STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 Walsh Street Crookston, MN 56716

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS) was completed as directed for 2 of 2 residents (R64, R296) reviewed for significant change in status. Findings include: R64's quarterly Minimum Data Set (MDS) dated [DATE], identified R64 had moderate cognitive impairment and required supervision or touch assistance with toileting hygiene, bed mobility, transfers and ambulation. Diagnoses included dementia, Alzheimer's, repeated falls, heart disease and diabetes. R64's discharge assessment MDS dated [DATE], identified R64 required substantial to maximum assist with toileting hygiene, and bed mobility, partial to moderate assist with transfers and ambulation was not attempted. R64's quarterly MDS dated [DATE], identified R54 required substantial to maximum assist with toileting hygiene and bed mobility and was dependent on staff with transfers. R64 was unable to ambulate. R64's quarterly MDS dated [DATE], identified R64 was dependent with toileting hygiene, required substantial to maximum assist with bed mobility and was dependent on staff with transfers. R64 was unable to ambulate. When interviewed on [DATE], at 10:23 a.m. registered nurse (RN)-C stated she completed R64's MDS when it was due. Licensed practical nurse (LPN)-C notified her when a resident was due for an MDS and also tracked when significant changes needed to be done. RN-C did not track that sort of thing and just followed the list she was provided. During interview on [DATE], at 11:22 a.m. LPN-C stated whenever new dependencies were coded a significant change MDS needed to be completed. R64 should have had one done. Therapy had been working with him and so she had not recognized that R64 was no longer ambulating. It was important to complete significant change MDS when changes occur with residents so there was further discussion regarding that resident's care, the care plan was brought up to date and staff were providing care accordingly. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE], at 2:34 p.m. the director of nursing stated she would have expected a significant change MDS be completed for R64 when he was newly coded dependent with transfers and non ambulatory. It was important to complete the significant change MDS so the resident's care plan was update and accurate and staff were providing the care the resident needed. R296's quarterly MDS dated [DATE], identified R296 had moderate cognitive impairment and required substantial or maximum assistance with toileting hygiene, dressing, bed mobility and transfers. R296 required partial to moderate assist with ambulation. Diagnoses included dementia, osteoarthritis, anxiety, muscle weakness, kidney disease, heart disease and diabetes. R296's care plan problem with start date [DATE], identified a problem with mobility due to R296 was limited with bed mobility, transfers and toileting with goal to receive extensive assistance of one to two people to steady for transfers and toileting and two people to boost up in bed. The newly identified care plan problem with mobility on [DATE], indicated the facility was aware of the significant decline with R296's mobility, however, the medical record lacked evidence a significant change assessment had been initiated. R296's Physical Therapy Discharge Summary dated [DATE], identified R296 was discharged due to had reached her highest practical level. R296's had participated with therapeutic activities for wheelchair mobility and transfers. Refused to exercise or walk due to back pain with diagnosis of fracture at L1. R296's progress notes [DATE] through [DATE], identified the following: On [DATE], R296 had experienced a fall that resulted in a lumbar fracture. On [DATE], physical therapy had evaluated R296 and order received for therapy three times per week. On [DATE], R296 was admitted to hospice services. A death in facility MDS tracking record dated [DATE], identified R296 expired at the facility under hospice care During interview on [DATE], at 11:13 a.m. registered nurse (RN)-C stated she was responsible for completing R296's MDS but was not aware a significant change MDS was needed. LPN-C notified her when MDS were due and if significant changes were needed. When interviewed on [DATE], at 11:15 a.m. LPN-C stated she was aware when residents required a significant change at the facility daily interdisciplinary team (IDT) meetings. LPN-C identified a hospice admission would be an automatic reason to complete a significant change MDS, and she had not schedule an MDS assessment. There should have been a significant change MDS assessment completed for R296 with her decline in condition as well as her hospice admission. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE], at 2:24 p.m. the DON stated she would have expected a significant change MDS assessment to have been completed for R296 related to her decline in mobility as well as her hospice admission. It was important to complete the significant change MDS assessments to identify and capture when a resident has a change for the good or the bad and ensure the staff were providing the care to the resident to meet their needs. The facility's undated Comprehensive Assessments and Care Planning policy, identified the RN coordinator with input from the IDT would determine if it was necessary to complete a significant change MDS. A significant change assessment would be appropriate if there were a consistent pattern of changes with two or more areas of decline or improvement or one area that required extensive care plan revision.