STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40614 Based on observation, interview and document review the facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R30, R44, R45, R60, R52) who required assistance with dining. Findings Include: During an observation on 10/19/21 during breakfast on the 3rd floor dining room: 8:18 a.m., R45 was served breakfast meal and was sitting at table with R44 who was being assisted to eat her breakfast. 8:38 a.m., R45 remains sitting at table with breakfast in front of her. R45 had pushed her wheelchair away from the table. 8:56 a.m., nursing assistant (NA)-D sat down at table next to R45, scooted her up to the table, heated R45's breakfast tray in the microwave and assisted R45 to eat. 9:22 a.m., R45 finished her breakfast and remained sitting at the table. During an observation on 10/20/21, during the breakfast meal on the 3rd floor dining room: 7:30 a.m., R45 was seated at a table in the dining room with wheelchair back reclined to a 60 degree angle. R45 was periodically sitting herself straight up in the chair, then laying back down. 7:47 a.m., R45 remains reclined in wheelchair and has attempted to sit up straight 3 times but was unable to hold her position sitting straight. 7:58 a.m., R45 sat up straight than reclined back down. 8:03 a.m., R45 sat up and layed back down three times and began grabbing towards the table and yelling out. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:04 a.m., NA-E indicated they lay R45 back because otherwise she scoots forward and has fallen out of her wheelchair. NA-E stated R45 will usually relax and fall asleep with the back reclined. NA-D then moved the back of the wheelchair to a partially reclined position, at a 30 degree angle. 8:03 a.m., breakfast trays were delivered to floor 3 dining room. 8:09 a.m., breakfast was set in front of R45. 8:10 a.m., breakfast was served to R215 and R44 who were seated at the same table; breakfast was also served to R52 and R60 who were seated at the same table. 8:19 a.m., R215, R44, R52, and R60 remain seated with breakfast in front of them waiting for assistance. 8:30 a.m., transportation assistant (TA) sat down and assisted R215 with eating. Did not heat her french toast or bacon. 8:31 a.m., trained medication assistant (TMA)-B returned to R45's table and removed lid from meal and started to assist R45. Did not heat meal. 8:32 a.m., R44, R52, and R60 remained seated in wheelchair at table with breakfast in front of them. 8:36 a.m., NA-E sat at table with R60 and started to assist with feeding; NE-E did not reheat R60's meal. R52 remained seated at the same table with her meal in front of her 8:51 a.m., R44 remains sitting at table with breakfast in front of her. 8:55 a.m., NA-E completed assisting R60, took residents tray to the cart, washed her hands, then went to assist R52 with her meal. 9:04 a.m., TA sat next to R44, 55 minutes after being served her tray and began assisting R44 with her meal. R44's pureed french toast and bacon was not reheated prior to assisting R44. 9:05 a.m., NA-E indicated they had a call in today and are short people to assist residents with eating. NA-E indicated they usually have 2 NA's, the nurse or TMA and one other staff member to assist with feeding residents so running very late today with only one TMA, 1 NA and one other staff member assisting. NA-E further stated that over the weekend R30 began requiring feeding assist and had a new admission 4 days ago requiring assistance with meals also. 9:22 a.m., TMA-B indicated they were short of help today and had a call in. When questioned if someone else could come assist, she indicated they were busy as other floors were short of help also. During observation on 10/20/21 on 3rd floor during lunch: 12 residents were present. 12:24 p.m., R45 is in dining room, sitting at table with wheelchair reclined 30 degrees yelling out. TMA-B assisted R45 by leaning her back to a 60 degree angle. R45 continued to yell out. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:32 p.m., R45 continues to yell out, NA-B set her up straight. R45 continued to yell out and was mumbling. Lunch trays were delivered to the floor. 12:35 p.m., R45 continues to yell out and was laid back in her chair. R45 continued to yell out 4 more time prior to being assisted with meal 12:36 p.m., Tray delivery began to residents in dining room. 12:38 p.m., R45 was served her tray. 12:44 p.m., NA-E continues to deliver trays to residents in the dining room. R215 sitting at table was served her lunch. 12:45 p.m., R30 and R52 were seated in the dining room and received their meal. 12:50 p.m., TMA-B began to assist R45 to eat. 12:52 p.m., R44 was served her lunch. 12:56 p.m., R44 and R215 remain with food in front of them at the table waiting for assistance to eat. 1:16 p.m., NA-E sat down next to R215 and began assisting her with her lunch. Tray was not reheated and included soft shell tacos with meat, cheese, lettuce and tomatoes. R44 continues seated at table with R215 waiting for assistance. R30 and R52 also continue to sit at table in dining room waiting for assistance. 1:18 p.m., the director of nursing arrived on the floor and stated she would see if someone from another floor could come assist residents still waiting for assistance. 1:26 p.m., R44 remains sitting at table with her meal in front of her awaiting assistance. 1:28 p.m., RN-D entered the 3rd floor dining room and sat with R30 to assist with lunch. RN-D did not warm up the meal. R30 did not immediately accept the food; RN-D put the cover back on the meal and told resident she would let her rest a little bit then would come back to check on her. RN-D left the table, washed her hands, then returned to assist R30. 1:31 p.m., NA-E sat next to R44 and began assisting her to eat with a fork. R44 was served pureed taco meat, lettuce and tomatoes. Food was not reheated. 1:33 p.m., RN-D left R30's table, and went to R60's table and proceeding to assist R60 with eating her meal. R30 had only eaten approximately 0-25% of her meal and did not attempt to feed herself after RN-D exited to assist another resident 1:44 p.m., NA-E sat down with R30 and offered assistance and encouragement to eat. R30 accepted the assistance. R45 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R45's Admission record, printed 10/20/21, identified a diagnoses of Alzheimer's disease, chronic pain syndrome, and low back pain. R45's quarterly, Minimum Data Set (MDS) assessment, dated 9/6/21, identified severe cognitive impairment, and required extensive assist of 1 person with eating. R45's care plan dated 6/28/21, identified a problem with physical functioning related to mobility and self care impairment. Interventions included assist of 1 with oral care, bed mobility, dressing, locomotion and personal hygiene. The care plan did not include assistance with eating. R215 R215's admission record printed 10/21/21, indicated an admitted [DATE], and identified a diagnoses of dementia with Lewy Bodies (abnormal deposits of a protein which leads to problems with thinking, movement, behavior, and mood), displaced fracture of humerus (upper) left arm, displaced fracture of left clavicle, and fracture of one rib. R215's admission MDS assessment was not completed. R215's baseline care plan dated 10/15/21, identified R215 has diagnosis of dementia resulting in cognitive loss, diminished decision making capabilities and safety and security issues and was placed in the secure Alzheimer's care unit. Interventions included to establish predictable care routines as much as possible to decrease confusion. The care plan did not address assistance with eating. R44 R44's admission record, identified a diagnoses of Alzheimer's disease, and dementia with behavioral disturbance. R44's annual, MDS assessment, dated 9/4/21, identified severe cognitive impairment, and required 1 person extensive assist with eating. R44's care plan dated was requested but none received. R30 R30's Admission Record, printed 10/21/21, indicated diagnoses including vascular dementia with behavioral disturbance and delusional disorder. R30's Minimum Date Set (MDS) assessment dated [DATE], indicated the resident had severe cognitive impairment and required supervision with eating. R30's care plan indicated an ADL (activities of daily living) self care deficit as evidenced by need for verbal cues, set-up and reminders to complete ADL cares related to diagnosis of dementia. Interventions included to assist with daily hygiene, grooming, dressing, oral care, and eating as needed. R52 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R52's Admission record, printed 10/21/21, indicated diagnoses including Alzheimer's disease and dementia without behavioral disturbance. R52's quarterly MDS dated [DATE], indicated the resident had severe cognitive impairment and required extensive assistance with eating. R52 care plan printed 10/21/21, directed staff to assist resident with dining when needed. R60 R60's Admission Record, printed 10/21/21, indicated diagnoses including dementia without behavioral disturbance and Parkinson's disease. R60's quarterly MDS dated [DATE], indicated the resident had severe cognitive impairment and required extensive assistance with eating. R60's care plan printed 10/21/21, indicated the resident will have ADL (activities of daily living) needs met with staff assistance. During interview on 10/20/21, at 11:15 a.m. the director of nursing (DON) indicated a call in occurred for 3rd floor that morning so staffing was an issue. The DON confirmed her expectation is when the tray is served, residents should be assisted to eat with minimal waiting time. A policy on dignified dining was requested and none received. 31767

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R42) observed to self-administer eye drops. Findings include: R42's admission form printed 10/21/21, included a diagnosis of paranoid schizophrenia, altered mental status, anxiety disorder, cataract and glaucoma. R42's admission Minimum Data Set (MDS) assessment dated [DATE], included severe cognitive impairment requiring extensive assistance with activities for daily living and supervision of one person for eating. Provider orders dated 10/14/21, included Cosopt Solution 22.3-6.8 mg/ml to instill one drop in both eyes two times a day for glaucoma and natural balance tears solution 0.1-0.3% to instill 1 drop in both eyes three times a day for dry eyes. Physician orders did not identify an order for self administration. R42's plan of care dated 9/10/21, included R42 had an alteration in visual acuity related to glaucoma, but interventions did not include self-administration of eye drops. During interview and observation on 10/20/21, at 7:41 a.m., trained medication assistant (TMA)-A was observed during medication administration for R42. While preparing medications, TMA-A stated R42 was given Cosopt eye drops in both eyes an hour earlier and liked to administer them herself. TMA-A brought natural balance tears solution 0.1-0.3% to R42's bedside and handed her the bottle. R42 then took the bottle and put one drop in both eyes and handed the eye drops back to TMA-A. TMA-A returned the eye drop bottle to the cart and indicated she wasn't sure if a self medication assessment was completed and did not believe she had seen an order for R42 to self administer eye drops. During interview on 10/21/21, at 9:45 a.m., TMA-A confirmed no order for self administration of eye drops was found and added that R42 refuses to let staff administer them to her. TMA-A indicated she monitored R42 during the self administration of eye drops and had notified a nurse prior that R42 was requesting to self administer but was unable to indicate whom or when she notified the nurse. During interview on 10/20/21, at 10:00 a.m., the director of nursing (DON) confirmed residents should not self administer eye drops without a physician order and prior to an assessment completed by a registered nurse. The DON confirmed neither were completed. Policy review titled Medication Self Administration dated 6/1/17 included: - Residents are not permitted to administer or retain any medication in his or her room unless their attending physician writes an order for self-administration of the medication and the resident is assessed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming. Findings include: R4's facesheet printed 10/21/21, included diagnoses of morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R4 had refused to completed the brief interview for mental status, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 required extensive assistance of one staff for personal hygiene. R4's plan of care dated 1/21/20, indicated hygiene was important to R4 and the goal was to maintain hygiene and health. In addition, the care plan indicated R4 had an ADL self -care deficit related to impaired cognition and mobility, and would have facial hair trimmed as needed with the assist of staff. During an interview and observation on 10/18/21, at 3:22 p.m., many white whiskers of varying lengths were observed on and under R4's chin, along with multiple long (approximately 1-2 inch) white hairs on her neck. When asked if she was aware of the hair, R4 stated she was not happy about it, but she didn't have a razor. R4 stated the facility didn't supply razors; she had asked several times. During an interview on 10/21/21, at 10:08 p.m., when asked how nursing assistants (NA's) managed chin hair on female residents, trained medication aide (TMA)-A stated NA's shaved the hair on bath day with disposable razors. Shaving cream and an ample supply of disposable blue razors where observed in the supply closet. When asked specifically about R4, TMA-A acknowledged R4 had chin hair, adding if a resident was diabetic and did not have their own razor, she did not shave them due to the risk of nicking the face, and instead informed the nurse. TMA-A did not recall telling a nurse that R4's chin needed to be shaved. During an interview on 10/21/21, at 10:17 a.m., licensed practical nurse (LPN)-A stated diabetic residents needed to have their own electric razor in order to shave chin hair, and family or guardian would need to supply it. LPN-A was aware of R4's whiskers and neck hair, but acknowledged she had never asked the social worker to contact R4's guardian to purchase an electric razor. During an interview on 10/21/21, at 10:40 a.m., the social worker (SW)-A stated she could facilitate getting electric razors for residents, adding nursing staff just needed to tell her. Informed R4 had chin hair and according to the nursing staff, would need an electric razor to remove the hair since she was diabetic. SW-A stated we just had R4's care conference yesterday, I could have asked the guardian. The guardian would say yes, she has the money for that. SW-A stated she would email the guardian right away and ask. