STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	1000 Forest Street Buhl, MN 55713

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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 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** 42587 Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was completed for all sections for 1 of 1 residents (R15) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2019, identified the purpose of the RAI process was to help ensure holistic care was provided. Findings include: R15's admission MDS dated [DATE], identified sections C and D were marked as not assessed. A section of the RAI labeled, SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine the resident ' s attention, orientation and ability to register and recall new information. These items are crucial factors in many care planning decisions. A section of the RAI labeled, SECTION D: MOOD Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. On 10/29/24 at 3:04 p.m., R15 was observed walking up and down the hall with her walker making a huffing sound, R15 appeared distressed. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 3:14 p.m., R15 was observed in the dining area walking without her walker and mumbled shit under her breath. A staff member asked her if she needed some help and assisted her to a table and provided R15 with a cup of coffee. On 10/31/24 at 10:32 a.m., the director of nursing (DON) reviewed R15's admission MDS and verified sections C and D were not assessed. The DON stated social service was responsible for those sections and she would expect the sections to be assessed and the information entered. The DON stated the MDS coordinator was responsible to ensure all sections were completed prior to uploading the document. The DON verified if the MDS coordinator was missing information and not getting a response they should have reached out to her or the administrator for assistance. The DON stated the information was important to have to ensure the resident was receiving needed care. On 10/31/24 at 11:20 a.m., social service designee (SSD)-A stated the process was for her to complete the assessments and scan the document to the MDS coordinator. SSD-A reviewed R15's admission MDS dated [DATE], and verified the information was missing in sections C and D. SSD-A stated the information was needed to make sure R15 was receiving needed care. Resident Assessment Instrument dated 9/2010, identified the assessment coordinator was responsible for ensuring the Interdisciplinary Assessment Team conducted timely resident assessments. The information derived from the assessments would help the staff to plan care that allowed the resident to reach their highest practicable level of functioning.

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F 0684 Level of Harm - Minimal harm or potential for 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** 47263 Based on interview and document review the facility failed to perform nurse assessments, and resident monitoring to ensure timely recognition of clinical decline, provider notification and prompt transfer to a higher level of care occurred for 1 of 1 resident (R29) reviewed for hospitalization . Findings include: R29's significant change Minimum Data Assessment (MDS) dated [DATE], indicated R29 was cognitively intact with the diagnosis of orthostatic hypotension, diabetes, hypopituitarism, and epilepsy. Section N indicated R29 received insulin daily. The report Order Summary, Active Orders as of 9/12/24, listed the following orders: -Blood sugars (BS) 5 times daily update diabetic center with severe hypoglycemia BS less than 60. -Contact MD if BS less than 70 or greater than 400 per protocol in chart under physician orders tab every shift. -Please document any additional low bs noted that need correction with snack -Glucagon kit 1 mg inject 1 mg as needed for low BS per protocol. BS 50-69, 15 G carb (4 glucose tabs) BS less than 50, 30 G carb (8 glucose tabs) If pt not alert give Glucagon 1 mg IM, repeat 15 minutes if unresponsive. Recheck BS every 15 minutes till greater than 100. Eat recheck 1 hour. -Zofran ODT 4mg give every 6 hours as needed for nausea and vomiting. R29's careplan for 9/2024 provided by the facility included Diabetes Mellitus initiated on 3/15/2022, which included instruction for monitoring and reporting to the doctor as needed signs and symptoms of hypoglycemia and or hyperglycemia. Monitoring for dehydration was added to the care plan on 11/9/23. The 9/2024, Weights and Vitals Summary for blood pressure (BP), temperature, respirations, and pulse had the following documented 9/12 into 9/13/24: 9/12/24 1:14 p.m. 84/64 pulse: 63 7:49 p.m. 86/63 pulse: 76 9/13/24: there were no documented vital signs. The chart lacked evidence to show staff had obtained and monitored R29's vital signs for clinical decline. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/2024, Weights and Vitals Summary for BS showed the following: 9/12/24 -11:10 a.m. 73 mg/dL -11:25 a.m. 75 mg/dL -4:50 p.m. 194 mg/dL -9:02 p.m. 116 mg/dL -10:45 p.m. 45.0 mg/dL 9/13/2024 -2:20 a.m. 120.0 mg/dL Nursing Assistant (NA) documentation sheets provided by the facility included the following BS. 9/12/24 10:45 p.m. 42 9/13/24 1:02 a.m. 123 3:05 a.m. 120 EMR Progress notes 9/12 to 9/13/2024 were as follows: 9/12/24 at 11:48 a.m., registered nurse (RN) E-MAR [electronic medication administration record] entry: BS was low and needed a snack and was going to an appt. 9/12/24 at 12:47 p.m., RN entry. Prior to leaving for appointment R29's BS had been dropping so R29 was given snacks before R29 left with family member (F)-1. R29's F-1 notified the facility R29's BS was 312 and rising, and R29 was vomiting. It was decided they would return to the facility and R29's doctor appointment would be re-scheduled. Note indicated a nurse would assess R29 upon return. 9/12/24 at 7:08 p.m., E-MAR entry by licensed practical nurse (LPN)-B: resident did not eat, not feeling well. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/13/24 at 5:16 a.m., by LPN-A. Resident BS 42 at 22:45 [10:45 p.m.]. R29 reported they did not eat dinner. LPN-A prepared sandwich, chips, yogurt, and drinks and encouraged intake. R29 had been extremely pale, BP very low on PM shift, 86/63 and 64/40, unable to take bp on nights due to constant heaving and emesis, able to get BS up to 143. Covid test negative. R29 had nausea and frequent episodes of emesis. At 0400 [4:00 a.m.] R29's BS dropped to 87. R29 continued to vomit. At 0430 [4:30 a.m.] spoke with R29 to be seen in ED, R29 agreed. Parents called. At 0445 [4:45 a.m.] EMT's arrived. Unable to find vein for IV. R29 was transported by ambulance to Hibbing hospital. MD was faxed. The EMR lacked evidence of documented vital signs, BS, assessment and monitoring. In addition, the EMR lacked evidence that the hypoglycemic orders were followed and that the RN and or provider had been consulted and or notified of R29's worsening medical condition. During an interview on 10/30/24 at 10:39 p.m., LPN-A stated at shift change [on 9/12/24] it was reported R29 had had low BP, low and high BS, and had vomited on days and afternoons. That night LPN-A was on the Tamarack unit but as the LPN they rounded on willow and birch, and passed medications on Birch at 2:00 a.m., and 4 a.m. The Nursing assistants rounded on all units and checked Dexcom meters [meter giving continuous BS values]. LPN-A stated they first checked on R29 around 10:45 p.m. R29 had been vomiting, didn't feel well, had pale skin, and had a very low BS. To get R29 BS up, LPN-A indicated they had prepared a bunch of food and drink options and had encouraged R29 to eat. R29 had a hard time with it because of the nausea and vomiting. LPN-A couldn't recall how frequently they had checked R29's blood sugar after it was low [documented 42 and 45], but they remembered they had checked it and the Nursing assistants also checked it and had called and given them updates when R29 vomited. LPN-A stated [on 9/13/24] at 4:00 a.m., R29's BS started to drop again, but they couldn't get it back up again. R29 was still vomiting. They then contacted R29's parents and talked to R29 who agreed to go to the ED. The EMS crew tried to get an iv [intravenous access] in but couldn't because R29 was so dehydrated. LPN-A confirmed they had not gotten any follow-up BPs or vital signs on R29 that shift, nor had they called the doctor for R29's low blood sugars or to notify the doctor of R29's declining medical condition. LPN-A explained they didn't usually call the doctor on nights, but if there was something pressing, they would call. They felt they had done what they could for R29 and when it was out of their LPN scope, they had gotten R29 to the ED as fast as they could. When asked in retrospect if the on-call RN or provider should have been notified about R29's condition at any point during the night shift, LPN-A stated no. During an interview on 10/31/24 10:52 p.m., LPN-B stated they had received report on 9/12/24, from day shift that R29 was not feeling well. They recalled R29 had thrown up on the afternoon shift and had lower than usual blood pressures. They had called R29's family (F1) and updated F1 on R29's status. F1 had suggested R29 may need their hydrocortisone dose doubled. LPN-B explained when R29's body was under stress, their hydrocortisone dose had to be increased. LPN-B stated they had done a communication to the assistant director of nursing about R29's hydrocortisone dosing. LPN-B did not recall a blood pressure as low as 64/40 on their shift but indicated they had reported to the oncoming night nurse R29 needed to be watched closely due to their low bp, vomiting, and blood sugars. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 10:05 a.m., registered nurse (RN)-A stated they remembered the situation but had not received a call regarding R29 [RN-A was on call RN]. RN-A reviewed R29's EMR and stated there were gaps in documentation. With a report of low blood pressure, R29's blood pressure should have been rechecked and monitored for trending. The on-call doctor should have been called for a blood sugar as low as 45, especially since R29 had been throwing up for hours. RN-A stated if had they been working, or been called that night, they would have wanted to send R29 to the emergency department with the first low sugar. During an interview on 10/31/24 12:46 p.m., NA-A stated they knew R29 had been sick a few days and had thrown up all afternoon. NA-A stated they had probably checked on R29 about every hour. NA-A stared on a check R29 had been sweaty and pale and their BS had been really low, so they notified the nurse. They tried to get R29 to drink something, but R29 had projectile vomited everywhere. That was when the nurse decided to transfer R29 to the ED. During an interview on 10/31/24 at 11:04 a.m., the director of nursing (DON) opened R29's EMR and stated R29's blood pressure (BP) trended low so nurses may not have been alarmed by R29's BP. The DON verified the following orders were current on 9/12-13/2024: -contact medical provider if bs less than 70 or greater than 400 and chart under physician. -If BS under 50 give 30 grams of carbs or 8 glucose tabs. -Recheck blood glucose every 15 minutes until greater than 100. - Zofran 4 mg [milligrams] give every 6 hours as needed for nausea and vomiting. The DON confirmed the record did not contain evidence of BP monitoring or BS rechecks per protocol, nor had Zofran been given for nausea and vomiting. The DON stated when a resident was ill critical thinking should be used, they expected documented assessments each shift, and vital sign completion to assess for illness. Orders should be followed. Per order, the provider should have been called with the first low blood sugar. In addition, the provider should have been called for an order to send R29 to the ED. The lack of nurse notes and vital signs make it difficult to review and determine if R29 should have been transferred to the ED sooner than they were. During an interview on 10/31/24 12:15 p.m., medical doctor (MD)-D stated the on-call should have been called regarding low BP and vomiting. At the least the on-call would have initiated sick day steroids R29 needed to fight illnesses. Steroid dosing should have started when R29 started to vomit. Had the on-call been called about the low blood pressures or the low blood sugar R29 would have been sent to the ED. R29 could have benefited from earlier transfer to the ED, however the delay likely did not make a significant difference in R29's outcome. R29's ED Provider Notes dated 9/13/24, listed the following diagnoses: hypoglycemic, hypotension due to hypovolemia, dehydration, adrenal crisis, nausea and vomiting, and fever in adult. The note indicated R29 required straight catheterization to treat urinary retention. R29's initial ED blood sugar was 43 and the repeated result was 50. While in the ED R29's treatment included IV administration of dextrose 10%, dextrose 50%, a two-liter fluid bolus, hydrocortisone, nausea medication, and antibiotics. The noted indicated R29 required admit to the hospital for further evaluation and treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's Range Hibbing Hospital Discharge Summary dated 9/21/24, indicated R29 had been admitted to the hospital on 9/12/24, and was discharged on [DATE], with the following diagnosis: dehydration, urinary retention, hypoglycemia, acute colitis, fever in adult, hypotension due to hypovolemia, nausea and vomiting, low serum cortisol, hypopituitarism, and uncontrolled type two diabetes without complication with long-term current use of insulin. Discharge orders included a 13-day course of the antibiotics Cipro and Flagyl for the associated diagnosis of sepsis unspecified organism. The undated, untitled document page 3 subtitle Diabetic Management instructed staff to notify the provider if two BS results were lower than 70 or greater than 400 in a 24-hour period and/or a change in condition. If no change notify provider on the next business day. Page four subtitle Hypoglycemia: if a patient was hypoglycemic and able to swallow, staff were instructed to: -administer six ounces of juice, milk, regular pop, or other high carbohydrate beverage or boost via mouth or feeding tube. -repeat BS after 10 minutes, if less than 70 repeat intervention -if after two attempts to treat BS and still under 70 notify provider -once R is stable recheck BS after 60 minutes. -communicate any hypoglycemic event to provider the following business day. The Nursing Care of the Resident with Diabetes Mellitus dated April 2009, under Management of Hypoglycemia for symptomatic responsive resident instructed staff to: -immediately give four ounces of juice or five to six ounces of soda -recheck BS in 15 minutes -repeat juice if indicated, recheck BS in 15 minutes -monitor vital signs -if no improvement notify the physician for further orders Instruction under Documentation included document: -skin -level of consciousness -pain -accurate input and output -urinary symptoms including retention and incontinence (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-blood pressure problems including orthostatic hypotension -blood sugar results Policies related to nurse assessment, provider notification, on-call RN, and transfer to ED/hospital were requested and not received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review the facility failed to provide non- pharmacological interventions prior to administration of an as needed (PRN) antipsychotic medication for 1 of 1 resident (R11) reviewed for PRN psychotropic medication use. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had diagnoses which included dementia and pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder). In addition, R11 was severely cognitively impaired with no hallucinations, delusions, behaviors, or rejection of cares. R11's MDS identified she had unclear speech but could usually understand and be understood. R11's care plan dated 11/17/22, identified R11 had as needed lorazepam (a medication used to treat anxiety, a benzodiazepines which are medications that slow down the nervous system) for agitation/anxiety, dyspnea (shortness of breath), and uncontrolled pain. Interventions included to administer lorazepam as ordered and monitor for medication side effects. In addition, R11's care plan dated 2/16/22, identified R11 had cognitive loss related to a diagnosis of dementia. Interventions included to administer medications as ordered, anticipate needs, ask yes/no questions, offer reminders and cues, and to call family as needed. R11's current physician orders included the following: Lorazepam 0.5 milligrams (mg) by mouth every six hours as needed for pain until 12/1/24. Prior to administering, assess for unmet needs related to inconsolable crying. Offer verbal reassurance, snacks, fluids, music. Attempt all non pharmacological interventions prior to administration, document what was attempted. R11's October 2024, medication administration record identified R11 received PRN doses of lorazepam 0.5 mg orally on the following dates and times: 10/2/24 at 7:26 p.m. 10/11/24 at 3:07 p.m. 10/15/24 at 3:34 p.m. 10/16/24 at 4:15 p.m. 10/22/24 at 4:57 p.m. R11's October 2024, medication administration record identified R11 did not have non pharmacological interventions documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a document titled Mood and Behavior Log for October 2024, did not having any documentation of behaviors by the nursing assistants. A review of R11's October 2024 progress notes did not identify what non pharmacological attempts were made prior to administration of lorazepam. On 10/30/24 at 12:36 p.m., the director of nursing (DON) reviewed R11's electronic medical record (EMR) and verified no non pharmacological interventions were documented prior to administering lorazepam in October. The DON stated she would have expected staff to document the non pharmacological interventions that were tried prior to the lorazepam administration. The Comprehensive Home Care Resource Manual dated January 2014, identified staff needed to create and maintain a correct and accurate medication record for each client receiving medication assistance or administration .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49877 Based on observation and interview, the facility failed to monitor the temperature for 3 of 3 unit kitchenette refrigerators. In addition, the facility failed to ensure the use of hair restraints during food service. This practice had the potential to affect 37 of the 38 residents at the facility who take in sustenance orally. Findings include: Unit Kitchenette Refrigerators On 10/28/24 at 1:12 p.m., dietary manager (DM) stated the facility has 3 unit kitchenette refrigerators. The refrigerator's store resident snacks, beverages, and personal food. Items commonly stored in the refrigerators include milk, cheese sticks, and yogurt. DM stated the unit kitchenette refrigerators are cleaned daily by kitchen staff, but the temperatures were not monitored or recorded by kitchen or any other staff. Furthermore, the temperatures of the unit kitchenette refrigerators have not been monitored or recorded since he was hired approximately one year ago. DM immediately recognized the lack of temperature monitoring was a food safety issue. During observation on 10/28/24 at 1:20 p.m., DM located an internal thermometer in each unit kitchenette refrigerator. The temperature of each refrigerator was within safe cold food storage range. None of the unit kitchenette refrigerators had a temperature tracking sheet posted. On 10/28/24 1:31 p.m. DM reported the lack of unit kitchenette refrigerator temperature monitoring to the administrator. Administrator stated the temperature of all facility refrigerators must be monitored and recorded daily. During interview on 10/29/24 12:05 p.m., registered dietitian (RD) stated she was unaware the temperatures of the unit kitchenette refrigerates were not being monitored or recorded. RD identified this was a food safety issue and plans to resume the practice of auditing temperature logs. A policy, Refrigerators and Freezers, revised December 2014, identified monthly tracking sheets for all refrigerators will be posted to record temperatures. Furthermore, employees will check and record refrigerator and freezer temperature daily. Hair Restraints During observation on 10/29/24 at 10:44 a.m., DM was in the kitchen and began to transfer baked fries