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure a gait belt was used when transferring/walking 1 of 5 residents (R296) reviewed for falls. This resulted in actual harm for R296 who fell while being transferring and received a lumbar fracture. The facility implemented corrective action prior to the investigation so the deficient practice was issued at past non-compliance. Findings include: R296's quarterly Minimum Data Set (MDS) dated [DATE], identified R296 had moderate cognitive impairment, used a wheelchair or walker with mobility and required maximum assistance with toilet hygiene, transfers and ambulation. Diagnoses included Alzheimer's disease and osteoarthritis. R296's care plan dated [DATE], identified R296 was at risk for falls. Interventions included to follow standard fall prevention policy and use walker or wheelchair. Approaches included to ambulate with a full wheeled walker, contact guard assist of one staff with gait belt and wheelchair to follow. R296 was on a scheduled toileting plan and approaches included to offer toileting assistance every morning and bedtime with cares and after the noon meal. Staff were instructed to provide incontinence care after each incontinent episode. R296's Emergency Department Provider Notes dated [DATE], identified R296 had a syncopal (fainting) episode while on the toilet and may have hit her head. R296 was taking the medication Eliquis (a blood thinner used to prevent clots) and R296 complained of pain all over. R296 was medicated for pain and returned to the facility with no change in orders. A Nursing Home Incident Report Summary dated [DATE], identified R296 had a witnessed fall on [DATE], at 12:00 p.m. when staff was assisting R296 in the common bathroom by the dining room. R296 was assisted up from the toilet for staff to assist her with peri care and adjust her clothing. R296 fell on the floor and was unresponsive for approximately ten minutes. R296 was sent to the emergency room (ER) for evaluation and returned to the facility the same day. The following day, R296 was sent to the ER a second time due to reports of continued significant pain. R296 returned to the facility the same afternoon with a diagnoses of lumbar compression fracture. R296's Riverview Health Transfer Note dated [DATE], identified R296 had a new diagnosis of lumbar compression fracture and muscle spasms. The invetigative report submitted to the state agency dated [DATE], identfied nursing assistant (NA)-C stated she was assisting R296 in the bathroom next to the dining room on the memory care unit. R296 stood up from the toilet without problems and NA-C was able to provide peri cares and pull up R296's pants without problem. Then R296 fell forward and hit her head on the safety bar while falling forward. Staff were educated to remain within hands reach at all times and to utilize a gait belt and all staff will participate in the training. R296's progress note(s) identified the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE], A fax was sent to R296's primary provider to notify R296 had fell to the floor, hitting her head, when staff were assisting her with toileting hygiene. R296 left the facility by emergency medical services to be evaluated at the ER. - [DATE]. R296 continued to have extreme pain with movement and blood pressure was elevated. R296 was sent to the ER to be evaluated. R296 returned with diagnosis of lumbar fracture and pain medication was ordered. - [DATE], R296 had pain and discomfort with movement and repositioning. Grimacing and yelling out in pain. Did receive as needed pain medication which was effective for approximately two hours. R296 did not get out of bed and refused both breakfast and lunch. - [DATE], A physical therapy evaluation was completed, and therapy ordered three times per week. - [DATE], R296 was in bed until mealtime and then did not want to sit for very long. Refused breakfast or to get up for her noon meal. Stated she was in a lot of pain and would holler out in distress with movement of any kind. - [DATE], R296 had been in bed most of shift. R296 did go out for supper but refused to eat anything. R296 took some of her scheduled medications along with as needed medication for back pain which was effective. - [DATE], R296 was evaluated for hospice and admitted to hospice services with primary diagnosis of Alzheimer's disease. - [DATE], R296 passed away with her family at her bed side. When interviewed on [DATE], at 6:30 p.m. family member (FM)-D stated R296 had been on hospice at the facility and expired. A staff member had taken her to the bathroom, and she fell , hitting her head, and had gone downhill after her fall. During interview on [DATE], at 9:39 a.m. nursing assistant (NA)-A stated she always used a gait belt when walking or transferring patients. She remembered R296 transferred and ambulated with assist but would take off on her own sometimes. When interviewed on [DATE], at 9:53 a.m. NA-B stated R296 was assist of one with toileting and she had never noticed her trying to go to the bathroom on her own. NA-B always used a gait belt with transfers and when assisting anyone to ambulate. During interview on [DATE], at 10:00 a.m. registered nurse (RN)-C stated she was working when R296 fell . RN-C heard R296 fall and rushed into the bathroom to see what happened. RN-C found NA-C standing frozen and R296 was lying flat on her back with her head close to the door that was opposite of the toilet, her body at an angle with her feet between the toilet and sink. NA-C was standing between the toilet and R296. R296 was unresponsive and did not have a gait belt on. RN-C called for help and 911 was called. When R296 returned from the ER, no imaging had been done on her back. The following day RN-C sent her back in due to extreme