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/21, at 1:57 p.m., the director of nursing (DON) stated she would expect staff to address female residents with chin hair. When the DON was informed that nursing staff stated they could not use a disposable razor to cut facial hair if the resident was diabetic, the DON stated nurses were allowed to shave a diabetic resident who had chin hair using a disposable razor, or they could request the family or guardian provide an electric razor. The DON stated this resident sometimes refused care and that may be why she had whiskers, but admitted refusal for shaving chin hair had not been documented by staff. R11 R11's facesheet printed 10/2/21, included diagnoses stroke and dementia. R11's quarterly Minimum Data Set (MDS) assessment date 7/24/21, indicated R11 was not able to complete the brief interview for mental status, had minimal difficulty hearing, impaired vision, clear speech, was usually understood and could usually understand. R4 required extensive assistance of one staff for personal hygiene. R11's plan of care dated 1/15/20, indicated hygiene was important to R11 and the goal was to maintain hygiene and health. In addition, the care plan dated 1/14/21, indicated R11 had an ADL self-care deficit related to dementia, physical and visual impairment, and R11 would have assistance with daily hygiene and grooming. During an interview and observation on 10/20/21, 08:25 a.m., R11 stated his fingernails were rough as he rubbed a finger across the nail of this left thumb. Fingernails noted to be long and jagged, especially his left thumbnail, thick and pale yellow in color. R11 stated he would like his nails trimmed. During an interview on 10/20/21, at 12:29 a.m., (NA)-C stated NA's cleaned and trimmed resident fingernails on bath day. NA did not recall giving R11 a bath on 10/6/21. NA-C was given the NAR bath day worksheet she filled out that day which had no markings for Nail care: fingers. NA-C was asked what it meant when there was no marking, and stated that meant the nurse needed to look at the residents fingernails when they looked at the residents skin. Together observed R11's nails. NA-C picked up R11's hands and looked at his nails and said, they should be trimmed and admitted they were long and that the left thumbnail was jagged. During an interview on 10/20/21, at 1:45 p.m., together with the DON, observed R11's nails. The DON admitted they were jagged and a little long. The DON stated she expected them to be trimmed, and R11 needed a good filing at least. Informed the DON that R11's bath sheet for 10/6/21, was blank for nail care. The DON stated no checkmark for fingernails did not mean they weren't looked at it meant the resident did not need nail care. During an interview on 10/21/21, at 4:45 p.m., due to conflicting explanation of what a checkmark or no checkmark meant for nail care on the bath day worksheet, the DON was asked to clarity. The DON stated if nail care was checked off, it meant the NA cleaned, trimmed and filed the nails. If there was no checkmark, that indicated the resident was on coumadin or was diabetic and the nurse would need to look at the nails. R11 was neither diabetic or on a blood thinning medication. Bath day worksheets for R11 indicated: (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/13/21: nail care for fingers: ok 9/20/21: nail care for fingers was not checked, which according to the DON meant nails were to be addressed by the nurse. 10/6/21: nail care for fingers was not checked, which according to the DON meant nails were to be addressed by the nurse. 10/13/21: nail care for fingers was checked, which according to the DON meant R11's nails were cleaned, trimmed and filed. The observation of R11's fingernails a week later on 10/20/21, showed them to be long and left thumbnail jagged. During an observation on 10/21/21, at 12:30 p.m., observed R11's nails to still be long, but left thumbnail was no longer jagged. Facility policy titled Personal Needs, with revised date of October 2016, indicated the facility strived to promote a healthy environment by meeting the personal needs of the residents. Personal care and ADL support would be provided according to the residents care plan. Compliance with care delivery needs and interventions would be determined by observation of care delivery. Personal care and support included grooming, nail care and shaving.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28591 Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions including completion of dressing changes and administer ordered antibiotic treatment for 1 of 3 residents (R43) with non-pressure related wounds. In addition, the facility failed to ensure elevation of swollen legs and utilization of compression wraps. This deficient practice resulted in actual harm for R43, who acquired an additional wound on the left lower leg and the medial and lateral wounds increased by 3-4 centimeters each in size. In addition, the facility failed to ensure treatment orders were provided as ordered for 1 of 3 resident (R4) reviewed for wound care who was at risk for non-pressure related wounds, Findings include: R43 was admitted to the facility on [DATE]. Diagnosis listed on the diagnosis sheet in the medical record included: cellulitis (inflammation of the subcutaneous connective tissue) of the left lower leg, non-pressure chronic ulcer (a break in the skin or mucous membrane) of the lower left leg, type 2 diabetes mellitus, venous insufficiency (veins unable to adequately circulate the blood), lymphedema (lymphatic system blockage causing swelling in the arms or legs), peripheral vascular disease (circulation condition that narrows blood vessels causing reduced blood flow to the limbs) and arteriosclerotic heart disease (ASHD) (a build up of cholesterol plaques in the walls of the arteries, causing obstruction of blood flow). R43's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R43 as having a brief interview for mental status (BIMS) score of 12 indicating the resident had minor impairment in cognition. The MDS indicated R43 required extensive assistance with activities of daily living (ADL's). The MDS indicated R43 had 2 non-pressure related ulcers. The MDS identified interventions including non-surgical dressing to feet as well as ointments. R43's discharge MDS assessment dated [DATE], identified R43 as having a BIMS score of 12 indicating the resident had only minor impairment in cognition. The MDS indicated R43 required extensive assistance with ADL's. The MDS indicated R43 had a non-pressure related ulcer on the lower left leg. R43's current care plan dated 6/9/21 identified R43 as having impairment in skin integrity related to a venous ulcer (see wound assessment) . Interventions listed: provide treatment as ordered, monitor for redness, warmth, swelling and drainage, report progress or decline to provider and assess and measure all skin integrity areas per policy. The care plan identified R43 as having impairment ADL's due to a self-care deficit that included respiratory failure, congestive heart failure (CHF) (when the heart does not pump blood like it should) and chronic obstructive pulmonary disease (COPD) (inflammation in the lungs that causes obstruction of airflow). Although the care plan directed to see the wound assessment for R43's lower leg ulcer, there was no wound assessment in the medical record. In addition, it was noted in R43's history to have swollen legs as well as orders for compression wraps, this was not included in the plan of care nor were interventions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a discharge hospital progress note dated 9/21/21, indicated R43 was hospitalized from 9/12//21 to 9/21/21, with a diagnosis of cellulitis in the legs, gastrointestinal bleed, acute kidney disease (when kidneys fail to filter body waste from the blood) and a low hemoglobin (HGB). (protein in the blood that carries oxygen to the body). The note dictated by medical doctor (MD)-A indicated R43 had chronic venous status ulcers to the lower left leg (medial and lateral). Wound care treatments were recommended for a few days to stabilize her healing prior to discharge. Physical therapy with advanced wound therapy was recommended on an out patient basis after discharge. The discharge notes did not include R43's wound progress or measurements while in the hospital. Recommendations included follow up with outpatient wound care for R43. Review of a facility re-admission skin assessment dated [DATE], identified R43 as having a vascular skin concern on the front lower left leg. The assessment did not include a description of the skin concern. There were no other skin assessments completed since the re-admission assessment on 9/21/21, of which only indicated R43 had a vascular skin concern. There was no documentation describing the condition of the wound. On 10/18/21, at 2:40 p.m. R43 was observed to have several fluid filled blisters on her left lower leg. R43's left lower leg was shiny, swollen and pinkish in color. There was a Kerlix wrap on the left lower leg, but the dressing was partially off exposing the blisters. R43 was sitting in her wheelchair with her legs down. R43 indicated she was unsure if the wounds were worsening or getting better, but that they were still painful. R43 indicated that her wound dressings often would fall down her leg, exposing the wounds. R43 further indicated that staff do not always replace the dressing when this happens. On 10/20/21, at 12:30 p.m R43 was observed sitting in a wheelchair with her legs down. R43's left leg remained pinkish, swollen and shiny. There was a dressing on the leg that was coming off, exposing several fluid filled blisters. R43 stated she had cellulitis in her legs. R43 indicated she had blisters that would come and go, but was unsure if she had any other open areas. Ace wraps were on the lower leg, but were falling down as well. On 10/21/21, at 12:30 p.m. registered nurse (RN)-A was observed to change R43's lower left leg dressing. R43 had a 9.0 cm by 8.0 cm open area on the lower front part of the left leg. A 7.0 cm by 6.0 cm open area on the outer part of the lower left leg and a 6.0 cm by 6.0 cm open area on the outer back of the left leg. The dressings were noted to have yellowish colored drainage on the gauze when removed. The center of the wounds were pinkish in color with maceration (skin broken down by moisture) on the edges of each ulcer. There were several fluid filled blisters surrounding the ulcers. Interview with RN-A indicated she did not routinely measure or document the description of R43's lower leg wounds, because she thought that was only done with PU's. RN-A stated the lateral wound on the lower left leg was new and did not have when the resident returned from the hospital. RN-A indicated she observed R43's wound daily and had last observed on 10/20/21. RN-A stated R43 continues to get fluid filled blisters that form and then heal, as well as swelling in the legs RN-A also confirmed there were no discharge notes from the hospital stay, that included measurements or the description of the lower left leg wounds. RN-A also confirmed there were no measurements or description of the wound after returning from the hospital, or when the new ulcer on the lateral left leg had been identified. R43 complained of pain during the dressing change, but had received pain medication prior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R43's current physicians orders dated 10/1/21 to 10/31/21, included a dressing change to the lower left extremity ulcer. The order included to cleanse the lower left leg wound with saline and apply a acetic acid (antimicrobial agent to treat infections) compress. Apply silicone barrier cream (skin protectant) to wound perimeter and cover with a wet aquacel Ag (antimicrobial dressing) followed by a ABD pad (absorbent dressing). Change daily and as needed. The orders also included to assess the wound daily. The physicians orders also included an order dated 10/8/21, for Cipro 500 milligrams (mg) twice daily (BID) for 10 days and penicillin V 250 mg four times a day (QID) for 10 days. Review of a progress note by doctor of podiatry medicine (PDM)-A dated 9/30/21, indicated R43 was seen to re-evaluate the lower left leg medial and lateral ulcerations. R43 was also seen for debridement of the lower left leg ulcers. The progress note identified the medial and lateral ulcers of the lower left leg to have slough tissue in the wound bed. Wound measurements were done before debridement and after debridement and listed below: Medial ulcer of the left lower leg Pre-debridement- 3.8 cm length by 3.9 cm width and 0.4 cm depth Post-debridement- 3.8 cm length by 3.9 cm width and 0.4 cm depth Lateral ulcer of the left lower leg Pre-debridement- 7.7 cm length by 4.0 cm width and 0.3 cm depth Post-debridement- 7.7 cm length by 4.0 cm width and 0.3 cm depth Review of a progress note by PDM-A dated 10/7/21, identified R43 as having ulcerations of the medial and lateral aspects of the lower left extremity. The progress note indicated there was increased redness of R43's left lower extremity and worsening of the skin of the periwound. A culture was completed which was positive for pseudomonas and enterococcus (bacteria). The progress note also indicated R43 was to have compressive wraps on, but did not during the appointment. The progress note identified the medial ulceration on the lower left leg having no slough tissue present and no new epithelial tissue present. The ulceration on the lateral aspect of the lower left leg identified the ulcer to have no slough tissue or epithelial tissue in the wound. The note indicated there was increased erythema and skin breakdown of the periwound which appears to be drainage from the wound bed. Erythema present of the left lower extremity. The note further indicated R43 had been seen previously at the advanced would healing clinic (AWHC) on 9/30/21, and had increased redness of her left lower extremity and worsening skin of the periwound. The ulcerations of the lower left extremity are unchanged since last visit, although measurement were not included with this visit. R43 has numerous comorbidities which are making it difficult for the ulcerations to heal. In addition to the progress note, there was a notation included under special considerations indicating a volunteer at the facility relates R43 had not been receiving as much help with dressing changes. The volunteer added this was due to lack of staff available. