroke, depression, high blood pressure, and restless leg syndrome. R13's Care Area Assessment (CAA) dated 8/4/23, for functional status indicated he had right-sided weakness from a stroke with decrease range of motion to the affected side. The CAA indicated R13 had reached his baseline and declined restorative programs historically. R13's CAA for falls dated 8/4/23, indicated he had a non-skid pad in his recliner. The CAA reported R13 was dependent on staff assistance for total lift transfer as he was unable to bear weight or stand on his own. A fall risk assessment dated [DATE] indicated R13 was a risk for falls related to his impaired mobility, dementia, weakness and immobility from a stroke, incontinence, and obesity. The assessment indicated R13 had frequent confusion related to his dementia. The assessment identified additional risk factors including his dependence on staff for total lift transfer, medication regimen, toileting hygiene assistance requirement, and reported episodes of dizziness upon standing. The assessment identified an intervention to continue with non-skid on top of soaker pad in recliner. R13's physician orders identified in the fall assessment included the following: - lorazepam (Ativan) 0.25 milligrams (mg) tablet, Give 0.25mg oral three times a day for anxiety, dated 12/16/23. - bupropion hydrochloride (HCl) (Wellbutrin) 100mg tablet, Give 100mg oral three times a day for depression, dated 6/15/23. - lisinopril 20mg tablet, Give 20mg oral once daily in the morning for high blood pressure. - mirtazapine (Remeron) 30mg tablet, Give 30mg oral at bedtime daily for anxiety, dated 6/6/23. - sennosides-docusate sodium (Senna-S) 8.6-50mg tablet, Give 1 tablet as needed for constipation, dated 6/6/23. - sertraline (Zoloft) 100mg tablet; Give 150mg once in the morning for anxiety, dated 6/15/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's care plan last updated 11/3/23, identified he was at risk for falls related to his weakness, poor balance, obesity, history of stroke, swelling, vitamin D and other vitamin deficiencies, and history of falls. The care plan identified interventions of a non-skid mat on top of his recliner, use of a mechanical lift and assist of two staff for transfers, and use of a wheelchair and assist of one staff for locomotion. R13's care plan identified his impaired mobility related to his right-side hemiplegia and hemiparesis from the stroke, obesity, and history of falling. R13's care plan lacked documentation of assessment of his safety with a remote-controlled recliner. An event report for an unwitnessed fall dated 2/11/24, indicated R13 was found by staff laying on the floor in front his recliner in his room. The recliner was found in the max raised position. The event report indicated R13 was alert and conscious with no observed injury. The event report indicated R13 was checked on 30 min prior, call light in reach, remote control for recliner in reach. Was reclined and denied needs/complaints at that time. A fall scene investigation report dated 2/11/24, indicated staff commented it appeared R13 raise the recliner to a vertical position using the remote and slid off onto the floor. The interdisciplinary team (IDT) reviewed the incident and wrote on the report encourage/recommend store remote in pocket of chair. The nursing assistant (NA) care sheet indicated under the Safety/Position header for R13, encourage and recommend to store remote to chair in pocket of chair. A review of R13's electronic health record (EHR) lacked documentation of assessment for his safety to use a remote-controlled recliner, or documentation of discussion of risk versus benefits of having remote-controlled recliner and safety risks involved. During interview on 5/30/24 at 7:46 a.m., R13 was unable to recall being assessed for his safety using the remote-controlled recliner. During interview on 5/31/24 at 9:43 a.m., NA-D stated fall interventions could be found in a resident's care plan and was unsure of what specific fall interventions R13 had in place. NA-D stated R13 did not attempt to self-transfer and was not aware of recent falls for him. During interview on 5/31/24 at 9:53 a.m., licensed practical nurse (LPN)-A stated fall interventions were listed on a resident's care plan and care sheets for NAs. LPN-A stated R13 was off and on for his risk for falls due to his restlessness. LPN-A identified keeping his door open as one way to keep a better eye on R13. LPN-A was not able to identify any specific interventions for R13. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/31/24 at 3:07 p.m., registered nurse (RN)-B verbalized being aware of R13's fall from the recliner on 2/11/24. RN-B was unaware of any formal safety assessment for a remote-controlled recliner but stated if an issue was identified, the family and resident might be interviewed to determine their understanding of the issue. RN-B stated if the resident was safe and understood the recliner and the remote control, it may have been care planned and then the remote control should stay in the pocket of the recliner. RN-B stated if safety was a concern and the resident and family still wanted the recliner despite of the safety issues, they would still have that choice and education could be provided on the risks. RN-B stated that would be documented in a progress note. RN-B was unable to locate documentation of safety assessment of R13 and his remote-controlled recliner or documentation of a risk versus benefits conversation. During interview on 5/13/24 at 4:28 p.m., the director of nursing (DON) stated if a resident has a fall, staff were expected to implement immediate interventions to provide for that resident's safety as needed. Falls were discussed during IDT meetings to determine root cause analysis and if further interventions are needed. The DON stated fall interventions are updated on the NA care sheets and on the resident's care plan once they are developed. A safety assessment for R13 and the remote-controlled recliner was requested but not received. A request for a resident risk assessment related to resident equipment was requested but not received. A facility policy titled Accident: Managing Resident Falls policy dated, 8/15/18, included evaluation and analyzing hazards and risks for potential resident falls will occur upon admission, quarterly, annually and as needed. The nursing staff in conjunction with the IDT, resident, and/or resident representative will implement the residents plan of care with interventions to reduce the risk of falls if appropriate. 