from a baking sheet to a holding pan. DM was not wearing a beard net and was observed to have a goatee approximately 1/4 inch in length. During interview on 10/29/24 at 10:51 a.m., DM stated kitchen staff are required to wear beard nets if their facial hair was longer than 1/4 inch. DM states his goatee was 1/4 inch, and he was not required to wear a beard net. DM was going off of past experience and was unsure if the length requirement was based on facility policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 10/29/24 at 12:05 p.m., RD stated staff are required to use hair restraints while in the kitchen. All head hair must be covered, and facial hair only needs to be covered if it was beyond a certain length. DM could not recall the exact length requirement and was going off of what was done at the hospital. RD indicated DM's goatee was neatly trimmed and did not require a beard net. During interview on 10/29/24 at 1:41 p.m., administrator expected staff to use hair restraints while in the kitchen but was uncertain about the requirement for beard nets. Stated we have always just gone with requiring a beard net for facial hair longer than 1/4 inch. Administrator proceeded to consult the facility culinary infection prevention policy and the Centers for Medicare & Medicaid Services (CMS) State Operations Manual Appendix PP. Upon review, administrator indicated facial hair, regardless of length, must be restrained when working with food. Administration planned to implement the use of beard nets with facial hair to reduce the risk of food becoming contaminated with hair. A policy, Culinary Infection Control - General Practice, undated, identified culinary staff wear a hair net to restrain all hair at all times. Wear beard restraints if necessary. CMS State Operations Manual Appendix PP, issued 8/8/24, identity according to the current standards of practice such as the Food Code of the FDA, food service staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

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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 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. 49877 Based on interview and document review the facility failed to resolve technical issues timely to ensure staffing data was submitted, for 2 of 4 quarters reviewed (quarter 2 and 3), to the centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings Include: Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D for quarter 2 2024 (January 1 - March 31) and quarter 3 2024 (April 1st through June 30th), identified no data had been submitted. As a result, the metric for Registered Nurse (RN) hours and licensed nursing coverage was suppressed for those quarters. On 10/30/24 at 11:00 a.m., the human resources director (HR) stated it was her responsibility to gather the staffing data each quarter. She sends the data to the administrator who submits to CMS. HR indicated the facility was made aware of the submission errors in March of 2024 following an internal audit. HR explained the root cause of the submission errors was related their time and labor software program being switched to the cloud. They have been assigned a software support specialist to assistance with technical issues. On 10/30/24 at 11:15 a.m., the administrator confirmed she submits the staffing data each quarter to CMS and has never received a notice of submission failure. States she was made aware of the submission errors following the internal audit. In response, the administrator looked back at her past 2 years of CMS submissions and stated they all said, submission failed. At that time, the administrator did not reach out to CMS because she thought their time and labor software support specialist would be able to resolve their technical issues. Administrator identified reaching out to their software support specialist on 4 occasions since being made aware of the submission issue. Most recent contact attempt was on 10/10/24. As of today 10/30/24, administrator reports the issue will be resolved within the next two weeks. The expectation was for staffing data to be submitted each quarter before the deadline. It was important to ensure staffing data was submitted before the deadline because it could interfere with the facility's overall star rating and impact the accuracy staffing information being presented to CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	1000 Forest Street Buhl, MN 55713