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R43's medication administration record (MAR) dated 10/1/21-10/31/21, included a order for Cipro and penicillin V. Both antibiotics were ordered by the provider on 10/8/21, in the afternoon. The MAR showed both medications were not given until 10/13/21, 6 days after the medication had been ordered. R43 had missed 9 doses of Cipro and 18 doses of Penicillin V. R43's treatment administration record (TAR) dated 10/1/21-10/31/21, showed no documentation on 10/4 or 10/21, that the treatment to R43's wounds had been done. Although R43 had an outpatient visit from the PDM on 10/7/21, to evaluate R32's lower left leg ulcers there were no measurements completed to monitor healing. The only measurements that had been completed since the residents hospital stay on 9/21/21 were on 10/21/21, when the surveyor requested RN-A to measure and assess the resident's wounds. A voice message was left for PDM-A on 10/21/21, at 1:30 p.m. to inquire on R43's lower leg wounds, with no response. A phone conversation with PDM-A's clinic nurse on 11/9/21, at 3:00 p.m. to have provider return a call when available. There was no response. Interview with RN-A on 10/21/21, at 12:30 p.m. verified R43's left leg ulcers had not been assessed to appropriately monitor the healing of the wounds. RN-A also confirmed there had been no documentation by the facility related to the description of the wounds when returning from the hospital on 9/21/21. RN-A further stated there were times that she was responsible for over 40 residents and and did not always get to R43's dressing changes, but confirmed she had signed them off on the treatment administrative record (TAR), due to the current staffing shortage (1 licensed nurse for 43 residents). Interview on 10/21/21, at 1:00 p.m. the director of nursing (DON) indicated it was not required for the staff to measure/document on non-pressure related wounds. The DON indicated only PU were measured , described and documented. RN-A further stated staff were to monitor healing with observations, when changing the dressing. RN-A indicated she was not aware that the dressing were not always getting done. DON stated that the staff are not required to measure skin wounds unless it is caused by a pressure ulcer and that they just monitor by observations. The DON confirmed she was unable to find any weekly skin documentation for R43 in the past couple of months. Interview on 11/5/21, at 2:00 p.m. the DON confirmed the ordered Cipro and Penicillin V had not been started until 10/13/21, missing several doses of both medications. The DON stated the medications were missed from 10/8 -10/12, because the order did not get transcribed to the MAR, so the nursing staff didn't see the order. Although the facility was aware of R43's lower left leg wounds, skin breakdown risk and edema, the staff did not comprehensively assess, monitor or implement all interventions to prevent further skin breakdown, to determine if wounds were improving or needing further interventions to promote healing. Interventions that had not been implemented included: administering antibiotics per order (causing a delay in treatment), elevating edematous legs, applying compression wraps and changing dressings to the lower left leg wounds, as ordered. This failure occurred from 9/21/21 to 10/20/21, (after return from hospital) and resulted in a new skin breakdown on the back of the left lower leg, and worsening of the wounds on the medial and lateral left leg. The medial wound increased by 5.2 cm in length and 4.1 cm in width. The lateral wound increased by 2. 0 cm in width. The new breakdown on the back of the leg measured 6.0 cm in length by 6.0 cm in width. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy Pressure and Non-Pressure Injuries dated 8/2/21, indicated upon admission/re-admission a head to toe evaluation will be completed on every resident and will be documented on the evaluation form. If skin is compromised initiate a injury tracker form (1 per wound) and assess weekly. Initiate a comprehensive skin integrity care plan based on the residents history, risk factors and current skin assessment conditions. Report any changes to the physician. 42073 R4 R4's facesheet printed 10/21/21, included diagnoses of cellulitis of leg (skin infection), lymphedema (swelling of leg due to build-up of lymph fluid), venous insufficiency (failure of veins to adequately circulate blood), morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R4 declined to complete a brief interview for mental status, did not exhibit any behaviors - including rejection of care, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 did not walk and required extensive assistance of two staff for bed mobility, transfers and toileting. R4 was frequently incontinent of urine and always incontinent of stool. R4 had an infection of her foot requiring a dressing. Physician orders included: 3/23/21: Wash feet with soap and water every evening. 10/8/21: Use skin marker, mark area of redness and notify provider if worsening. Assess every shift. 10/15/21: Right lower extremity and right dorsum (top) foot and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area): acetic acid soaks two times a day for 7 days. R4's plan of care dated 1/21/20, indicated R4 had actual skin integrity break related to mobility and incontinence at that time, and a goal indicated skin would show signs of progressive healing without signs of infection. The care plan did not identify current skin infection and treatments ordered to enhance healing and reduce infection. In addition, the care plan indicated R4 displayed signs of mood and behavior possibly related to paranoid personality disorder and a goal indicated R4 would not refuse cares important to her health. Interventions included education on the importance of receiving cares and R4's refusals would be monitored. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review indicated R4 was seen by a physician or nurse practitioner on 9/29, 10/4, 10/8, 10/11, and 10/14. The 9/29, note reiterated importance of R4 wrapping her legs due to lymphedema; but there were ongoing refusals by R4 to wrap them. The 10/4, note indicated R4 was being seen following communication from nursing that when R4's shoes were removed at bedtime, maggots were noted crawling out of her right shoe and in between her toes. R4 had open areas to the right foot: one at the dorsum and the other at the lower part of the shin, both laterally. The 10/8, note indicated R4 was being seen regarding worsening pain, redness, and warmth of lower right extremity, and worsening edema. An antibiotic was started. The 10/11, note indicated follow-up of right lower extremity cellulitis, with the redness subsiding. The 10/14, note indicated R4 had no resolution of right lower leg cellulitis and another antibiotic was started. During an interview and observation on 10/18/21, at 3:51 p.m., R4 was in a hospital gown, and was sitting on the side of her bed, facing the door with her legs over the side of the bed. R4's bare feet rested directly on the tile floor. Significant edema was noted to both lower legs and feet. The right lower leg and foot were reddened, and areas of skin on dorsum of the right foot were peeling. R4 had a panniculus which hung over the outer aspect of her right thigh and over the side of the bed. The right side of the panniculus was slightly reddened as compared to the left side. No obvious open areas during a quick observation when R4 lifted her gown to show her panniculus. During an interview on 10/19/21, at 2:56 p.m., when asked if staff had recently been soaking her right foot and panniculus with a special solution, R4 stated her foot had been soaked maybe twice since arriving to the facility a year and a half ago. No soaking supplies observed in room except for a white plastic basin, upside down on the floor between her bed and wall, toward the top of the bed. R4 stated no one had been washing her feet either. No signs of black marker markings on reddened area of skin on right leg or right foot, as ordered, to indicate improved or worsening redness. During an interview on 10/20/21, at 8:17 a.m., when asked what kinds of skin treatments R4 had, licensed practical nurse (LPN)-A stated, If she would let me do anything with her wounds -- she refuses. LPN-A opened the TAR (treatment administration record), and stated, See the 2's? Those are refusals. When asked about soaks for foot and panniculus with acetic acid, LPN-A stated, I don't know anything about that. LPN-A was asked to look at the order, but could not find it until it was pointed out, then she read it. LPN-A confirmed the order was added on 10/15/21, and admitted she was unaware this order existed and therefore had not performed the treatment. When pointed out that R4 had multiple wound care orders, LPN-A was asked how many wounds R4 had and she stated she didn't know. LPN-A was unaware of the physician order dated 10/8, to mark R4's areas of redness with a skin marker either, stating she never saw that order, and shrugged her shoulders when asked how she knew if the wound was worsening or improving. It was noted on the MAR (medication administration record) that LPN-A had signed off marking the areas of redness on 10/11, 10/13, 10/14, 10/17, and 10/20. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/20/21, at 11:44 a.m., when asked if R4 had foot and panniculus soaks, the director of nursing (DON) looked at the physician orders in the electronic medical record (EMR) and stated not at this time, adding that R4 was very non-compliant and that the provider was aware of her non-compliance. The order for the acetic acid soak dated 10/15/21, was pointed out and the DON stated Oh, that started on the 15th. When asked if it were being done, the DON looked at the TAR and stated the evening shift had been doing it consistently and identified the two nurses who had documented performing the treatment. The DON also stated that LPN-A had signed off that she performed it on 10/17. The DON was informed that when the acetic acid soaks were pointed out to LPN-A, she did not know anything about it. When asked if it were possible LPN-A signed off as performing the treatment when she had not, the DON stated, I can't say. Requested to look at R4's skin with the both the DON and LPN-A. During an observation and interview on 10/20/21, at 1:59 p.m. in R4's room with LPN-A and DON, R4's skin and acetic acid soak treatment were observed. R4's panniculus had generalized, slight redness; skin was smooth and intact except for one dime size scab noted. The center of R4's abdomen had a healed vertical scar with a small scab at the proximal end. Right lower leg, middle section had closed, blistered skin. Dorsum of right foot had peeling skin. No open wounds noted. LPN-A was asked how the cellulitis of R4's right lower leg and foot looked to her and she stated slightly better. LPN-A stated to the DON, I didn't know about this [order for acetic acid soaks] till she [surveyor] asked me about it this morning. After the treatment was over, again asked LPN-A and DON if LPN-A had been doing this treatment prior to today and LPN-A stated she would have to go back and look at the R4's record. During a telephone interview on 10/21/21, at 9:02 a.m., registered nurse (RN)-A was asked if she was aware of a new treatment for R4's skin using an acetic acid soak. RN-A stated she was not aware. When brought to her attention that she initialed performing the treatment twice on 10/18, RN-A stated, I might have signed off on it at the end of the shift and not done it. RN-A further stated, I didn't know about this order and we are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can. When asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, Okay. RN-A had not told the DON or administrator how she felt about her workload. During a telephone interview on 10/21/21, at 9:06 a.m., (RN)-C was asked if she was aware of a new treatment for R4's skin using an acetic acid soak, RN-C stated, I offered the treatment to R4, but she refused to let me clean her abdomen and feet. Asked again if she was aware of a new order for acetic acid soak, RN-C stated, no, she had not seen the order, then stated she offered the acetic acid soak to R4 and R4 refused. RN-C stated she had filled out an SBAR (situation, background, assessment, recommendation) documentation to the physician about the refusal and that it should be in R4's record. RN-C stated she also sent a copy of the SBAR to the DON. According to an interview with the DON on 10/21, at 1:57 p.m., there was no SBAR documented about this in R4's EMR, nor did she receive a copy of an SBAR. During an interview on 10/21/21, at 10:21 a.m., when informed staff say she refused care a lot of the time, R4 stated how can I refuse if they don't asked me! Stated they aren't asking her things that she is allegedly refusing. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/21/21, at 1:57 p.m. with the DON and the corporate director of clinical services (DCS)-C, both confirmed it was the expectation that nurses carry out physician orders unless a resident refused. The DON stated R4 often refused care and treatment. The DON stated the physician had been been informed of R4's refusals and that multiple SBAR's regarding refusals has been sent to the physician. This documentation was requested. The DON admitted there was no SBAR in R4's record from 10/20, nor did she receive communication from an RN about a refusal. The DON and DCS-C were informed three nurses were unaware of the 10/15, order for acetic acid soaks yet they documented they performed the treatment. In addition, the nurses admitted they were not washing R4's feet, nor were they marking the area of redness on her skin, yet documenting these treatments had been performed. The DCS-C stated the process for nurses being aware of new physician orders needed to be improved, that she expected nurses to complete orders as directed, and expected nurses to be truthful in their documentation. During an interview on 10/21/21, at 3:48 p.m., based upon the request for SBAR documentation to physicians pertaining to R4's refusals of care, the DCS-C provided three pieces of documentation: 1) SBAR dated 10/2/21, for change of condition, 2) Nursing home orders dated 10/4/21, and 3) History and physical note dated 9/29/21. None were SBAR's indicating refusal of care. Only the history and physical note dated 9/29/21, read: R4's plan of care calls for daily application of Solaris Velcro ready wraps to control lower extremity lymphedema, but not currently being used due to non-compliance. The DCS-C admitted these documents did not address the refusals that the staff and the DON had been reporting to the surveyor, and added we need to fix that. A facility policy for carrying out physician orders was requested, and a policy titled Medication Orders was received which did not address carrying out physician orders.