44651 R99's admission Minimum Data Set (MDS) record had not been completed. R99's Clinical Admission Documentation dated 5/22/24, included R99 was alert and oriented, took antidepressant medications (which can cause dizziness and drowsiness), required supervision for bed mobility and assist of one staff with transfers and toileting, and indicated R99 did not have a history of falls in the past 6 months. The documentation included R99 had a stroke two months before admission and a diagnosis of weakness. R99's PT (physical therapy) Evaluation and Plan of Treatment dated 5/22/24, included R99 was on fall precautions, and had unknown falls win the past year. R99's baseline care plan dated 5/22/24, included R99 did not have a history of falls, however lacked interventions related to PT evaluation determination of fall risk. R99's medical record lacked documentation of R99's nursing fall risk assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 5/26/24, indicate R99 had an unwitnessed fall with head strike and was found on the floor in their room next to the bed after trying to self-transfer from the wheelchair to the bed. R99's Event Report dated 5/26/24, indicated R99 was lifted from the floor using a mechanical lift and assessed for injury. The form included a section labeled INTERVENTIONS - Immediate measures taken which lacked documentation. Further, the section labeled Outcome of interventions was documented as No Interventions Used. R99's Fall Scene Investigation Form dated 5/26/24, outlined the details and some potential contributing factors of the fall, and indicated the care plan was reviewed, however no interventions were added to the care plan. During interview on 5/28/24 at 3:10 p.m., R99 stated they fell two days ago because they tried to self-transfer from the bed to go to the bathroom. R99's family member (FM)-A stated R99 sometimes had poor judgement and decision-making and lacked impulse control, and they weren't sure what kind of interventions the facility put in place to help prevent it from happening again. During interview on 5/31/24 at 10:12 a.m., nursing assistant (NA)-A stated they knew who was at risk for falls by reviewing the care plan, or if therapy informed them. They indicated R99 felt he could do everything and had a fall over the weekend but was not aware of any resident-specific interventions to reduce risk of falls. During interview on 5/31/24 at 10:51 a.m., registered nurse (RN)-A stated clinical coordinators assessed for fall risk at admission and reviewed medications and other risk factors, and then briefed the nursing staff on the results. If a resident fell the nurse assessed the resident for pain, started a fall form, and handed the fall form to the clinical coordinators to review, identify, and document any interventions in the record. During interview on 5/31/24 at 11:06 a.m., registered nurse (RN)-B/clinical coordinator stated they completed the baseline care plan on the day of admission and determined fall risk at that time by asking the resident or the family about their fall history. The official fall risk assessment was completed within seven or eight days after admission with the MDS timing requirements. If a resident fell staff completed a fall form and the interdisciplinary team (IDT) would discuss the fall and the need for any interventions at their next meeting, however immediate interventions were not generally implemented beyond an initial resident condition assessment. Upon review of R99's medial record, RN-B confirmed the facility did not have any initial or additional fall interventions care planned for R99, however it was important to do what they could to decrease risk of falls and injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/31/24 at 12:05 p.m., director of nursing (DON) stated the initial falls risk assessment was completed within the first week to 10 days after admission, based on MDS guidelines, otherwise they relied on the therapy evaluation to determine risk. Staff implemented immediate interventions after a fall if the care plan had not been followed or if something needed to be corrected, and if the care plan was not followed staff should report it to the on-call nurse. The staff nurses completed a fall event form and submitted it to the nurse manager, and it would be reviewed at the next IDT meeting which met three days per week. The IDT team would determine what, if any, interventions would be implemented to prevent future falls, and/or, prevent injury. If there was an issue needing immediate correction, such as a maintenance concern or wet floor, it should be dealt with immediately, otherwise, typically, interventions were added when the IDT team met. Upon review of R99's record, DON confirmed they did not see any fall interventions after the PT evaluation on 5/22/24, or any additional interventions after the fall on 5/26/24. The Accident: Managing Resident Falls policy dated 8/15/18, included evaluation and analyzing hazards and risks for potential resident falls will occur upon admission, quarterly, annually and as needed. The nursing staff in conjunction with the IDT, resident, and/or resident representative will implement the residents plan of care with interventions to reduce the risk of falls if appropriate.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to comprehensively assess, discuss risks and benefits, obtain informed consent, and attempt alternatives prior to installation of grab bars for 2 of 2 residents (R96, R146) reviewed who were observed to have grab bars affixed to their beds. Findings include: R96's admission Minimum Data Set (MDS) dated [DATE], indicated they were severely cognitively impaired, required partial/moderate assistance with bed mobility and transfers, and had diagnoses of fractures, heart failure, and anxiety. The MDS indicated R96 did not use a bed rail. R96's admission Observation Detail Report dated 5/7/24, included R96 required extensive assistance of one staff for transfers, was occasionally incontinent of bladder and bowel, had a fall in the previous 31-180 days, and did not use bed rails. R96's progress note dated 5/7/24, indicated staff completed admission paperwork with R96's family member and power of attorney, however, the note lacked evidence of discussion of bed rail risks, benefits, and consent. R96's Physical Therapy PT Evaluation and Plan of Treatment dated 5/8/24, included R96 was able to safely use bilateral mobility bars on bed to allow greater bed mobility, however, the document lacked comprehensive nursing assessment. R96's care plan dated 5/8/24, included R96 was at risk for falls and had bilateral grab bars on the bed to aid in turning, repositioning, and bed mobility per physical therapy recommendation. R96's Admission Fall Risk Screen dated 5/14/24, indicated R96 was at risk for falls and fell on [DATE], and had another fall the month prior. R96's progress note dated 5/14/24 at 11:17 p.m., indicated R96 was found on the floor with bleeding from one side of their head and sent to the hospital for evaluation. R96's Orders printed 5/30/24, included OK to use bilateral mobility bars on bed for turning, repositioning, and bed mobility starting 5/24/24. R96's medical record lacked evidence of comprehensive nursing assessment, discussion of risks/benefits, alternatives, and consent for bedrails prior to installation. During observation on 5/28/24 at 4:32 p.m., R96 was seated in their wheelchair in their room and had a large bruise on the right side of their cheek and forehead. Grab bars were affixed to both side of R96's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 5/31/24 at 10:00 a.m., R96's bed had grab bars affixed to both side of the bed as before. During interview on 5/31/24 at 10:12 a.m., nursing assistant (NA)-A stated R96 was confused and unable to use the bed rails to turn themselves, however, could use them to steady themselves during cares. During interview on 5/31/24 at 10:51 a.m., registered nurse (RN)-A stated the clinical coordinators assessed residents along with therapy to determine if the application of bedrails was appropriate. The grab bars were then added to the resident care plan. During interview on 5/31/24 at 11:06 a.m., RN-B / clinical coordinator stated they reviewed the residents record upon admission to see if the resident could benefit from grab bars and maintenance applied them. They completed the grab bar observation assessment documentation including risk and benefits, alternatives, and informed consent approximately one week later when the MDS assessments were due and then get an order for the grab bars from the provider. Upon review of R96's medical record RN-B stated they were unable to find the safety observation documentation, evidence of risk/benefit education, alternatives, and consent. RN-B confirmed the grab