pain and then they found the fracture in her back, which was a new fracture. RN-C thought NA-C could possibly have caught R296 as she fell backward and possibly slowed or prevented her fall if she had been using a gait belt with the transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When interviewed on [DATE], at 2:24 p.m. the director of nursing (DON) stated it was her understanding that a gait belt had not been in use when assisting R296 with toileting just prior to her fall and R296 had a syncope episode and fell , and a gait belt was not in use. Staff were expected to use a gait belt whenever there was hands on assist with any transfer or ambulation. After the investigation of the fall staff, including the NA involved were educated on signs and symptoms of syncope and interventions to use as well as use of a gait belt with transfer and ambulation. Observation of other residents transferring and ambulating were observed during the course of the survey and all staff utilized the transfer belt as appropriate. Staff interviews identified staff knew when to use a gait belt. The facility policy Transfer Belt dated [DATE], identified staff were to review the resident's care plan or assignment sheet for the resident's transfer and ambulation status. Fasten the transfer belt around the resident's waist, allow the resident to get and maintain balance after assisting to stand and ambulate resident with grasp on transfer belt at the resident's back, until assisting resident back to a sitting position.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41575 Based on interview and document review, the facility failed to ensure the provider documented a thorough rationale for continued use of medications for 1 of 5 residents (R64) reviewed for unnecessary medication use. Findings include: R64's undated Active Orders report identified R64 had current physician orders for sertraline (an antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazadone (an antidepressant medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinued date 3/26/24. R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation. R64's medical record was reviewed and lacked any other documentation or dictation from R64s provider regarding the justification of continued use of the antidepressant medications. When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was brought up to them as it was recognized as a problem for the facility. When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were. During telephone interview on 7/31/24 at 3:00 p.m., CP-E stated he had made recommendations to taper R64's antidepressant medications in August 2023. CP-E usually brings the issue up every few months when a provider declines a recommendation. R64 had experienced a number of falls and medication changes in March 2024 and so by the time he was going to readdress the issue with the provider again, the antidepressant medications were the least of his worries. CP-E verified the time between his recommendations in August until R64 had change in condition was seven months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 3:27 p.m., a telephone interview was attempted with the medical director (MD)-F with no answer. A message was left for return call. On 8/1/24 at 3:15 p.m., MD-F returned call. MD-F stated he was aware of the issues with some of the primary providers failing to respond adequately to pharmacist recommendations. It had been discussed during the last quality assurance performance improvement (QAPI) meeting and the pharmacist had provided a list of the providers who frequently did not address medications recommendations. MD-F was planning to set up a meeting with the providers to find out what the issues were and why they were not responding appropriately to the pharmacist recommendations.

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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** 41575 Based on observation, interview and document review, the facility failed to ensure there was a process to ensure a gradual dose reduction (GDR) or adequate medical justification documented for psychotopic medications was implemented for for 1 of 5 residents (R64) reviewed for unnecessary medications. Findings include: R64's quarterly Minimum Data Set (MDS) dated [DATE], identified R64 had moderate cognitive impairment and R64's mood interview did not identify syptoms of depression. R64 received antidepressant medication on a daily basis. R64's undated Active Orders report identified R64 had current physician orders for sertraline (an antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazodone (an antidepressant medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinue date 3/26/24. R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation. R64's medical record was reviewed and lacked any other documentation or dictation from R64s provider regarding the justification of continued use of the antidepressant medications. On 7/30/24, at 9:42 a.m. R64 was lying in bed watching television. R64 was fully dressed and groomed and stated he had already been up for his breakfast and now returned to bed. R64 was pleasant and smiling. When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was brought up to them as it was recognized as a problem for the facility. RN-C did not identfy what the nursing process was to address GDR's or a rationale from the provider. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were. DON did not identfy what the nursing process was to address GDR's or a rationale from the provider outside of the CP-E's recommendations. A policy for psychotropic medication dose reduction was requested, however, none was received.