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	245184	A. Building B. Wing	10/21/2021

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R42) received proper assistive device of a hearing amplifier to maintain hearing abilities. Finding include: R42's admission Minimum Data Set (MDS) assessment dated [DATE], identified R42 had severe cognitive impairment, moderate difficulty with hearing, used a hearing aid or other hearing appliance, required extensive assistance with transfers, bed mobility, toileting, dressing, and personal hygiene. The MDS identified R42 had medical diagnoses of weakness, anemia, end stage renal disease (kidney disease), vision impairment, and received dialysis treatment R42's care plan printed 10/19/21, indicated R42 had a hearing impairment as evidenced by hearing loss and used amplifier; interventions included attempt to minimize excess noise and communication device of amplifier, maintain, and use amplifier. Nurse progress note dated 8/31/21, at 2:40 p.m. indicated R42 was alert and oriented, very hard of hearing, needed hearing aids but used an amplifier, does not have one [amplifier] with her, and R42 was given one of the facilities amplifiers to use. On 10/19/21, at 9:11 a.m. R42 was observed and interviewed in her room, R42 stated she was extremely hard of hearing, when asked if she wore hearing aides or had a device to assist with hearing the resident stated she did not. During the interview with R42, a loud voice and repetition in questions was required. On 10/19/21, at 1:55 p.m. nursing assistant (NA)-A indicated R42 was hard of hearing and confirmed R42 used an amplifier when she first arrived at the facility, however NA-A stated R42's amplifier was not able to be located currently. NA-A was observed in R42's room and attempted to locate the amplifier and was unsuccessful. On 10/20/21, at 7:56 a.m. NA-C stated R42 was hard of hearing and had no hearing aids or hearing amplifier and NA-C stated, but she [R42] should. On 10/20/21, at 12:16 p.m. R42 and family member (FM)-A were observed in R42's room. FM-A stated R42 was provided a hearing amplifier from the social worker (SW) when she was admitted , however he had not observed R42 use the device and was not able to find the amplifier in R42's room or know the location of the amplifier. During the interview with R42, a loud voice and repetition was required, R42 stated she had not used the amplifier and confirmed she was very hard of hearing. On 10/21/21, at 9:36 a.m. interview with social worker (SW) stated R42 admission assessment verified R42 was hard of hearing and was provided a hearing amplifier at admission. SW stated R42 was admitted to a room on first floor, and had transferred to second floor room. The SW indicated staff were expected to move the amplifier to R42's transferred room. The SW indicated she would provide R42 with a replacement hearing amplifier. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy titled care of the hearing impaired resident dated 12/16 indicated: - Arrange for consultation with an otologist if needed - Provide pencil and paper or magic slate to communicate in writing or an erasable board, if the resident is able.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28591 Based on observation, interview and document review the facility failed to educate, assess and monitor catheter care for 1 of 1 resident (R5) who was independendently performing self urinary catheter cares. Findings include: R5 was admitted to the facility on [DATE]. Diagnosis listed on the diagnosis sheet in the medical record included: muscle weakness, right artificial shoulder joint, paraplegia (damage to the spinal cord causing paralysis of all or part of the trunk, legs or pelvic organs), neuromuscular dysfunction of the bladder (lacks bladder control), injury of the spinal cord, osteoarthritis (wearing down of the protective tissue at the end of the bones), diabetes mellitus (too much sugar in the blood), chronic kidney disease (loss of kidney function to eliminate waste from the body) and placement of a urostomy (an opening in the abdomen that re-directs urine away from the bladder that's diseased or injured. Observation on 10/18/21, at 3:43 p.m. R5 was in her room watching TV. There was a strong odor of urine throughout the room. There was a urinal hanging [NAME] commode in the room, that had urine in it. R5 stated she has a urostomy that she manages herself. Observation and interview on 10/20/21, at 8:30 a.m. R5 was in her room rummaging through papers on her table. There was a strong odor of urine throughout the room. There was a catheter bag hanging on the night stand. Half of the bag was filled with urine. There was no cap on the end of the tubing (connector) and hanging down on the floor. R5 stated she takes care of her urostomy herself and that she also switches her drainage bag and leg bag in the morning and at night. R5 indicated she did not always clean the ends of the tubing (connector) when switching her bags. R5 further indicated she did not rinse her bags either. R5 stated she empties the urine into the urinal and places it on the commode and the staff will empty the urinal. R5 stated she also washes around her stoma every day. R5 indicated she has had a urostomy most of her life and she was capable of taking care of it. Review of the quarterly minimum data set (MDS) assessment dated [DATE] identified R5 as having a brief interview status (BIMS) of 15 (no impairment in cognition). R5 required extensive assistance with activities of daily living (ADL's) including toileting and personal cares. The MDS indicated the staff did all the effort and R5 does none to complete the activity. R5 was able to eat independently. The MDS identified R5 to have a ostomy. R5 exhibited only 1 behavior that included verbal aggression towards others. No behaviors of being resistive or refusing cares identified on MDS. The MDS identified R5 to have impairment of upper and lower extremeties Review of the annual MDS assessment dated [DATE], identified the resident as having a BIMS of 14 (meaning minimal impairment in cognition). R5 required extensive assistance with ADL's, including toileting and personal care. R5 was able to independely feed herself. The MDS identified R5 to have a ostomy. The MDS identified R5 as having mild depressive symptoms but did not exhibit any behaviors. The MDS identified R5 to have impairment of upper and lower extremeties. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current bowel and bladder evaluation dated 4/16/21, indicated R5 was continent of bladder. There was no documentation related to R5 having an ostomy. R5's current plan of care dated 4/16/21, identified R5 as having a urinary ostomy related to impaired mobility, physical limitations, infection, neuromuscular dysfunction of the bladder related to paraplegia at age 19 and pyelonephritis. Interventions included: provide ostomy care as needed, report changes in amount, frequency and color and odor of urine and report signs and symptoms of a urinary tract infection (UTI). The care plan identified R5 with a self care deficit related to being paraplegic and physical limitations. Interventions included: assist with daily hygiene, grooming, dressing and oral cares and mechanical lift for transfers. The care plan did not include R5 independently performing her own ostomy/catheter care nor did it include target behaviors that included R5 had been refusing catheter/ostomy care. R5's progress notes for the past year, did not include an assessment/training or any documentation pertaining to self ostomy/catheter cares. During the survey, the surveyor attempted to observe R5 performing self ostomy/catheter care during the survey, but the resident refused. Review of R5's urinalysis (UA's) results in the past year, showed R5 has not had a urine tract infection since 8/2/20. Interview on 10/20/21, at 9:00 a.m. registered nurse (RN)-A indicated R5 has been taking care of her ostomy since admission. RN-A indicated she was unsure if R5 had been assessed or trained to provide self ostomy care. RN-A stated she did not think that R5 was fully capable of providing self ostomy/catheter care. RN-A verified R5's room often spells of strong urine. RN-A confirmed she had not re-assessed R5's capabilities of providing her own ostomy care. Interview on 10/20/21, at 9:15 a.m. nursing assistant (NA)-A indicated R5 had been taking care of her own ostomy/catheter care. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-A was aware of the strong urine smell but thought it was because sometimes the urinal sits for a while before staff gets to it. NA-A also stated she had not attempted to provide ostomy care, because she had been told by other NA staff that R5 would refuse. Interview on 10/20/21, at 9:30 a.m. nursing assistant NA-B indicated R5 had been taking care of her own ostomy/catheter care for as long as she can remember. NA-A indicated the staff will empty the urinal when full and measure the output, but that was all that they did. NA-B felt R5 could use assistance with her cares, but that she was told the resident would refuse. NA-B indicated she had taken care of R5 for over a year. Interview on 10/21/21, at 1:45 p.m. NA-C stated R5 takes care of her ostomy care and will empty the leg bag and catheter bag in a urinal. NA-C stated then the staff will empty. NA-C indicated staff did not assist R5 with any of her ostomy/catheter care and was unsure if R5 was taking care of her catheter bags properly. A policy was requested related to assessment and self care of ostomy's/catheter drainage bags.

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	245184	A. Building B. Wing	10/21/2021

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review the facility failed to monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive dialysis care plan to reflect emergency care, and monitor fluid restriction for 1 of 1 residents (R42) receiving hemodialysis. Findings include: R42's admission Minimum Data Set (MDS) assessment dated [DATE], identified R42 had severe cognitive impairment, required extensive assistance with transfers, bed mobility, toileting, dressing, and personal hygiene. The MDS identified R42 had medical diagnoses of weakness, anemia, end stage renal disease (kidney disease), vision impairment, and received dialysis treatment. R42's care plan printed 10/19/21, indicated R42 was at risk for nutritional status change related to increased nutrient needs and interventions included: renal diet with regular textures and regular consistency,1.5 L [liter] fluid restriction, alternation in kidney function due to end stage renal (kidney) disease, evidenced by hemodialysis and interventions included: assessment of skin condition weekly by licensed nurse, check access site daily fistula/graft/catheter-signs of infection (redness, harness, swelling, pain, drainage elevated temperature, body chills), observe for post dialysis hangover - vital signs, mental status, excessive weight gain between treatments, nausea, vomiting, weakness, headache, severe leg cramps , observe for signs and symptoms of bleeding, hematuria bleeding gums, tarry stool, increased bruising. R42's treatment administration record (TAR) and the order summary report printed 10/19/21, indicated AV [Arteriovenous], fistula thrill and bruit checked daily, check dialysis catheter dressing daily for redness, drainage, or warmth -Notify NP [nurse practitioner] if any of these symptoms present every evening shift, and 1.5 L [liter] fluid restrictions, no water mug and dialysis Tuesday, Thursday, and Saturday at 11:00 am. Nutrition assessment dated [DATE], indicated renal diet and fluid restriction of 1.5 L fluid restriction. On 10/19/21, at 9:24 a.m. R42 was observed in her room and seated on her bed. A covered blue handled insulated mug, one opened six ounce diet ginger ale can, one unopened six ounce can of diet ginger ale, coffee in a brown handled mug, and an approximate 4-ounce clear plastic glass half filled with water was on R42's bedside table. R42 indicated the staff provided her too much to drink and she indicated she wasn't supposed to drink the amount the staff bring her, and further indicated she saved the drinks for later. R42 stated she had a dialysis catheter on her upper right chest area, and R42 pulled down her top and revealed a right tunneled catheter placed near the right subclavian (upper neck area) covered with a transparent dressing. R42 indicated the dialysis clinic monitored her dialysis site and she further indicated the facility staff had not monitored the dialysis access site. On 10/19/21, at 1:55 p.m. an interview with nursing assistant (NA)-A stated R42 was not on a special diet or fluid restriction and indicated R42 drank coffee, diet ginger ale, and received a water pitcher. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/19/21, at 2:25 p.m. registered nurse (RN)-A stated she has worked at the facility for nine weeks and was an agency nurse. RN-A stated hand off shift report was not received on R42 today and she was the nurse responsible for R42 today. RN-A stated yesterday and today [10/18/21 and 10/19/21] R42's dialysis site was not assessed and further indicated she was not aware R42's current dialysis site location. RN-A stated R42 had no dressings or skin treatments ordered. RN-A confirmed she was expected to assess R42 yesterday and did not have time. RN-A stated if R42 was on a fluid restriction and/or renal diet that was the responsibility of dietary staff. On 10/20/21, at 7:37 a.m. licensed practical nurse (LPN)-A stated she was not aware of any dressing or skin treatments ordered to monitor or assess for R42. LPN-A stated R42 was not on a special diet and further stated just an allergy to wheat flour and chocolate. On 10/20/21, at 7:56 a.m. an interview with NA-C stated staff were to limit the amount of fluids R42 drank and confirmed R42 should not have a mug of water on her bedside table. On 10/20/21, at 8:10 a.m. the second floor nursing station desk was observed with an envelope with R42's name and included the dialysis communication form from 10/19/21 and was blank and not filled out by the facility. On 10/20/21, at 10:30 a.m. during a phone interview with registered nurse (RN)-B stated she was an RN at the dialysis facility R42 received dialysis at on Tuesdays, Thursday, and Saturday . RN-B indicated R42's dialysis access site was a right tunneled subclavian catheter placed and indicated the dialysis nursing staff change R42's dressing. RN-B further indicated the facility staff were expected to assess the dialysis site daily for signs and symptoms of infection and ensure the dressing was intact and notify dialysis of concerns. On 10/20/21, at 11:03 a.m. an interview with the director of nursing (DON) indicated R42's care plan or medical record were expected to identify R42's dialysis facility, who to call for dialysis emergency, and expected staff send the facility's communication form filled out with the resident to dialysis. DON stated she was unaware of R42's care plan specific to dialysis. On 10/20/21, at 11:59 a.m. an interview with LPN-A stated she was not aware if R42 had a dressing or dialysis catheter site and confirmed as the nurse she was expected to monitor and assess dialysis access sites and confirmed she was expected to be aware of R42's dialysis catheter site and location. LPN-A confirmed she was not aware of a dressing on the subclavian tunneled dialysis site for R42. On 10/21/21, at 12:45 p.m. during an interview NA-B and TMA-B, NA-B indicated the facility's communication form that was sent with resident's to provider appointments was not expected to go with R42 from the facility to the dialysis center. However, TMA-B indicated the facility was expected to send R42 with a communication form to dialysis. NA-B stated she was not aware the communication form was expected to be sent to dialysis, but indicated the nurse or the NA would be responsible to send the form to dialysis with R42. NA-B confirmed with the health unit coordinator (HUC) and verified R42 had a communication form the HUC provided, and nursing or NAs were expected to fill out the form with information and sent with R42 to dialysis. NA-B confirmed the facility failed to send a communication form with the resident to dialysis. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/21, at 11:47 a.m. the DON stated she was responsible for R42's care plan and stated she had not time to look at care plan to see if catheter care was on the care plan or included in the medical record. The DON stated she expected nursing staff to be aware of R42's dialysis access site location and monitor the site for signs and symptoms of infection, and expected the dialysis communication form filled out by staff and sent with R42 to dialysis Policy titled Hemodialysis dated 4/13/21, indicated: -Determine where the dialysis procedure will take place -Obtain a clear understanding of roles and responsibilities between the facility and the dialysis center and define in writing this will include but not limited to the following: - Responsibility of monitoring lab values - How physicians orders will be validated - How provider orders will be communicated during the nursing staff -Assure daily assessment documentation of fistula or graft site -Monitor fluid status of residents and maintain fluid restrictions as ordered by the provider or dialysis center -Manage special dietary regime and dietary restrictions as ordered -Utilize dialysis center communication for continuity of care between the facility and dialysis

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	245184	A. Building B. Wing	10/21/2021

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 28591 Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) of grooming, personal hygiene and for 2 of 2 residents (R4 and R11) who required assistance and were dependent on staff for ADL's, provide dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining, provide treatment and services for non-pressure related skin concerns for 2 of 3 residents (R43, R4) who required assistance, monitor dialysis treatment, and fluid restrictions for 1 of 1 residents (R42) receiving hemodialysis. This deficient practice had the potential to affect all 64 residents who resided in the facility. Findings include: Interview on 10/18/21, at 3:25 p.m. R53 expressed concerns of short staffing. R53 stated her call light does not get answered timely when she needs assistance. R53 indicated it takes up to 45 minutes at times for the staff to come and assist her. R53 indicated it seemed worse on the weekends. Interview on 10/18/21, at 3:37 p.m. R4 expressed concerns of a facility staffing shortage. R4 indicated she has to wait for lengthily periods of time to get assistance after she puts her call light on. R4 stated the staff were always in a rush to take care of her because they had so many other residents to attend to. Interview on 10/18/21, at 5:33 p.m. R39 expressed concerns of short staffing. R39 stated the past 2 nights she had her call light on to assist her with toileting. R39 indicated she was incontinent from head to toe. R39 indicated she yelled out loudly until the next door neighbor came and went to get help at the sedk but there was no one there or in the hall. R39 was unsure how long she had to wait, but it was at least 45 minutes During a resident council group interview on 10/20/21, at 10:00 a.m. R10, R11, R18, R21, R23, R24, R26, R34, R35, R42, R48, and R54 were in attendance. These residents expressed concerns related to staffing. The residents stated staff worked short a lot of the time. The residents indicated it took up to an hour for their call lights to be answered and assisted with their activities of daily living (ADL's) The residents indicated this occurred at various times of the day and happened at least daily. The residents further indicated staff were always in a hurry when assisting them, because they did not have the time to get everything done if they did not. The residents stated these concerns were brought forward to management months ago, but felt staffing had not improved. See the below deficiencies that were issued that included short staffing Refer to F550: The facility failed to provide a dignified dining experience for 6 of 6 residents (R215, R2, R44, R45, R60, R30) who required assistance with dining. Refer to F677: The facility failed to provide ADL (activities of daily living) care to 2 of 2 resident (R4 and R11) reviewed for ADLs and who were dependent upon staff for grooming. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to F684. The facility failed to monitor, assess and provide treatment for non-pressure related skin concerns for 1 of 3 residents (R43) who had a skin wound, and failed to ensure activities of daily living (ADLs) were provided, including nail care, for 1 of 4 residents (R25) reviewed who were dependant on staff for activities of daily living. Refer to F684: The facility failed to comprehensively assess, monitor and implement interventions including completion of dressing changes and administer ordered antibiotic treatment for 1 of 3 residents (R43) with non-pressure related wounds. In addition, the facility failed to ensure elevation of swollen legs and utilization of compression wraps. In addition, the facility failed to ensure treatment orders were provided as ordered for 1 of 3 resident (R4) reviewed for wound care who was at risk for non-pressure related wounds, Refer to F698. The facility failed to monitor dialysis treatment, utilize communication form with dialysis, provide a comprehensive dialysis care plan to reflect emergency care, and monitor fluid restriction for 1 of 1 residents (R42) receiving hemodialysis. Interview on 10/19/21, at 2:25 p.m. registered nurse (RN)-A indicated she has worked at the facility for nine weeks and was an agency nurse. RN-A indicated hand off shift report was not received on residents on the second floor (east wing) at times. RN-A stated she was expected to assess R42's change in condition on 10/18/21, and did not have time due to the shortage of nurses and working short. Interview on 10/20/21, at 7:37 a.m. licensed practical nurse (LPN)-A indicated because of working short, she was not able to complete all resident treatments during her shift. LPN-A indicated she was the only nurse for the east and west wing on second floor and staffing should include a nurse for both wings. LPN-A indicated treatments included dressing changes. LPN-A further indicated nursing staff were expected to assess the electronic medical record (EMR) dashboard daily for resident alerts. LPN-A indicated the EMR residents alerts included when a resident had not had a bowel movement for 72 hours. LPN-A stated she was expected to monitor the dashboard daily. However LPN-A indicted she had not looked at the dashboard on a regular basis. Observation and interview on 10/20/21, at 9:05 a.m. observed that not all residents that needed assist with eating were getting assisted with their meal. There were 2 staff assisting the residents. NA-E indicated the staff were short today because a NA had called in sick. NA-E indicated that was why there was not enough staff to assist the residents who needed help with eating breakfast. NA-E indicated on a regular day there are 2 NA's, a licensed nurse or a TMA on the 3rd floor and usually another staff person who is trained to assist with feeding. NA-E stated there was only 1 TMA and 1 NA working. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 10/20/21, at 9:22 a.m. trained medication aid (TMA)-B confirmed being short one nursing assistant (NA) on the third floor memory care unit that day. When asked if the facility ever floated staff from other floors to help TMA-B confirmed sometimes that happened. TMA-A further stated that probably wouldn't happen that day as the second floor was also swamped and only had three NA's working the floor when there should be four. Upon subsequent interview at 11:51 a.m., TMA-B confirmed neither she nor NA-E (the only other staff working on the third floor) had received a break that day. TMA-A further confirmed they had started their shift at 6:00 a.m. NA-E was also interviewed at that time as had just gotten off the phone attempting to call supervisory staff to request assistance with resident care. NA-E confirmed she was the only NA working on the third floor that shift and further confirmed residents weren't getting turned and toileted every two hours per their plan of care. NA-E further stated feeling like she wasn't doing her job and also was afraid for a resident who was impulsive with transfers and without another set of eyes feared he would fall. NA-E confirmed she had called called several different staff requesting assistance who either had not answered the call or had not gotten back to her. During interview on 10/20/21, at 11:15 a.m., the director of nursing (DON) confirmed a NA had called in ill today, and was scheduled on the 3rd floor. The DON verified there were not enough staff to assist all residents that needed help with eating their breakfast, in a timely manner. During a telephone interview on 10/21/21, at 9:02 a.m., RN-A was asked if she was aware of a new treatment for R4's skin using an acetic acid soak. RN-A stated she was not aware of this. Acetic acid soaks to R4's right lower extremity, right dorsum (top) foot, and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area), twice a day for seven days had been ordered on 10/15/21. When brought to her attention that she initialed performing the treatment twice on 10/18, RN-A stated, I might have signed off on it at the end of the shift and not done it. RN-A further stated, I didn't know about this order and we are constantly rushed; we can't do everything. Everyone is frustrated; I get done what I can. When asked if she washed R4's feet with soap and water, RN-A replied no. When informed she initialed that she did soak R4's feet several times this month, RN-A replied, Okay. RN-A had not told the DON or administrator how she felt about her workload. Interview on 10/21/21, at 10:00 a.m. RN-A indicated she was currently the only full time licensed floor nurse. RN-A indicated she often will work a double shift due to call ins or short staff RN-A stated last month the licensed nurse that was working on the 2nd floor resigned, and was replaced with a TMA. RN-A indicated there are 43 residents on the 2nd floor, and many of them have treatments that include dressing changes to wounds and pressure ulcers (PU), gastric tube feedings and include tracheostomies RN-A stated that not all treatments get done at times. RN-A further indicated that often there are only 3 NA's on the 2nd floor when there usual is 4 NA's, to take care of 43 residents. Interview on 10/21/21, at 10:30 a.m., NA-B indicated she works the 2nd floor and is responsible for an average of 13-15 residents at a time. NA-B indicated she felt most resident cares were provided, but not always timely. NA-B stated when this happens the residents become anxious and upset. NA-A confirmed there is often 3 NA's to 43 residents on a daily basis. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/21/21, at 10:15 a.m. the facility human resource director (HRD) staff. confirmed there was a facility staffing shortage. The facility HRD s indicated they try and fill the shifts with on-call staff, contracted staff as well as double shifts. The facility HRD indicated the facility did not have a mandated requirement for staff to stay and cover the open shift if they were unable to replace the open shift, and then they staff work short. The facility HRD further indicated the facility offers incentives to fill in an open shift, to try and get it covered. The facility HRD indicated staffing is determined by acuity levels and census. The facility HRD indicated the facility has had a loss of staff to going back to school or resign in the past month. A total of 3 full time licensed staff and 3 full time NA's, who had not been replaced as of yet. The facility HRD stated they have reached out to contracted agencies, but found that they were short as well. The facility HRD further stated the have been recruiting in various ways but currently do not have any applicants. The current staffing schedules per acuity and census includes: Day shift- 2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Evening shift-2nd floor (2 licensed nurses and 4 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift- 2nd floor (1 licensed nurse and 2 NA's) There are 43 residents on the 2nd floor Day shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA Evening shift-3rd floor (1 licensed nurse and 2 NA's) Due to shortage 1 nurse has been replaced with a TMA Night shift-3rd floor (1 licensed nurse and 1 NA) There are 21 residents on the 3rd floor Review of the schedule for the past 3 months (from 8/1/21 to 10/18/21), noted there were 32 open shifts that had not been replaced and 20 shifts for staff call ins. Staff overtime hours: 8/21- 193.59 9/21- 149.59 10/21-10/20/21- 58.08 Current opening for NA's: Day shift- 3 full time NA's (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Evening shift- 3 full time NA's Nights- 1 full time NA Current opening for licensed staff: Day shift- 4 full time nurses Evening shift- 4 full time nurses Night shift- 2 full staff nurses Nurse managers: 2 full time nurses Interview on 10/21/21, at 11:30 a.m. the DON confirmed the above interview with the facility HRD. The DON indicated in the past month they have had several staff resign or go back to school that had been seasonal. The DON indicated contracted staff are utilized but there are very few because they are short staffed as well. The DON confirmed the staffing schedule for each floor that was