bars were placed on the bed before the required elements were completed, and it was important to complete the assessments to prevent possible injuries, including entrapment, and to ensure the family is aware of the potential risks prior to installation. During interview on 5/31/24 at 11:24 a.m., therapy department staff (TS) stated they recommended grab bars when needed, maintenance applied them, and nursing completed the assessments and paperwork. During interview on 5/31/24 at 12:05 p.m., director of nursing (DON) stated therapy will determine the need for bed rails and then staff obtained an order from the provider. Maintenance then installed the grab bars, and the resident was re-evaluated at least quarterly to ensure they were still appropriate. The nurse managers were responsible for discussing risks and benefits with the resident and/or family and obtaining consent for the grab bars and they completed the observation in the electronic record. DON confirmed the observations were often completed several days after the bars were already installed, and they relied on the therapist's recommendation to ensure safety. If nursing or the family requested them, nursing completed the observation/assessment prior to installation. DON stated they did not attempt or document any alternatives prior to use of grab bars, as they were installed to assist in maximizing independence and bed mobility and there were no alternatives. They indicated sometimes the admitting nurse talked with the resident or family and another nurse might have completed the documentation pertaining to the bed rails several days later and would not have knowledge of any discussion which may or may not have taken place at admission, however residents needed to be comprehensively assessed prior to installation to minimize likelihood of injury from the rails. The Bed Rail Use policy dated 10/27/21, included upon admission, readmission, or change of condition, residents will be screened to determine the need for special equipment or accessories (side rails, for example.) Staff will assess the resident to identify appropriate alternatives and assess for risk of entrapment, review the risks and benefits with resident and representative, obtain informed consent, and obtain a physician order, prior to installing bed rails. Staff will update the resident's care plan to reflect the use of the bedrails. 48299 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: R146's face sheet undated, indicated R146 admitted [DATE] and had diagnoses of nondisplaced intertrochanteric fracture of right femur, unspecified fall, weakness, essential tremor, and depression. R146's baseline care plan observation dated 5/28/24, identified R146 was oriented to person and time and had forgetfulness and intermittent confusion. R146 required assistance of one with bed mobility, toileting, dressing, and grooming/hygiene. R146 transferred with a standing mechanical device with assistance of two and did not walk. R146 had a history of falls with fracture prior to admission and did not use grab bars and was incontinent of bladder and bowel. R146's paper baseline care plan dated 5/28/24, identified R146 used a left and right mobility bar and had a foley catheter and occasional, accidental incontinence. R146's progress note dated 5/29/24, indicated staff reviewed R146's baseline care plan with resident; however, the note lacked evidence of discussion of bed rail risks, benefits, and consent. R146's order started 6/1/24, identified OK to use bilateral mobility bars on bed to assist with turning, repositioning and bed mobility. R146's Physical Therapy PT Evaluation and Plan of Treatment dated 5/28/24, identified an equipment during tasks assessment was added to the document 6/4/24, and R146 was able to safely utilize bilateral mobility bars on bed to allow greater independence with bed mobility; however, the document lacked comprehensive nursing assessment. During observation on 5/30/24 at 8:59 a.m., nursing assistant (NA)-B assisted R146 with changing incontinent brief and repositioning while R146 was in bed. NA-B instructed R146 to turn by using the bed rail and directed R146's hand to the bed rail. During interview on 5/31/24 at 10:51 a.m., registered nurse (RN)-A stated the clinical coordinators assessed residents along with therapy to determine if the application of bedrails was appropriate. The grab bars were then added to the resident care plan. During interview on 5/31/24 at 11:06 a.m., RN-B/clinical coordinator stated they reviewed the residents record upon admission to see if the resident could benefit from grab bars and maintenance applied them. They completed the grab bar observation assessment documentation including risk and benefits, alternatives, and informed consent approximately one week later when the MDS assessments were due and then get an order for the grab bars from the provider. RN-B stated it was important to complete the assessments to prevent possible injuries, including entrapment, and to ensure the family it aware of the potential risks prior to installation. During interview on 5/31/24 at 11:24 a.m., therapy department staff (TS) stated they recommended grab bars when needed, maintenance applied them, and nursing completed the assessments and paperwork. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/31/24 at 12:05 p.m., director of nursing (DON) stated therapy will determine the need for bed rails and then staff obtained an order from the provider. Maintenance then installed the grab bars, and the resident was re-evaluated at least quarterly to ensure they were still appropriate. The nurse managers were responsible for discussing risks and benefits with the resident and/or family and obtaining consent for the grab bars and they completed the observation in the electronic record. DON confirmed the observations were often completed several days after the bars were already installed, and they relied on the therapist's recommendation to ensure safety. If nursing or the family requested them, nursing completed the observation/assessment prior to installation. DON stated they did not attempt or document any alternatives prior to use of grab bars, as they were installed to assist in maximizing independence and bed mobility and there were no alternatives. They indicated sometimes the admitting nurse talked with the resident or family and another nurse might have completed the documentation pertaining to the bed rails several days later and would not have knowledge of any discussion which may or may not have taken place at admission, however residents needed to be comprehensively assessed prior to installation to minimize likelihood of injury from the rails. During interview on 5/31/24 at 1:12 p.m., NA-C confirmed R146 had grab bars and stated R146 did not use the bed grab bars during cares and repositioning that morning. During interview on 5/31/24 at 1:45 p.m., RN-B/clinical coordinator confirmed they did not have a nursing assessment for R146's grab bars. Therapy had given an okay for grab bars on the day of R146's admission, and R146's grab bars were noted on the paper baseline care plan. The Bed Rail Use policy dated 10/27/21, included upon admission, readmission, or change of condition, residents will be screened to determine the need for special equipment or accessories (side rails, for example.) Staff will assess the resident to identify appropriate alternatives and assess for risk of entrapment, review the risks and benefits with resident and representative, obtain informed consent, and obtain a physician order, prior to installing bed rails. Staff will update the resident's care plan to reflect the use of the bedrails.