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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** 42075 Based on observation, interview and document review the facility failed to ensure medications were safely and securely stored for 1 of 1 resident (R70) reviewed for medication storage. Findings include: R70's quarterly Minimum Data Set (MDS) dated [DATE], identified R70 had moderate cognition and required assistance with activities of daily living (ADL)'s. R70's diagnoses included stage IV pressure ulcers of the sacral region, right hip and left hip, and type 2 diabetes. During observation on 7/30/24 at 4:18 p.m., Vashe (Dakin's) solution wound cleanser and Nystatin powder (an antifungal medication used to treat infections) were sitting on the dresser in R70's room. R70's undated physicians order report included Dakin's 0.125% wound cleansing solution. The report failed to include orders for Nystatin powder. R70's medical record lacked assessment and care plan to have medications stored at the bedside. During interview on 7/30/24 at 4:18 p.m., R70 stated the medications were always left on the dresser in her room and the nurses use the medications for her dressing change. R70 was uncertain of the medication's names. On 7/31/24 at 10:05 a.m., licensed practical nurse (LPN)-A stated R70 had a current order for wound cleanser solution, however, there were no current orders for Nystatin powder. Further, LPN-A stated the medications should not be left in R70's room in an unsecured area. On 7/31/24 at 10:32 a.m., registered nurse (RN)-A stated she was aware of the unsecured medications left in R70's room. RN-A stated medications left in a resident's room should be in a secured and safe place that is out of reach to residents. The Self-Administration of Medications policy dated 2/19, identified medications self-administered medications must be stored in a safe and secure place, which is not accessible y other residents. If safe storage is not possible, the medications will be stored on a central medication cart or in the medication room.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to provide timely INR (a standardized measurement of how long it takes the blood to clot) level results for a resident on warfarin sodium (a blood thinning medication) for 1 of 2 resident (R52) reviewed who were taking warfarin. Findings include: R52's quarterly Minimum Data Set (MDS) dated [DATE], identified R52 had diagnoses that included end stage renal disease, heart failure and vascular disease. R52 used anticoagulant medication (blood thinner). R52's care plan revised 6/27/24, identified R52 had a pacemaker (a small device that's placed (implanted) in your chest to help control your heartbeat). Staff were directed to observe R52 for complaints of dizziness, arrhythmia (irregular heartbeat), bradycardia (slow heartbeat), tachycardia (fast heartbeat), chest pain, syncope, and dyspnea (shortness of breath). R52 was on dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) related to end stage renal disease. Staff were directed to administer medications as ordered and draw labs per order. Staff were directed to report lab abnormalities promptly. R52's physician orders identified the following: - On 1/26/24, warfarin (a blood thinne that reduces the formation of blood clots. Warfarin is used to treat or prevent blood clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious conditions.) 3 milligrams (mg) by mouth once a day in the evening. - On 7/29/24, INR special instructions: send results to R52's medical provider for paroxysmal atrial fibrilation (the most common type of irregular heartbeat that often causes the heart to beat too quickly. One of the biggest concerns with AFib is the risk of stroke. In fact, people with AFib have about 5 times greater risk of stroke than those who do not have AFib). R52's nursing progress notes identified the following: On 5/29/24 at 12:13 p.m., R52's INR result was 2.1. The results were faxed to R52's medical provider. On 6/10/24 at 11:24 a.m., nursing reviewed R52's clinic documentation for an INR reading of 2.1 on 5/29/24. Per R52's medical provider, recheck INR in one month. On 6/27/24 at 10:34 a.m., R52's INR result was 1.9. The results were faxed to R52's medical provider. On 6/28/24 at 6:59 a.m., per R52's medical provider regarding R52's 6/27/24 INR, recheck in 1 month. No changes (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 1:00 p.m.[Recorded as Late Entry on 7/30/24 at 7:41 a.m.] R52's INR result was 1.5. An email dated 7/30/24 at 7:48 a.m., identified registered nurse (RN)-C scanned and emailed R52's 7/29/24 INR result to R52's medical provider. A response from R52's medical provider office dated 7/30/24 at 5:09 p. m., identified R52's medical provider reviewed R52's INR result. An INR check was ordered for one week with no changes in warfarin dose. R52's Coagulation Facsimile Transmittal dated 7/30/24, identified R52's INR result that day was 1.5. The form did not identify the INR sample had been collected on 7/29/24, what R52's INR goal range was, nor that R52's result was sub-therapeutic. During an interview on 7/31/24 at 9:53 a.m., trained medication aide (TMA)-A stated she did not do anything with obtaining an INR. The nurses took care of all that. When a resident was due to have an INR obtained, the order was on the nurses' treatment sheets. During an interview on 7/31/24 at 10:02 a.m., licensed practical nurse (LPN)-B stated only the unit managers took care of resident INR orders and she did not do anything besides administer the medication. During an interview on 7/31/24 at 10:03 a.m., registered nurse (RN)-B stated when a resident was admitted or started on warfarin, an order was placed into the resident's electronic medical record (EMR). The facility used a PT/INR meter in