identified above, and that not always are they fully scheduled due to call ins or open shifts that that could not be replaced. The DON indicated they try to replace these open shifts with contracted staff, on-call staff and part-time staff before they ask the full time staff. The DON indicated they offer all staff incentives for picking up additional hours as well. The DON indicated she had not been aware of staff not completing their work or not providing cares because of being short. The DON indicated she was aware that during shortage times, residents were not always assisted with meals timely. The DON indicated they try and do the best that they can to replace staff. The DON indicated all 3 of the nurse managers had resigned, otherwise they would assist with meals when short. The DON indicated she was unsure of what more they could do, because they had already closed the 1st floor short term care unit. Review of the Facility Assessment Tool updated on 10/18/21, included the following: 73 residents requiring assistance with dressing, 51 with bathing, 55 with transfers, 40 with eating, 74 with toileting and 25 with mobility needs. The staffing plan indicated a 1:22 ratio of licensed staff for day shift and evening shift and 1:40 on the night shift. For direct care staff (NA's) 1:10 on 2nd floor day and evening shift and 1:8 on the 3rd floor. The ratio on the night shift is 1:14. The assessment indicated staff assignments are kept as consistent as possible working within individual staff members scheduled hours and maintaining appropriate trained staff in each area Policy titled Nurse Staffing dated October 2017, indicated -Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staffing requirements :a nursing home must have on duty at all times of sufficient number of qualified nursing personnel including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of all the residents at the nurses station . Review of a facility policy Nursing Staffing Sufficiency dated 6/1/17, indicated nursing staff is efficient for each unit if: -if there is adequate staff to meet direct care needs, assessments and supervision -the workloads for direct care staff are reasonable -residents and family do not report insufficient staff meeting needs of the residents -staff are responsive to resident needs with call lights being answered promptly -the facility ensures each resident receives nursing care in accordance with his/her plan of care -sufficient nursing staff contribute to identified quality of care and life. 31767 44630

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40614 Based on interview and document review, the facility failed to implement a system to ensure controlled medications were accurately reconciled prior to destruction to prevent potential loss or diversion. This practice had the potential to affect the 6 residents identified for destruction of medications. Findings include: During observation and interview on 10/21/21, at 10:12 a.m., during tour of second floor medication room, trained medication assistant (TMA)-B indicated narcotics are destroyed at the time they are removed from the cart and is documented on the Resident Controlled Substance Record on the bottom portion, in a separate box titled Medication Disposition Record (MDR). Once the book is full, it is turned into the director of nursing (DON) who maintains the records. Upon review of the narcotic destruction book, multiple entries were noted to not be completed in the MDR section of the form. TMA-B confirmed they were incomplete and indicated she was told to fill out the bottom portion which included date, quantity destroyed, quantity sent with resident, 2 nursing signatures and comment section. Review of Resident Controlled Substance Record MDR section revealed: -Oxycodone 5 mg, 18 received. No administrations were listed. Discontinued date of 5/28/21 with 2 staff signatures. No date of destruction, quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg half tab, with amount received 26 1/2 tablets. Ten entries were present with last listed as 5/16/21 at 10:24 p.m. with 17 remaining tablets which was crossed out. Previous entry was 5/16/21 at 12:20 a.m., with 18 tablets remaining. Medication discontinue date was not included. Destroyed date was 5/17/21 with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg/ml (liquid) with 60 ml's received. Thirty administrations occurred with amount remaining documented as 30 ml's. A date of 5/17/21 was present and destroyed written with 2 unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Hydromorphone 1 mg (1/2 tab) with amount received documented as 30. Zero entries to administration was present. Medication discontinued and destroyed with date of 5/17/21 and two unreadable signatures present. No quantity destroyed or reconciliation of amount remaining was completed. -Lorazepam 2mg/1 ml (liquid) with 30 ml's received and 2 entries for administration present. Destroyed 5/17/21 present with 2 unreadable signatures. No quantity destroyed or reconciliation of amount remaining was completed. -Oxycodone 5 mg with 10 received. No entries present for administration. Discontinued 5/25/21 present with unreadable signatures. No date quantity destroyed or reconciliation of amount remaining was completed. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/21/21 at 11:15 a.m., the director of nursing confirmed staff are required to have 2 nursing staff count and reconcile medication amount remaining by counting and comparing with quantity to be destroyed prior to destruction of narcotic medications. The DON further confirmed their process included completing the bottom portion of the Resident Controlled Substance Record, which she confirmed on the above entries was not completed. A policy on destruction of narcotic medications was requested and not received.

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	245184	A. Building B. Wing	10/21/2021

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31767 Based on interview and document review the facility failed to provide rationale related pharmacist recommendation for a gradual dose reduction (GDR) of omeprazole (a proton pump inhibitor that decreases the amount of acid produced in the stomach), and Tessalon [NAME] (a medication used to suppress coughs) for 2 of 5 residents (R23, R30) reviewed for unnecessary medications. Findings include: R23's Admission Record (face sheet) printed 10/21/21, indicated an admitted [DATE], and diagnoses including dementia with Lewy bodies and interstitial pulmonary disease (a disease causing scarring of the lungs). R23's Order Summary Report printed 10/21/21, indicated an order for Tessalon [NAME] capsule, give 100 mg (milligrams) by mouth two times a day for cough. R23's Note to Attending Physician/Prescriber, dated 8/19/21, indicated a recommendation by the consulting pharmacist to decrease Tessalon [NAME] to 100 mg by mouth daily. R23's medical record did not include evidence the physician had responded to the recommendation or provided rationale for continued use. R30's Admission Record printed 10/21/21, indicated an admitted [DATE], and diagnoses including gastro-esophageal reflux disease (GERD-occurs when the lower esophageal sphincter (LES) does not close properly, so stomach contents leak back, or reflux, into the esophagus), and other specified disorders of bone density and structure. R30's Order Summary Report printed 10/21/21, indicated an order for omeprazole capsule delayed release. Give 20 mg by mouth one time a day for GERD. R30's Note to Attending Physician/Prescriber, dated 3/23/20, indicated a recommendation by the consulting pharmacist to reduce omeprazole dose to 20 mg by mouth daily on Monday, Wednesday, and Friday for six doses then discontinue. Monitor for GI (gastro-intestinal) symptoms. R30's medical record did not include evidence the physician had responded to the recommendation or provided rationale for continued use. When interviewed on 10/21/21, at 4:55 p.m. the director of nursing (DON) confirmed the physician had not addressed the recommendation for reduction for R23's Tessalon [NAME] and R30's omeprazole. DON further stated during the Covid-19 pandemic it had been difficult to get a response back from the physician related to pharmacy recommendations. The policy titled, Unnecessary Drugs, dated 6/1/18, indicated: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy) or 2. For excessive duration or 3. Without adequate monitoring or 4. Without adequate indications/reason for its use or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued or 6. Any combination of the reasons above.

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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** 31767 Based on interview and document review the facility failed to monitor for abnormal involuntary movements for 2 of 4 residents (R23, R39) reviewed on anti-psychotic medication. Findings include: R23's Diagnosis Report printed 10/21/21, indicated diagnoses including dementia with Lewy bodies (abnormal deposits of a protein which leads to problems with thinking, movement, behavior, and mood), and dementia with behavioral disturbance. R23's quarterly Minimum Data Set (MDS) assessment dated [DATE], included a brief interview for mental status (BIMS) score of 13 indicating intact cognition. The MDS further indicated the resident received an antipsychotic medication daily. R23's Order Summary Report printed 10/21/21, indicated an order for Seroquel (an anti-psychotic medication) 12.5 mg (milligrams) by mouth one time daily; and Seroquel 25 mg by mouth at bedtime. R23's care plan printed 10/21/21, indicated the resident had an order for anti-psychotic medication with potential for associated drug related complications. Interventions included to complete an AIMS (abnormal involuntary movement scale) baseline assessment and every 6 months per facility protocol. Further review of R23's medical record revealed the last AIMS assessment had been completed on 11/27/20. R23's Nursing Recommendations form from the consulting pharmacist dated 9/27/21, indicated R23 had a current order for Seroquel. The form further indicated that antipsychotics require routine monitoring for adverse events such as Tardive Dyskinesia (involuntary and repetitive body movements). The standard of practice is to obtain a baseline abnormal involuntary movement (AIMS) assessment at baseline and at least every 6 months thereafter. Recommendation to complete AIMS assessment. R39's Admission Record (face sheet) printed 10/21/21, indicated an admitted [DATE], and diagnoses including dementia with Lewy bodies and hallucinations. R39's admission MDS assessment dated [DATE], included a brief interview for mental status (BIMS) score of 6 indicating severe cognitive impairment. The MDS further indicated the resident received an antipsychotic medication daily. R39's Order Summary Report printed 10/20/21, included orders for Seroquel 50 mg by mouth one time daily; Seroquel 75 mg by mouth at bedtime; and Seroquel 25 mg by mouth as needed for overnight behavioral dyscontrol. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Nursing Recommendations form from the consulting pharmacist dated 9/27/21, indicated R39 had a current order for Seroquel. The form further indicated that antipsychotics require routine monitoring for adverse events such as Tardive Dyskinesia. The standard of practice is to obtain a baseline abnormal involuntary movement (AIMS) assessment at baseline and at least every 6 months thereafter. Recommendation to complete AIMS assessment for this new admission. When interviewed on 10/21/21, at 4:53 p.m. the director of nursing (DON) confirmed R23's last AIMS assessment was conducted on 11/27/20 (almost one year ago) and R39's medical record did not include evidence an AIMS assessment had ever been completed. A policy on anti-psychotic medication monitoring was requested but not received by the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 3 refrigerators and emergency kit (E-kit) observed for medication storage. This had the potential to affect all residents in the facility. Findings include: During tour of medication room on second floor on [DATE], at 10:12 a.m., trained medication aide (TMA)-B opened the medication room door with a key. TMA-B indicated the director of nursing (DON) and the nurses working for the day, have keys to the medication room. When requested to open the refrigerator, TMA-B used a key on a chain bolted to the side of the refrigerator to open the paddle lock on the refrigerator door. Inside the refrigerator, was a liquid bottle of lorazepam intensol (a schedule IV, controlled medication) 2mg/ml. TMA-B indicated they used to have the locked refrigerator key on their key ring with the door key, but a few years ago, they got attached to the refrigerator. Tour of nurses station, and three medication storage room at 11:11 a.m. also included a key to open the paddle lock on refrigerator door affixed to refrigerator. During observation and interview on [DATE], at 11:20 a.m., the director of nursing (DON) entered nurses station floor 1 medication room with a key. A paddle lock was present on the refrigerator and the key was attached to the refrigerator, which the DON used to open the refrigerator. The refrigerator was empty and the DON indicated the medication room on floor 1 was currently not in use for residents medications at this time, however, did store the E-kit. During interview on [DATE], at 11:25 a.m., the DON indicated the E-kit is paddle locked and the only way to access the E-kit is by filling out a form titled Emergency Kit/Order Usage Form and faxing it to the pharmacy then phoning the pharmacy and receiving the paddle lock code. The DON confirmed since floor 1 is empty, the E-kit isn't verified as present or locked and secured as there is no way to access the E-kit without pharmacy approving and giving the code. Upon inspection of the E-kit, 2 compartments were present that included upper tray and lower box. Two secure holes to hook the paddle lock through was present with the paddle lock securing only the bottom box. A snap lock was present on the top tray, which was opened and revealed alprazolam (schedule IV) 0.25 mg, clonazepam (schedule IV), lorazepam (schedule IV), pregabalin (class V) and tramadol 50 mg (schedule IV). The five medications are included on the Drug Enforcement Administration, Diversion Control Division list of controlled substances and regulated chemicals. The DON indicated staff must have missed securing the paddle lock to the upper tray only securing the bottom box and confirmed the controlled medications were not double locked. The DON indicated this is a newer process for staff and she would contact the pharmacy to get this remedied . A policy titled Storage of Medication dated [DATE] included: -All controlled drugs are stored under double-lock and key.