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Auburn Manor	501 Oak Street Chaska, MN 55318

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47372 Based on interview and document review, the facility failed to implement a Quality Assurance and Performance Improvement (QAPI) plan assuring care and services were identified to maintain acceptable levels of performance and continual improvement, and failed to conduct ongoing quality assessment and assurance activities, develop, and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 50 residents which resided in the facility. Findings include: Refer to F883 During document review, the quality assurance and performance improvement (QAPI) quarterly meeting minutes for 7/26/23, 1/30/24, 4/23/24, all indicate a section titled survey results and plan of correction (POC), with an agenda item, survey between 3/27 - 3/30/23 Results: Issues with Pharmacy Review, PPSC 23/PCV13/ Influenza vaccinations, COVID Vaccine Information Sheets, Vaccination offerings and Policy and TB testing. During an interview with the direction of nursing (DON) on 5/31/24 at 2:48 p.m., she stated the facility held quarterly QAPI meetings but had not developed performance improvement projects and did not have any formal documentation relating to the correction of previously and repeated quality deficiencies. She stated since the organization was under new management, QAPI activities are on hold and waiting for further instruction from new management on processes. A facility plan titled Quality Assurance/ Assessment and Performance Improvement Plan, undated, indicated the quality assurance/ assessment and performance improvement (QAPI) program is to utilize an on-going, data driven, pro-active approach to advance the quality of life and quality of care for all residents at ABC facility.

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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** 49617 Based on observation, interview and document review the facility failed to adhere to evidence based practices and assure resident catheter bags & ports were maintained in an appropriately placement for 2 of 2 resident (R7 & R146) whos catheter bags were on the the ground. The facility failed to ensure proper personal protective equipment (PPE) & hand hygiene was used for 2 of 2 residents (R146, R198) when providing care for residents on enhanced barrier precautions (EBP) & contact precautions. Furthermore the facility failed to identify and track potential infections for 1 of 1 resident (R198) reviewed for antibiotics use. Additionally, the facility failed to develop a written policy/procedure of infection surveillance and maintain a policy, procedure or water management plan to reduce the likelihood of Legionella and other serious bacterial diseases, which had the potential to affect all 50 residents. Findings Include: ENHANCED BARRIER, CONTACT PRECAUTIONS AND HAND HYGIENE R198's admission Minimum Data Set (MDS) dated [DATE], indicated impaired cognition. R198's undated face sheet indicated he had diagnoses including history of falls, diarrhea, a stage 3 pressure ulcer (a wound that breaks down skin and underlying tissue) of the sacral (tailbone) region, unspecified stage pressure ulcer to the left buttock, muscle weakness, depression, and anxiety. The face sheet also indicated the resident admitted to the facility on [DATE]. R198's Care Area Assessments (CAA) dated 5/21/24, for activities of daily living (ADLs) and functional status indicated he had a decline in ADL status related to a history of falls prior to his recent admission to the facility and fracture to his right lower extremity. R198's CAA for urinary incontinence for indwelling catheter dated 5/21/24, indicated he had an indwelling catheter related to his inability to void and urinary retention. R198's CAA for pressure ulcer and injury dated 5/21/24, indicated he had the potential for alteration in skin integrity related to his admission diagnosis. The CAA indicated R198 was frequently incontinent of bowel required staff assistance with ADLs and toileting hygiene. The CAA identified R198 had intrinsic risk factors for pressure injury including immobility, cognitive loss, incontinence, and poor nutrition. The CAA deferred to the care plan for further consideration. R198's order summary included the following orders: - Monitor resident for loose watery stools and update provider as needed every shift, dated 5/28/24. - Rest period after breakfast and lunch, side to side positioning only every, dated 5/20/24. - stool culture for Clostridium Difficile (bacteria that can cause inflammation of the colon and severe diarrhea) special instructions: discontinue when collected, every shift, dated 6/1/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Apply barrier cream to reddened areas after each dressing change every shift, dated 5/28/24. - Wound clinic referral (sacral ulcer/left gluteal fold), dated 5/20/24. - Treat midline coccyx-right unstageable wound: 1. Wash hands with soap and water prior to changing dressing. Cleanse wound using normal saline and gauze. Pat dry with gauze and gently wipe away any loose drainage or tissue. 2. Apply skin barrier film to wound perimeter and to the site of dressing adhesive and allow to dry prior to placing dressing. 3. Cut Adaptic or similar product and apply a small amount of Medihoney gel. Place Adaptic over wound with the Medihoney gel-side down. 4. Cover wound with a silicone border foam dressing. 5. Change Monday/Wednesday/Friday and as needed, dated 5/30/24. - Treat left ischial tuberosity unstageable wound: 1. Wash hands with soap and water prior to changing dressing. Cleanse wound using normal saline and gauze. Pat dry with gauze and gently wipe away any loose drainage or tissue. 2. Apply skin barrier film to wound perimeter and to the site of dressing adhesive and allow to dry prior to placing dressing. 3. Cut Adaptic or similar product and apply a small amount of Medihoney gel. Place Adaptic over wound with the Medihoney gel-side down. 4. Cover wound with a silicone border foam dressing. 5. Change Monday/Wednesday/Friday and as needed, dated 5/30/24. - Treat left buttock stage 3 wound: 1. Wash hands with soap and water prior to changing dressing. Cleanse wound using normal saline and gauze. Pat dry with gauze and gently wipe away any loose drainage or tissue. 2. Apply skin barrier film to wound perimeter and to the site of dressing adhesive and allow to dry prior to placing dressing. 3. Santyl: Apply a nickel-thick layer of Santyl onto a piece of Adaptic and place into depth of wound with the Santyl-side down. 4. Cover each wound with a silicone border foam dressing. 