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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** 42587 Based on observation, interview and document review, the facility failed to develop and implement a comprehensive water management program to reduce the risk of Legionella (a bacterial infection which can be found within man-made reservoirs) and associated infectious outbreak. These findings had the potential to affect all 38 residents within the facility. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in a timely manner for 1 of 1 resident (R190) who had a peripherally inserted central line (PICC). Findings include: Water Management: During the recertification survey, from 10/28/24 to 10/31/24, the facility's water management program was requested, and a series of policies were provided which included the following: Water Management Plan dated 2/2021, identified the individuals responsible for the program were the environmental service director (EVS), maintenance assistant and the administrator. The plan identified EVS would be responsible for oversight of the water management program. The plan identified the ice machine as a potential area where Legionella could grow and spread. The plan identified the ice machine would be cleaned and disinfected routinely on a quarterly basis by the maintenance staff. The plan further identified unoccupied areas (resident rooms) would be cleaned and disinfected by housekeeping on a weekly basis. The faucet is exercised during housekeeping duties to ensure stagnant water is flushed from the water lines. However, there were no provided diagrams of the facility's water system. Water Management Program Reduce Growth and Spread of Legionella undated, identified the purpose of a water management program was to provide education and guidance to staff to identify and manage hazardous conditions that would inhibit the growth and spread of Legionella. Water Supply dated 11/2009, identified the facility would handle and maintain it's water supply in accordance with recommendations of the Centers for Disease Control (CDC) the Healthcare Infection Control Practices Advisory Committee and the Food and Drug Administration (FDA). A document titled Minnesota Valley Testing Laboratories for room [ROOM NUMBER] bath identified the following information for a water sample: date collected - 1/31/24 date received - 2/5/24 date analyzed - 2/12/24, Legionella pneumophilia 474 MNP/100 milliliters (ml) (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 interview on 10/29/24 at 1:41 p.m., maintenance (M)-A reviewed the above test and stated he was not sure how to interpret the results and verified no further actions were taken after receiving the test results. M-A stated when a resident room was unoccupied they would run water for 15 minutes and flush toilets. M-A stated the facility had a diagram which identified hot and cold water but did not have a diagram of the facility's water system that would identify areas which would encourage the growth and spread of Legionella. M-A verified the water management plan was reviewed on 2/2021, and yesterday. M-A verified the facility did not have a system in place to track empty resident rooms, length of time empty, and cleaning/flushing toilets/running water. During an interview on 10/30/24 at 8:31 a.m., client services (CS)-F with Minnesota Valley Testing Laboratories identified MPN as most probable number and stated the number could be interchanged with colony forming units (CFU). CS-F verified when testing water the ideal result would be zero and would have expected some type of follow up with a result of 474 MPN/100 ml. During an interview on 10/30/24 at 8:48 a.m., the infection preventionist (IP)-G stated she had not been made aware of the Legionella test results from the water sample taken in January 2024. IP-G was not aware of the process for tracking empty rooms related to the water management plan. During an interview on 10/31/23 at 10:03 a.m., the administrator stated the water management plan could be a little more in-depth. The administrator verified she was aware a Legionella test had been completed but had not been made aware of the results. The expectation would be that she would be alerted if M-A did not know how to interpret the test results. 49877 R190: Admission [NAME] Data Set (MDS) dated [DATE], identified R190 was admitted to the facility on [DATE], cognitively intact, diagnosed with diabetes mellitus and depression, and receiving intravenous (IV) antibiotics. Order summary, physician signed on 10/18/24, contained orders for PICC line monitoring and dressing change. Orders lacked any information related to EBP. During observation on 10/29/24 at 8:52 a.m., R190s door lacked EBP signage and a personal protective equipment (PPE) cart was not located outside of room. During interview on 10/30/24 at 1:22 p.m., IP-G stated she reviews the medical record of newly admitted residents to determine if EBP were required. If EBP required, IP-G would post EBP signage on their door, place a PPE cart outside of their room, and add an EBP order to their medical record. IP-G stated having a PICC line would require EBP. Furthermore, IP-G acknowledged R190 has a PICC line and should already be on EBP but was not. IP-G explained it was on the list to implement EBP for R190. During interview on 10/31/24 at 10:03 a.m., DON stated she had the expection of timely implementation of EBP to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy, Infection Prevention and Control Manual Transmission-Based Precautions undated, identified EBP are implemented for residents at risk of developing or becoming colonized with a Multi Drug Resistance Organisms (MDRO). A resident with a central line was at risk. Furthermore, EBP should be implemented when completing high-contact care activities.