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	245184	A. Building B. Wing	10/21/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored. In addition, the facility failed to date-mark opened containers of food in a kitchen refrigerator and to ensure pans were completely dry before storing. Furthermore, the facility failed to ensure an adequately trained dietary supervisor oversaw and supervised all aspects of dietary services and ensured dietary cooks and aides received comprehensive training upon hire and on-going. This had the potential to affect all 65 residents who were served food from the kitchen. In addition, the facility failed to ensure proper infection control practices were followed while preparing food for 7 of 7 residents (R216, R2, R37, R38, R16, R215 and R44) and while assisting residents with their meal (R215) during 1 of 3 meals observed. Findings include: During the initial kitchen observation and interview on [DATE], at 1:45 p.m., observed dietary aide (DA)-C placing dishes through the Ecolab dishmachine. Rinse dial indicated a temperature of 130 degrees Fahrenheit (F) and wash dial was at 158 degrees F. A vial of Ecolab chlorine test paper strips were noted on top of the dish machine. The cap was off the vial, the vial was dusty and the paper label on the vial was faded to gray. The strips expired on [DATE]. DA-C did not know if the dish machine sanitized dishes with hot water or chemical. During an interview and observation on [DATE], at 1:59 p.m., while standing in the dishmachine room, cook (C)-C stated he did not know if the dish machine sanitized with hot water or chemical. C-C provided a clipboard with a form titled Dish Machine Log for [DATE]. The log had 13 columns for date, wash and rinse temperatures, ppm (parts per million) and staff initials for each meal service of breakfast, lunch and dinner. The logs for October and September were reviewed and noted that all of the readings were basically the same, three times a day for two months. C-C stated he did not write on this log -- another cook and the manager did. C-C pointed to the bottom of the log which indicated temperature and ppm standards of: High temp wash 150 - 160 F. High temp rinse 180 F. Chemical sanitizing (low temp): Wash ,d+[DATE] F. Rinse ,d+[DATE] F. Manufacturer recommended PPM: _____ (no number was written in this blank). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Standing in front of the dish machine, C-C explained the temperature readings on the dials. When ask how the ppm reading was obtained, C-C stated he didn't know how to measure that. The facility policy was requested, and C-C presented a policy titled Warewashing, revised date of ,d+[DATE], which indicated the dining services staff would be knowledgeable in the proper technique for processing dirty dishware, but it did not provide guidance on how to measure ppm for chemical sanitization of dishware. During a telephone interview on [DATE], at 2:47 p.m., the Ecolab representative (ER)-G stated the facility used chemical to sanitize dishes in their dish machine. During an interview and observation on [DATE], at 2:50 p.m., with C-C, multiple jelly roll pans were stacked one on top of another, upside down. C-C was asked to pick up a few of the top pans and the top two were still wet on the inside surface. Three multi-tiered wire carts that held pans and other kitchenware, did not have a solid bottom shelf. Multiple plastic cutting boards were observed stacked vertically, one against the other. During an interview and observation on [DATE], at 12:08 p.m., (C)-B stated chemical was used in the dish machine to sanitize dishes. While standing in front of the dish machine, C-B was asked how ppm of the chemical sanitizing solution was measured, and he replied they used the test strips that were on top of the dish machine. C-B admitted it did not look like the test strips had been used in a while and verified they had an expiration date of [DATE]. C-B then admitted he did not know how to test ppm, even though he admitted to writing 100 ppm and initialing the dish machine log on multiple days in October. During an interview and observation on [DATE], at 12:48 p.m. dietary manager (DM)-A stated chemical was used in the dish machine to sanitize dishes. When asked how the ppm of the chemical sanitizing solution was determined, DM-A stated with strips. DM-A then admitted she did not know how to test ppm and admitted she wrote 100 ppm on the log and initialed it, but didn't actually test the ppm. Together viewed the Ecolab chlorine test paper strips on top of the dish machine and DM-A verified they had expired on [DATE]. DM-A went to her office and took a padded mailing envelope out of a desk drawer and displayed testing strips, including Ecolab chlorine test paper strips, adding she was aware of these, but did not know what they were for. DM-A stated she would contact Ecolab for training. During an interview and observation on [DATE], at 1:40 p.m., the administrator was brought to the kitchen and explained staff did not know how to do required testing to measure chemical sanitation and that staff had been documenting ppm on the dish machine log without actually testing it. The administrator stated the kitchen staff were contracted workers and have had a lot of turn over, and the current staff had not received adequate training. The administrator stated he would contact Ecolab to do staff training as soon as possible. During an interview and observation [DATE], at 2:02 p.m., with C-B in the walk-in refrigerator, observed a large white pail of Papettis brand table-ready, peeled hard boiled eggs; 25 pounds in liquid. The pail had been opened, but had no date-opened marking. C-B stated they were good for seven days after opening and thought the pail was opened on [DATE]. Other foods without date-opened markings included cooked macaroni in a plastic container with cover and ham slices in a plastic container with cover. C-B removed the macaroni and ham from the refrigerator, stating they should have been marked when placed in the refrigerator and would discard them. (continued on next page)

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	245184	A. Building B. Wing	10/21/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE], at 2:11 p.m., C-B stated the hard boiled eggs were good until the manufacturer date of ,d+[DATE]. At 2:21 p.m., with DM-A and C-B, C-B stated he called his boss and was told the eggs were good for seven days and since they could not confirm the date opened, would discard them. During an interview on [DATE], at 10:12 a.m., DM-A stated she spoke to her district manager on the phone and received instructions on how to test ppm on the dish machine sanitization solution and would be training the rest of the kitchen staff. DM-A explained that the district manager told her to dip an (unexpired) Ecolab chlorine test paper into water that was on dishes that had just come through the dish machine. DM-A stated she had done that and recorded 50 ppm on the dish machine log. When asked what the required ppm was, DM-A stated she did not know. Requested DM-A to run a test load and measure the ppm with the Ecolab chorine test strips. When doing so, the sanitizing solution failed, testing at 10 ppm, verified by DM-A. During an interview on [DATE], at 11:32 a.m., the administrator was informed when DM-A measured the ppm of the sanitizing solution in the dish machine, it failed. The administrator stated he would contact Ecolab again and have kitchen staff start using disposable dishware for meal service in the meantime. During a telephone interview on [DATE], at 8:40 a.m., registered dietician (RD)-H stated she worked part-time on Mondays and as needed remotely, for the dietary contracted service like the rest of the dietary workers. Has ServSafe certification. RD-H stated she did not really provide guidance to the dietary staff, but was there for questions. RD-H stated she did monthly sanitation audits and had been focusing on hand hygiene within the kitchen. RD-H stated she learned about dish machine temperatures as part of her education, but did not know proper temperatures for heat or ppm for chemical sanitization. RD-H stated she looked at the dish machine log to make sure staff were recording the information, but would not be able to identify incorrect water temperatures or ppm. During a telephone interview on [DATE], at 12:31 p.m., the district manager for the contracted service (DMCS)-I stated she was also a registered dietician. DMCS-I stated DM-A started on [DATE], adding that DM-A was initially hired as a manager-in-training to go through their training program. DMCS-I stated that the prior manager had not worked out so DM-A had been put into the manager position, adding she is a go-[NAME]. DMCS-I stated she was onsite initially to train DM-A, and when she needed help with the dish machine this week, DM-A called her and she walked her through it. Furthermore, DMCS-I stated she oversaw this account and DM-A's training was through her, adding it's been Training on the fly - she calls and asks questions; I've been there as much as I can. DMCS-I was informed DM-A and C-B had admitted they did not know how to measure ppm and and did not actually check ppm on the dish machine, yet they filled in the ppm on the log. DMCS-I stated the expectation was for staff to be properly trained on monitoring and measuring temperatures and ppm on the dish machine, and not to falsify information if they didn't know how to do something. DMCS-I could not recall specially if she trained DM-A on this, nor could she confirm if either DM-A or C-B had this training online. DMCS-I stated there was no orientation record or checklist, but would provide online training records. Review of online training records for DM-A, C-B and C-C indicated completion of the following modules: 1. Cleaning and Sanitizing: content included using a cleaning solution in a bucket to clean surfaces. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Pots and Warewashing: content included a chemical sanitizing agent would be mixed with the final rinse water and sprayed onto to the Ware during the final rinse cycle. The temperature of the water and sanitizer mixture must be maintained at a temperature no lower than 120. Defer to the manufacturers guidelines and state/federal regulations. The training did not include guidance for monitoring and measuring ppm. This training also included a section on wet nesting which occurred when clean pans, plates, cups, and bowls were stacked together without completely drying first. This action could result in a breeding ground for bacteria, even on clean items. 3. Receiving and Storage of Food: content included receiving and storing refrigerator foods. 4. Labeling and Dating: content included labeling and dating leftovers with the dated prepared and the use-by date. During an interview on [DATE], at 3:58 p.m., reviewed kitchen findings with the administrator, including lack of knowledge to monitor and measure sanitization solution of dish machine, wet pans, and food not labeled when opened. The administrator stated he expected the staff would have had the required training for these things, but they have had so much turnover and it had been difficult to secure trained staff. The administrator stated with a contracted service, they had to work with whomever the service hired. In addition, the administrator stated that based on interactions with DM-A thus far, he believed she would be a good manager as she is responsive and is on top of things, and just needed more time and training. Facility policy titled Warewashing, with revised dated of ,d+[DATE], indicated all dishware would be cleaned and sanitized after each use. Staff would be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. All dish machine water temperatures would be maintained in accordance with the manufacturer recommendations for high or low temperature machines. Temperature and/or sanitization concentration logs would be completed as appropriate, and that all dishware would be air dried and properly stored. Facility policy titled Receiving, with revised dated of ,d+[DATE], indicated safe food storage procedures for time and temperature control would be practiced in the transport, delivery, and subsequent storage of all food items. All food items would be labeled and dated either through manufacturer packaging or staff notation. Facility policy titled Food Storage: Cold Foods, with revised dated of ,d+[DATE], indicated all food would be stored in wrapped or covered containers, labeled and dated. 31767 Infection Control Practices During observation on [DATE], at 8:13 a.m. transport assistant (TA) was observed seated at table with R30 encouraging her to eat. TA picked up a piece of bacon with her bare hands and handed it to the resident then continued to feed R30 oatmeal with a spoon. At 8:15 a.m., TA again was observed picking up apiece of bacon with her bare hands and handing it to R30 to eat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE], at 8:29 a.m. TA washed hands then sat down at another table in the dining room to assist R215. TA was observed to cut up R215's bacon using bare hands to secure the bacon while trying to cut it in bite-size pieces. When interviewed on [DATE], at 9:26 a.m. TA confirmed she should not have been touching the bacon with her bare hands when assisting residents with eating. On [DATE], at 12:48 p.m. NA-E was observed delivering a Styrofoam container to R38 with the resident's lunch. The meal included two soft shell tacos. NA-E picked up one of R38's taco's with her bare hands and demonstrated to R38 how to pick it up and eat it. NA-E then placed the taco back into the container, washed her hands, then continued to pass out meals to other residents. 40614 During observation on [DATE], at 12:44 p.m., nursing assistant (NA)-E served R216 tacos in a Styrofoam container with ground beef, tomatoes, lettuce all in separate serving cups and soft taco shell on bottom of container. NA-E used fork to put ingredients on the taco shell, then added sour cream. NA-E then picked up the soft taco shell and molded them closed with her bare hands and demonstrated for the resident how to pick it up. Did not observe hand hygiene after touching Styrofoam container and touching food, or between residents. The process was repeated for R2, R37 and R16. During observation on [DATE], at 1:16 p.m., NA-E opened R215's Styrofoam container with soft shell taco shell, ground beef, tomatoes, lettuce in separate serving cups. NA-E used a fork to put ingredients on taco shell, then added sour cream in an individual packet and spread with the fork. NA-E picked up taco shell with her bare hands molding it closed and offered R215 a bite of the taco. NA-E continued to use bare hands on taco to assist R215 to take 3 bites of taco. NA-E then set down taco, cut taco in half and using both hands offered another bite. NA-E then took R215's hands and put them on the taco shell and R215 attempted to take a bite but taco fell apart. NA-E using her bare hands took the taco from R215 and gave her 3 more bites and removed Styrofoam container picking up the banana bread with her hands and sitting it on a napkin in front of R15. During observation on [DATE], at 1:31 p.m., NA-E sat down by R44, opened Styrofoam container then touched the top of the straw with her bare hands and offered a drink of juice. R44 took a drink of the juice. During interview on [DATE], at 4:10 p.m., the director of nursing (DON) confirmed staff should never touch food directly with their hands whether washed or unwashed unless they have gloves on or are using a pair of silverware or tongs. A facility policy titled Dining Services Department Policy and Procedure Manual last revised ,d+[DATE], did include infection control considerations but only included the nursing staff shall be responsible for verifying meal accuracy and delivery of meals to residents/patients.