5. Change Monday/Wednesday/Friday and as needed, dated 6/1/24. R198's orders lacked documentation of enhanced barrier precautions (EBP) or updated transmission-based precautions (TBP). R198's care plan dated 6/3/24, indicated he had impaired skin integrity related to three different wounds on his bottom upon his admission. The care plan identified interventions of monitoring for signs and symptoms of infection daily, treatment per nursing and provider orders, redistribution mattress in bed, wheelchair cushion, and turning and repositioning every two hours while sitting and every two hours while laying. The care plan also identified R198's self-care deficit evidenced by his inability to toilet himself and incontinence of bowel and bladder. The care plan identified R198 required staff assistance with bed mobility, toileting, and transfers. R198's care plan lacked documentation of his indwelling urinary catheter and requirement of enhanced barrier precautions. A progress note dated 5/15/24 indicated R198 was admitted on [DATE] and had, three broken areas to bottom that were present when he arrived. A progress note dated 5/20/24 indicated an indwelling catheter was inserted per orders. A progress note dated 5/28/24 at 2:40 p.m., indicated new orders were received for the antibiotic Keflex and R198's family was updated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A progress note dated 5/28/24 at 10: 46 p.m. (22:46), indicated R198 had multiple soft/mushy stools that evening. The progress note indicated orders were received to monitor for loose/watery stools and update his provider. A progress note dated 5/30/24 at 10:45 p.m. (22:45), indicated after his return from wound clinic appointment, new orders were received to discontinue the Keflex and collect a stool sample to rule out a Clostridium Difficile infection due to R198's continuous loose stools the entire afternoon visit there. The progress note indicated R198 had no stools after he returned to the facility. R198's progress notes lacked documentation of his requirement for enhanced barrier precautions or need for transmission-based precautions. During observation on 5/28/24 at 4:51 p.m., there was no signage on R198's door to indicate he was on enhanced barrier precautions. There was a chair outside of his room with a bag of disposable plastic gowns on the seat. During interview on 5/28/24 at 7:21 p.m., registered nurse (RN)-E stated enhanced barrier precautions were for residents with an opening to the body, like wounds, catheters, or fistulas. RN-E stated a resident who was on EBP should have a sign on the door telling staff what PPE to wear and when, gowns, gloves, and sanitizer available. RN-E also stated the resident's care plan would be updated as well. RN-E stated R198 would meet the criteria for EBP. RN-E verified there was no signage outside his room indicating R198 required EBP and stated, we should definitely get that set up. During observation on 5/29/24 at 2:11 p.m., there was no signage on R198's door indicating R198 was on enhanced barrier precautions. The chair outside his room had a bag of plastic gowns and a box of gloves on the seat. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During continuous observation on 5/30/24 between 8:08 a.m. and 9:06 a.m., there was no signage on R198's door indicating he required EBP. The chair outside of his room had a box of gloves and bag of plastic gowns on the seat. At 8:16 a.m., nursing assistant (NA)-E approached R198's door to answer his call light. She performed hand hygiene, donned a gown and gloves, and stated R198 was on contact precautions because of his open wound. NA-E stated staff assisting with cares would need to wear personal protective equipment (PPE) and normally there's a sign on the door that explains what PPE and when staff need to wear it. NA-E gestured to a room across the hall that had an EBP sign on the door. NA-E entered R198's room and introduced self and surveyor and began assisting R198 with morning cares. At 8:33 a.m., licensed practical nurse (LPN)-B knocked on the door and entered the room with PPE in hand and no gown or gloves on. LPN-B set gown and gloves down on the bedside, brought paper towels from the bathroom and set them down on the foot of R198's bed. LPN-B set gloves and container of liquid solution on the paper towels, sanitized hands, and donned gown and gloves. NA-E asked R198 to help turn himself onto his left side and assisted him to turn over. LPN-B gathered wound supply basin from R198's closed closet with gloved hands and moved items on the bedside table. LPN-B doffed gloves in the bathroom and washed hands at the sink before donning new gloves. LPN-B assessed R198 for pain prior to starting wound cares, then removed the sacral dressing, then removed the dressing near thigh/groin. LPN-B doffed gloves, gathered clean supplies over the clean work area, did not perform hand hygiene, and donned new gloves. LPN-B cleansed the wounds from a head-to-toe laterality with the liquid solution and gauze and continued to ask R198's pain level. LPN-B doffed gloves, did not perform hand hygiene, donned new gloves, and measured his sacral wound. Using the same gloved hands, LPN-B cut a piece of foam and packed R198's sacral wound with the cut foam piece. LPN-B continued to wear the same gloves and re-measured the wound before using a pen to write down the measurements. LPN-B put the pen down and used the same gloved hand to remove a new dressing from the package and write the date on the dressing. While writing the date on the dressing, LPN-B's same gloved left thumb touched the inner gauze of the clean dressing. LPN-B applied Medihoney gel to the gauze pad before applying the dressing over R198's sacral wound with the same gloved hands. LPN-B doffed gloves, performed hand hygiene, donned new gloves, and used the liquid solution to clean the thigh/groin wound. LPN-B measured the second wound and continued with the same gloved hands to apply the Medihoney gel to the backside of the clean dressing before applying it to the wound. LPN-B doffed gloves and performed hand hygiene after wound cares were completed and exited the room. At 8:55 a.m., RN-D knocked and entered R198's room to assist with his transfer from bed to the wheelchair. RN-D verbalized hand hygiene was completed prior to entering his room and had on gloves but no gown. RN-D asked NA-E if there was a need for further PPE and NA-E stated there was not. NA-E and RN-D used a mechanical standing lift to assist in R198's transfer out of bed. After he transferred into his wheelchair with the assistance of two staff, RN-D doffed her gloves and performed hand hygiene at the sink in the bathroom and donned new gloves to apply a lidocaine patch (a type of over-the-counter medicated pain patch) to R198's hip. RN-D doffs gloves and performs hand hygiene before exiting his room. During interview at 9:06 a.m., RN-D stated the reasoning for PPE in R198's room is for infection prevention but was unaware of any precautions. RN-D stated, I don't think he's on any precautions, he just has that wound and we wouldn't want to spread whatever might be there. During observation on 5/30/24 at 11:46 a.m., the sign on the door across the hall from R198's room NA-E gestured to read, Providers and Staff Must Also: Wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, catheter, feeding tube, tracheostomy, wound care - any skin opening requiring a dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During continuous observation on 5/31/24 between 9:09 a.m. and 9:30 a.m., there was no signage outside R198's door indicating he required transmission-based precautions. The chair outside his room had a box of gloves on the seat. Trained medication assistant (TMA)-A entered his room at 9:17 a.m. without PPE on and exited the room at 9:19 a.m. No hand washing with soap and