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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** 42073 Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including masks, were worn correctly by dietary staff, and failed to ensure hand hygiene was performed by staff when delivering meal trays. In addition the facility failed to ensure hand sanitizer was available for hand hygiene. In addition, the facility failed to ensure room cleanliness when maggots were discovered in the shoe and on the foot of 1 of 1 resident (R4), reviewed for wound care. Furthermore, the facility failed to ensure proper infection control practices during a dressing change for 1 of 1 resident (R4) reviewed for wound care. In addition, the facility failed to consistently provide the necessary care and services in the management of tube feedings to prevent infection for 2 of 2 residents (R27, R51) reviewed for tube feedings. The deficient practices had the potential to affect all 65 residents who resided in the facility. Findings include: R4 R4's facesheet printed 10/21/21, included diagnoses of cellulitis of leg (skin infection), lymphedema (swelling of leg due to build-up of lymph fluid), venous insufficiency (failure of veins to adequately circulate blood), morbid obesity, diabetes, paranoid personality disorder and mild cognitive impairment. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R4 declined to complete a brief interview for mental status, did not exhibit any behaviors - including rejection of care, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R4 did not walk and required extensive assistance of two staff for bed mobility, transfers and toileting. R4 was frequently incontinent of urine and always incontinent of stool. R4 had an infection of her foot requiring a dressing. Physician orders included: 3/23/21: Wash feet with soap and water every evening. 10/15/21: Right lower extremity and right dorsum (top) foot and right lower abdominal panniculus (a sheet of fat tissue in the lower abdominal area): acetic acid soaks two times a day for 7 days. R4's plan of care dated 1/21/20, indicated R4 had actual skin integrity break related to mobility and incontinence at that time, and a goal indicated skin would show signs of progressive healing without signs of infection. The care plan did not identify current skin infection and treatments ordered to enhance healing and reduce infection. (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 and observation on 10/18/21, at 3:51 p.m., R4 who in a hospital gown, and was sitting on the side of her bed, facing the door with her legs over the side of the bed. R4's bare feet rested directly on the tile floor. Tile floor was dull and looked dirty with dark smudges. Multiple surfaces in the room were covered with R4's personal items and some facility supplies (boxes of gloves), on three overbed tables, a small bedside dresser, the window sill, and open storage next to the window. The only surface not covered was half of the overbed table closest to the bed. On the floor next to the bed, papers and envelopes were scattered about. On the commode were balled up elastic leg wraps and some clean towels. Black shoes were noted under an overbed table. A white rectangular plastic basin, upside down, was noted on the floor between bed and wall. During an interview on 10/19/21, at 2:56 p.m., when asked if staff washed her feet every day, R4 stated her feet had been soaked maybe twice since arriving to the facility a year and a half ago. No soaking supplies observed in room except for the white rectangular plastic basin, upside down on the floor. A progress noted dated 10/2/2021, at 12:02 a.m. indicated, During bedtime cares we removed her shoes on her right foot had maggots crawling out of her shoe and between her toes. The bottom of her right heel is very dry but not open. Her right leg and foot have ongoing edema and redness. Bilateral feet soaked, bed bath given, shoes cleaned and sprayed. Will continue to monitor. Advised resident to leave her shoes off when sleeping to let her feet air out. During an interview on 10/20/21, at 8:17 a.m., when asked about maggots on R4's feet, licensed practice nurse (LPN)-A stated she was unaware of that. Informed it was in the progress notes dated 10/2/21; then she read, stating that was something that should have been communicated to her. During an interview on 10/20/21, at 8:42 a.m., nursing assistant (NA)-A stated she was aware of the maggots, adding R4 was wearing her shoes and wouldn't let us change them .almost have to fight her to do it, and we can't do that. During an interview on 10/20/21, 12:47 p.m., noted the surface of the overbed table closest to the bed -- the one R4 used most often, was soiled. Half of the surface was cluttered with R4's personal items, including multiple condiments. The remaining surface was visibly soiled as evidenced by swirls of light grayish material. The metal coated bed rails were heavily soiled with finger prints and smudges. In addition, the floor was dirty with dark smudges. The housekeeping supervisor (HS)-A was brought in to look at R4's room and he validated that the surfaces needed to be cleaned and that they must have been overlooked by the other housekeeper. HS-A added housekeeping didn't like to disturb residents, but rooms should still be cleaned. HS-A stated he cleaned the floor the day prior, but only the areas not covered by pieces of equipment or furniture. HS-A admitted housekeeping did not routinely pick up or move items in resident rooms to clean under them. During an interview on 10/20/21, 1:12 p.m., housekeeper (H)-B admitted he didn't want to move things in R4's room when he cleaned, and stated he would go back and clean the bedrails and the surfaces that didn't have R4's personal items on them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled Dressing Change, Clean, dated 6/2017, indicated the purpose was to protect the wound, prevent infection and promote healing. The procedural steps indicated to create a clean field with paper towels or towelette drape. Documentation included to date and time the dressing change, document the wound size, site, depth, color and drainage, and progress of healing. Facility policy titled Cleaning Resident Rooms, dated 6/1/2017, indicated to carefully removed items on top of furniture to dust and then replace items exactly as they were. Clean top of window sills. Using all-purpose cleaner, clean countertops and front of cabinets. Sweep or vacuum the floor of the room that is not obstructed by furniture. Move small pieces of furniture to vacuum under or around it. Use spot remover for carpets. Note: this facility did not have carpet in resident rooms. Masks --During an observation on 10/18, at 6:08 p.m., Covid 19 unvaccinated dietary aide (DA)-B with mask below nose, dropped off tray cart on 2nd floor, west wing. Standing within several feet of staff, informed them the cart was there. --During an observation on 10/19, at 12:11 p.m., Covid 19 vaccinated (DA)-A wore mask below her nose as she worked along side Covid 19 unvaccinated dietary manager (DM)-A dishing food from steam table. --During an interview and observation on 10/20, at 7:48 a.m., Covid 19 unvaccinated (C)-B had no mask on. Mask was observed in his breast pocket. C-B stated he didn't wear a mask in the kitchen; can't breathe and it would be a hazard. --During an interview on 10/19, at 1:55 p.m., the director of nursing (DON) who was also the infection control nurse stated dietary workers were contracted staff, but when they were in the building, should follow our policy and wear a mask. Reviewed facility policy: Pandemic Preparedness and Response dated 3/23/21, which indicated all healthcare personnel would wear well-filling facemasks that always cover the mouth and nose where they might encounter residents or co-workers. The DON stated she would talk to the dietary staff and the manager about wearing facemasks properly. --During an interview on 10/19, at 2:02 p.m., C-B had mask on and stated I called my boss, we need to wear a mask. I didn't know that. I sent a message to everyone in kitchen; we didn't know that. --During an observation on 10/21, at 10:10 a.m., C-B had no mask on as he was walking about the kitchen with other staff members present. --During an observation on 10/21, at 10:21 a.m., in the entrance to the kitchen near the dishwashing room, DA-A and C-B were standing talking, about a foot away from each other, both with masks below their nose. --During an observation on 10/21, at 12:02 p.m., DA-A and C-C were standing shoulder to shoulder at steam table plating lunch, both with masks below their nose. Hand Hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R51's admission record, printed on 10/20/21 included diagnosis of multiple sclerosis, type 2 diabetes mellitus, and adult failure to thrive. R51's significant change Minimum Data Set (MDS) assessment dated [DATE] indicated moderate cognitive impingement, a percutaneous endoscopic gastrostomy (PEG), (a surgery to place a feeding tube) tube and totally dependant on staff staff for feeding assistance with 51% or more of feeding by tube feeding. R51's plan of care dated 9/24/21, indicated R51 was at risk for nutritional status change related to dysphagia (swallowing difficulty) and need for tube feeding. Interventions included Isosource 1.5 calories given three times a day with 2 cans during first feeding and one can at subsequent feedings. During observation on 10/18/21, at 6:03 p.m., tube feeding (TF) bag with approximately 500 cc of formula was hanging on a pole with purple tubing end, (end that connects to PEG tube) uncovered and unlabeled. Licensed practical nurse (LPN)-C indicated the TF system comes prefilled with the solution and the tubing already connected to the bag and is changed daily by the night shift. LPN-B proceeded to aspirate residual (checking amount in the stomach, which indicates how rapidly stomach is emptying), which was greater than 100 cc. LPN-C indicated she would hook up TF later. During observation on 10/19/21, at 2:45 p.m., TF bag with approximately 600 cc of formula remaining was hanging on a pole with tubing end uncovered with no date on bag or tubing of when opened. During observation on 10/20/21, at 8:21 a.m., R51's TF was connected to R51 and running with bag hanging on pole and approximately 800 cc in the bag, with no date present on bag or tubing for when opened. During observation on 10/20/21, at 10:37 a.m., R51 was sleeping in bed. TF was unhooked from R51 with no end on tubing. Approximately 600 cc remains in the bag. During observation on 10/21/21, at 8:34 a.m., LPN-A prepared medications for administration through PEG tube. A new syringe was brought into the room by LPN-A, but did not fit end of PEG tube. LPN-A then picked up a syringe from bedside table that was undated and out of original package and used syringe to administer medications via the PEG tube. LPN-A id not cleanse syringe or PEG tube sites prior to connection. LPN-A found R51's tube feeding (TF) bag was empty. LPN-A hung a new prefilled bag of Isosource 1.5 calories, labeled it with open date and administered via pump. LPN-A indicated all tube feeding bags and tubings should be labeled and are changed on evening shift. LPN-A further stated she normally would not use an undated, used syringe, but didn't have time to go get another syringe. During observation and interview on 10/20/21, at 9:05 a.m., LPN-A indicated the tubing should be capped in between feedings which are three times a day. LPN-A confirmed one bag is used daily and usually hung by night shift, which is discarded by evening shift after the 6:00 p.m. feeding. During observation on 10/21/21, at 2:15 p.m., R51 was not present in her room and administration pump was beeping. The TF bag with approximately 1000 cc of formula remaining in bag and tubing were hanging on the pole. The end of the tubing was uncovered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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	R27 R27's Admission Record printed 10/21/21, indicated R27 was admitted [DATE], diagnoses included dysphasia (difficulty in swallowing food or liquid), sepsis (infection), acute and chronic respiratory failure, and moderate protein calorie malnutrition. R27's 5 day scheduled Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, activities of daily living (ADL) required two person physical assist, and nutrition approach was a feeding tube with 51% or more of feeding by tube feeding. R27's order summary report printed 10/21/21, indicated enteral feed order three times a day for Replete intermittent gravity, 6 cans per day, change tube feeding set and bag daily in the morning. On 10/18/21, at 6:00 p.m. R27 was observed in his room, laying on his bed. R27, and a metal stand with a empty and unlabeled tube feeding (TF) bag was hanging on the pole with clear unlabeled tubing with an uncapped purple end. On 10/21/21, at 9:00 a.m. R27 was observed in his room and with metal pole and a bag hung with tubing; a purple tip was visible and uncapped at the end of the tube. LPN-A stated she was not aware a cap needed to cover the end of the tube feeding attachment when disconnected from the resident and not in use. R27's bedside table had a clear plastic piece and resembeled a cap for the end of a tube feeding . During interview on 10/21/21, at 11:12 a.m., the director of nursing (DON) confirmed tube feeding bag need to be labeled with date and time opened and end of tubing capped after each use and discarded if no date present. The DON also confirmed LPN-A should not have used a syringe that was open and unlabeled. A policy and procedure titled Enteral Nutritional Therapy (Tube Feeding) dated June 2017 was reviewed, but did not address, labeling of opened tubing, syringes or formula or ensuring end of tubing remains covered.