water was observed. During interview, TMA-A stated no report was received about his appointment the previous day. TMA-A stated R198 was on precautions for his open wounds, which is why TMA-A did not wear any PPE before when entering the room because I was just in there to check on him, I didn't need any PPE. TMA-A stated when applying his lidocaine patch and working closely with him, PPE of gown and gloves would be required. TMA-A stated the precautions were in place to ensure residents are safe from outside infections and to keep staff safe from any infections. TMA-A stated staff should sanitize their hands before going into the room and make sure they perform hand hygiene after performing cares with him. TMA-A re-entered R198's room and exited the room at 9:30 a.m. without performing hand washing with soap and water, walked to the medication cart to return something to the cart, then walked to the soiled utility room to wash hands with soap and water. During interview on 5/30/24 at 12:31 p.m., LPN-B, who also served as the facility's Infection Prevention Manager (IPPM) and wound nurse, stated staff were expected to perform hand hygiene prior to entering a resident's room and should be wearing whatever appropriate PPE is required for wound care. The IPM stated staff were expected to perform hand hygiene between glove changes and staff should change gloves any time they go from dirty to clean, like if staff take a dressing off and after cleaning the wound, staff would be expected to remove gloves and perform hand hygiene before donning new gloves and applying treatments or new dressings. If staff touched something that was not part of the clean supplies, the IPPM stated staff would be expected to change gloves and perform hand hygiene. The IPM stated staff were expected to doff PPE and perform hand hygiene before exiting a resident's room. The IPPM stated R198 was on enhanced barrier precautions because of his wound and catheter and staff were expected to wear appropriate PPE for transfers or boosts in bed. The IPM stated, as soon as you touch the patient, any of those high-contact cares, you should be dressed in PPE. The IPPM stated an in-house educational in-service was provided for staff about EBP. The IPPM verified missed opportunity for hand washing during wound cares when measuring the wounds and packing his wound and applying a new dressing. During interview on 5/31/24 at 9:43 a.m., NA-D verbalized being unaware of any changes to R198's condition. During interview on 5/31/24 at 9:48 a.m., LPN-A stated they were still processing R198's orders from his wound appointment yesterday. LPN-A reviewed his hard chart for the new orders and found the order to discontinue is Keflex. LPN-A stated the clinic called to discontinue that because R198 had loose stools while at the appointment. LPN-A stated R198 was on contact precautions that required gown and gloves for his wound care and his catheter cares. LPN-A stated his precautions have not changed since his appointment. LPN-A stated hand washing should occur before and after wound care and if hands are visibly soiled, LPN-A stated hand sanitizer would be appropriate for other opportunities for hand hygiene when working with R198. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During subsequent interview on 5/31/24 at 9:59 a.m., the IPM stated R198 had an order to collect a stool sample and send that out to rule out Clostridium difficile infection and staff still needed to collect the sample to send in. The IPM stated R198 should be on enteric precautions because of this and expected staff to wear gown and gloves according to what the enteric process was. The IPM stated hand washing with soap and water was expected of staff because that is what kills the virus so you have to wash with soap and water. The IPM stated R198 was previously on EBP and expected there to be signage on the door and an isolation or supplies cart outside his room. The IPM verified contact precautions (or enteric precautions) had not been implemented in addition to EBP because I haven't gotten there, but stated the nurse managers and charge nurses were able to set up TBP. The IPM verified at R198's room that there was no signage and no isolation or PPE supplies cart outside his room. A facility policy titled Hand Hygiene Policy and Procedure dated 3/2021, indicated the facility followed current Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene recommendations. The policy indicated handwashing with soap and water was indicated when hands were visibly dirty or were visibly soiled with blood or other bodily fluids, before eating and after using a restroom, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores (e.g., B. anthracis, C. difficile outbreaks). Furthermore, the policy indicated hand hygiene with alcohol-based hand sanitizer was indicated before having direct contact with a resident, before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure, after contact with a resident's intact skin, after contact with bodily fluids or excretions, mucous membranes, non-intact skin, and wound dressings, only if hands are not visibly soiled, when moving from a contaminated body site to a clean body site during resident care, after contact with inanimate objects (including medical equipment) in the immediate vicinity of a resident, and after removing gloves. An undated facility policy titled Enhanced Barrier Precautions indicated the organization would promote decreased transmission of Centers for Disease Control (CDC)-targeted and epidemiologically important multidrug-resistant organisms (MDRO) by utilizing enhanced barrier precautions (EBP). The policy indicated EBP were used in addition to standard precautions and expanded the use of PPE to donning of gown and gloves during high-contact resident care activities. EBP were indicated for residents with any of the following: infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or wounds and/or indwelling medical devices even when a resident is known to not be infected or colonized with a MDRO. The policy indicated for residents on EBP, high-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. A facility policy titled Contact Precautions (including Enteric) dated 2/2020, indicated employee would use standard/universal precautions in addition to contact precautions for residents/clients known or suspected to have serious illnesses easily transmitted by direct resident/client contact by contact with items in the environment. The policy indicated hand washing should be completed prior to donning gloves, gloves should be worn when entering the room and while providing cares and should be changed after having contact with infective material. The policy indicated gloves should be removed before leaving the resident/client's room and hand washing performed immediately and hands should not touch potentially contaminated environment surfaces or items and should wash hands again after exiting the room. The policy indicated precaution signage for all would be placed on the resident's door/apartment and additional information would be kept in the infection control cart. The policy indicated contact precautions may be considered for Clostridium difficile and diarrhea. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 5/31/24 at 5:12 p.m., the director of nursing (DON) expected staff to wear proper PPE when in close contact with a resident who was on enhanced barrier precautions. Staff who did not wear proper PPE had potential to spread MDROs (multi-drug resistant organisms). 48299 R146's face sheet undated, indicated R146 admitted [DATE] and had diagnoses of nondisplaced intertrochanteric fracture of right femur, unspecified fall, weakness, essential tremor, constipation, and depression. R146's baseline care plan observation dated 5/28/24, identified R146 was oriented to person and time and had forgetfulness and intermittent confusion. R146 required assistance of one with bed mobility, toileting, dressing, and grooming/hygiene. R146 transferred with a standing mechanical device with assistance of two and did not walk. R146 had a history of falls with fracture prior to admission and was incontinent of bladder and bowel and did not indicate EBP. R146's paper baseline care plan dated 5/28/24, identified R146 had a foley catheter and occasional, accidental incontinence and did not indicate EBP. R146's progress note dated 5/30/24 at 10:36 p.m., identified R146's foley catheter was discontinued. During observation on 5/29/24 at 2:41 p.m., R146 had a sign which indicated R146 was on enhanced barrier precautions and directed providers and staff to wear gloves and gown during high-contact resident care activities such as transferring, providing hygiene, changing briefs, wound care (any skin opening requiring a dressing). During observation on 5/30/24 at 8:59 a.m., NA-B had gown and gloves on to assist R146 with peri-cares and placed a clean incontinent brief on R146. NA-B removed the gloves used for peri-cares and used hand sanitizer. Unidentified staff entered R146's room with gown and gloves, and NA-B and unidentified staff boosted R146 up in bed while NA-B was not wearing new gloves NA-B adjusted R146 to eat breakfast in bed, exited the room with gown on, dropped an item off at the cart with breakfast trays, and went into the utility room about halfway down the hallway. NA-B removed the gown in the utility room and washed hands. During interview on 5/30/24 at 9:25 a.m., NA-B stated staff needed to use gown and gloves when residents have catheters, open wounds, and ostomy bags to keep residents safe. NA-B stated staff did not need to wear gowns and gloves when giving residents water or medication but needed gown and gloves to assist residents with transfers, personal cares, and anytime close to residents for extended time. NA-B stated they should have had gloves on when they repositioned R146 and slipped their mind. During interview on 5/30/24 at 12:31 p.m., infection prevention manager (IPPM) expected to wear appropriate PPE for transfers or boosts in bed for residents who had enhanced barrier precautions. IPPM stated, as soon as you touch the patient, any of those high-contact cares, you should be dressed in PPE. The IPPM stated an in-house educational in-service was provided for staff about EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 5/31/24 at 11:49 a.m., registered nurse (RN)-A stated staff wore gown and gloves during direct cares and when in residents' personal space for residents on enhanced barrier precautions. RN-A consulted the sign on residents' doors for directions on PPE. During interview on 5/31/24 at 5:12 p.m., the director of nursing (DON) expected staff to wear gloves when boosting a resident who had enhanced barrier precautions. Staff had close contact to resident and their bed linen and clothing and had potential to spread MDROs (multi-drug resistant organisms). An undated facility policy titled Enhanced Barrier Precautions indicated the organization would promote decreased transmission of Centers for Disease Control (CDC)-targeted and epidemiologically important multidrug-resistant organisms (MDRO) by utilizing enhanced barrier precautions (EBP). The policy indicated EBP were used in addition to standard precautions and expanded the use of PPE to donning of gown and gloves during high-contact resident care activities. EBP were indicated for residents with any of the following: infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or wounds and/or indwelling medical devices even when a resident is known to not be infected or colonized with a MDRO. The policy indicated for residents on EBP, high-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. ILLNESS TRACKING R198's face sheet undated, indicated R198 had diagnoses which included diarrhea, a stage 3 pressure ulcer (a wound that breaks down skin and underlying tissue) of the sacral (tailbone) region, unspecified stage pressure ulcer to the left buttock, muscle weakness, depression, and anxiety. The face sheet also indicated the resident admitted to the facility on [DATE]. R198's face sheet did not indicate infectious disease diagnoses. R198's order summary included the following orders: - amoxicillin-pot clavulanate (Augmentin) 875-125 mg twice a day 5/15/24 to 5/22/24. - cephalexin 500 mg twice a day 5/28/24 to 5/30/24. - Monitor resident for loose watery stools and update provider as needed every shift, dated 5/28/24. - stool culture for Clostridium difficile (bacteria that can cause inflammation of the colon and severe diarrhea, often due to antibiotic use) special instructions: discontinue when collected, every shift, dated 6/1/24. - Wound clinic referral (sacral ulcer/left gluteal fold), dated 5/20/24. R198's orders did not indicate transmission-based precautions. R198's medication administration record (MAR) indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	501 Oak Street Chaska, MN 55318

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- vital signs were monitored 5/15/24, 5/16/24, 5/19/24, and 5/26/24 and temperature 5/15/24 to 5/29/24. - monitor resident for potential allergic reaction while resident on cephalexin due to penicillin allergy with start day of 5/28/2024 until discontinued on 5/30/24. - wound care at least daily or twice a day since admission. R198's medication administration record (MAR) included the following regarding the order to monitor loose stools: - soft stools on evening shift of 5/28/24 and day shift of 5/31/24. - loose stools on day and evening shift of 5/29/24. R198's progress notes included the following: - 5/15/24 to 5/22/24 notes described the wounds as foul odor a couple times. Loose stools were not mentioned. - 5/28/24 at 10:46 p.m., R198 had multiple soft/mushy stools causing dressing to become soiled. Stool consistency was reported to nurse practitioner and order for Imodium given and to monitor resident for loose/watery stools and update nurse practitioner as needed. The Imodium was given once in the evening and results were somewhat effective. - 5/30/24 at 10:45 p.m., indicated R198 was seen by wound clinic and provided with orders to discontinue Keflex and send stool specimen for culture for Clostridium difficile. Clinic stated R198 had continuous loose stools the entire afternoon visit at the clinic. R198's progress notes did not indicate transmission-based precautions. R198's bowel movement documentation indicated R198 had loose bowel movements 5/20, 5/21, 5/22, 5/28, 5/29 and soft/formed bowel movements 5/18, 5/20, 5/29 and other dates did not indicate bowel movement consistency or no bowel movements documented. R198's wound/ostomy progress note dated 5/30/24, indicated R198 had watery stool with a sweet odor and no signs or symptoms of infection. During interview on 5/30/24 at 12:37 p.m., infection prevention manager (IPPM) acknowledged R198's orders for Imodium for loose and watery stools with increased incontinence. During observation on 5/31/24 at between 9:09 a.m. and 9:30 a.m., there was no signage outside R198's door indicating R198 required transmission-based precautions. The chair outside his room had a box of gloves on the seat. During interview, TMA-A stated no report was received about his appointment the previous day. During interview on 5/31/24 at 9:43 a.m., NA-D verbalized being unaware of any changes to R198's condition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 5/31/24 at 9:48 a.m., licensed practical nurse (LPN)-A stated they were still processing R198's orders from R198's wound appointment yesterday. LPN-A reviewed R198's hard chart for the new orders and found the order to discontinue Keflex. LPN-A stated the clinic called to discontinue Keflex because R198 had loose stools while at the appointment. LPN-A stated R198 was on contact precautions which required gown and gloves for his wound care and his catheter cares. LPN-A stated his precautions have not changed since his appointment. During interview on 5/31/24 at 9:59 a.m., IPPM stated R198 had an order to collect a stool sample and send that out to rule out Clostridium difficile infection and staff still needed to collect the sample to send in. The IPM expected there to be signage on the door and an isolation or supplies cart outside his room. The IPM verified contact precautions (or enteric precautions) had not been implemented in addition to EBP because I haven't gotten there, but stated the nurse managers and charge nurses were able to set up TBP. The IPM verified at R198's room that there was no signage and no isolation or PPE supplies cart outside his room. During interview on 5/31/24 at 10:34 a.m., registered nurse (RN)-A stated residents who did not present as themselves were assessed, kept in room if seemed contagious such as with temperature, and staff reached out to provider. Providers may then order x-rays, labs, urine specimens. Staff completed additional follow-up assessments such as vitals and lung sounds depending on the infection. RN-A documented in progress notes and had a book with a shift report. During interview on 5/31/24 at 1:21 p.m., IPPM stated weekly or every few days they pulled a report from the electronic medical record system, Matrix, which listed residents who had antibiotic orders with start and end dates and other order information. The report of antibiotics did not include resident signs or symptoms of infection. Staff called IPPM when antibiotics started. IPPM used information from the report to track antibiotic use and then placed in a tracking form on the computer which included information such as resident name, infection type, if resident had device, whether surveillance criteria met or not, diagnostic tests performed and results, antibiotic medication information, who started the antibiotic, if a time out was completed, if transmission-based precautions were needed. During interview on 5/31/24 at 3:55 p.m., registered nurse (RN)-C stated nurses assessed and monitored residents who had a change of condition or new symptoms which could indicate illness, such as loose stools. Nurses reported assessment, which included vital signs, and signs and/or symptoms of illness or infection to the provider and processed labs, diagnostic tests, or any other order given. Nurses placed general orders to flag oncoming shifts to monitor resident condition and could monitor vital signs, push fluids, or initiate standing orders if related to suspected illness or infection. Nurses documented in progress notes and a 24-hour communication report and had verbal reports between shifts. RN-C alerted IPPM right away if they were in the facility or left a voicemail or let the next shift know to communicate with IPPM. RN-C stated they could alert the care coordinator or director of nursing if IPPM not available. During follow-up interview on 5/31/24 at 4:33 p.m., IPPM stated they did not have a process for tracking illnesses not related to antibiotic use. IPPM had become aware of a tracking tool which would be put into place. IPPM stated nurses did not always alert them when symptoms started but sometimes [TRUNCATED]

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44651 Based on observation, interview, and document review, the facility failed to ensure dishware was maintained in a safe and sanitary manner by failing to remove chipped and cracked dishware from use within the facility. Findings include: During interview on 5/31/24 at 7:48 a.m., an unidentified resident stated the facility had a lot of chipped ceramic dishware, including bowls and cups. They stated they had sent them back and let the staff know, it bothered them, and they would not want to use chipped and cracked dishes at home, however the facility had not corrected the concern. During observation on 5/30/24 from 8:05 a.m., - 8:36 a.m., a.m., three bowls containing various amounts of leftover oatmeal were observed on the tables in the dining room after the residents finished breakfast, each with at least one chip in the outer lip of the bowl, exposing the material under the glossy coating. One nursing assistant was assisting a resident to eat oatmeal from another chipped bowl. One additional chipped bowl was in the clean pile to be used for the next resident who requested oatmeal. During observation and interview on 5/30/24 at 12:52 a.m., an unidentified resident was observed eating salad out of a bowl with a crack running from the lip down the inside of the bowl. The resident indicated they were served food in a chipped bowl the previous day as well. During interview on 5/30/24 at 12:52 p.m., dietary aide (DA)-B stated dishes with chips and cracks were thrown away when they were identified during dishwashing or when handling. DA-B was shown the resident's bowl with the crack and stated the staff needed to go through each one to remove those with cracks and chips. DA-B went to the kitchen to inform the dietary manager (DM). During interview on 5/30/24 at 1:04 p.m., DA-A stated when they did dishes, they would remove any broken dishware from service and throw them away, but if there were small chips out of them, they were still usable and placed back in the stack. During interview on 5/30/24 at 1:07 p.m., DM stated staff threw away and dishware when they were chipped or cracked to ensure residents did not get cut, and to ensure they were still able to be sanitized since the exposed area would be porous. During interview on 5/31/24 at 10:38 a.m., administrator stated they expected dishware to be clean and sanitized, with no chips or cracks. Staff should be looking at dishware when putting items in the dishware or on the shelves and discarding any with damage for sanitation purposes and minimize risk of foodborne illness. The Dishware and Glassware policy (undated) indicated chipped or cracked drinking glasses or china are discarded immediately.