the facility to collect an INR. Once the result was obtained, it was faxed to either the Coumadin Clinic or the resident's medical provider. The facility used a spreadsheet to track residents' results as well. Staff were expected to receive a response from the medical provider or Coumadin Clinic the same day. If the response was not received and the result out of range, then the nurse was expected to contact either the emergency room or the medical provider on-call. If the INR was in range and the response not received, the nurse may use discretion and contact the medical provider the following day. RN-B stated she was unfamiliar with R52 and was unable to determine what R52's goal range was by R52's EMR. During an interview on 7/31/24 at 10:39 a.m., RN-C stated she just did R52's INR on Monday 7/29/24. R52's INR goal range was 2.0-3.0 because R52 had atrial fibrillation. For R52, the result was always sent to R52's medical provider. RN-C would get the reading then fax the result to the medical provider, but also was able to scan the result and email it for a faster response. When the response was received, RN-C would schedule the next INR and also update the pharmacy if there was a change in medication and would update the warfarin spreadsheet as well. There was a Coagulation Facsimile Transmittal form that could be filled out and faxed as well. The form included resident demographics, the INR result and also included additional information such as the resident's goal range, and changes in condition such as an antibiotic that may influence the medical provider's decisions. RN-C stated she did get a response on Monday 7/29/24, but just forgot to enter it into the EMR. RN-C stated the INR was collected on 7/29/24, as ordered, but faxed to the medical provider on 7/30/24. When RN-C had to call R52's medical provider, it could be difficult. R52's medical provider was hard to reach and even more difficult to get a response from. RN-C received a response from R52's medical provider by email on 7/30/24, at 5:00 p.m. and put in the order for the next INR at that time but did not document in a nursing note. However, RN-C stated she did not attempted to determine why R52's INR was 1.5 such as missed doses and/or diet changes. RN-C stated a subtherapeutic result potentially could place a resident at risk for a blood clot or stroke. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 3:05 p.m., assistant director of nursing (ADON) stated the facility used a PT/INR meter to obtain resident INR results. When the result was obatined it woud be sent to either the Coumadin Clinic or the resident's medical provider, it just depended on the resident. Sometimes, the medical providers were pokey about getting order back to the facility and nursing had to refaxed and/or call for a couple days. Staff were expected to receive a response the same day and should call the medical provider each day until a response was received. If in range, a response was expected within a day or so. However, if the INR result was out of range and/or critical, nursing needed to call the medical provider on-call and get orders. R52's INR result on 1.5 on 7/29/24, should have been addressed by R52's medical provider and, if not, the medical provider on-call should have been contacted. However, the ADON stated she was unsure what the facility policy directed. Anytime an INR was below therapeutic range, the resident was at risk for clots, however, the staff were unable to control how/when the medical providers responded to communications. The ADON was unsure what the unit managers did in terms of investigation into out of range INR results. The ADON stated they had addressed these concerns with the medical director and were trying to set up a meeting to address this concern. During an interview on 7/31/24 at 3:22 p.m., the director of nursing (DON) stated INR results were expected to be provided to the medical provider the same day they were collected whether by fax, email or call. An out of range result, should be called in to the medical provider. Warfarin was a high risk medication and it needed to be addressed timely so it should always be a phone call with a response received the same day. If out of range, it placed the resident at risk for bleeding and/or a clot/stroke. The DON stated she would not expect a floor nurse to investigate why a resident's INR result was out of range, but expected the unit managers to do so. Staff had ever reported to her a difficulty regarding communication response regarding warfarin or INRs specifically, but had addressed difficulty getting responses for faxed communication. The medical director had been informed of those difficulties but had not responded. During a phone interview on 8/1/24 at 3:15 p.m., the facility medical director stated he was not happy with the fax system. Currently, someone had to go and get the faxed document from the fax machine and place the document on the correct provider's desk and was inefficient. Guidelines directing staff when to contact the provider regarding INR results needed to be implemented. The medical director stated he expected nursing to contact the medical provider when the INR was out of range. The facility policy Coagucheck/INR Meter Specimen Collection undated, identified the procedure for sample collection and unacceptable specimens. However, the policy did not address the timely reporting of INR results and/or directed staff what to do when a response was not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35575 Based on observation, interview and document review the facility failed to ensure enhanced barrier precautions (EBP) were utilized with residents with a catheter for 2 of 2 residents (R1, R69) reviewed for catheters. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and had an indwelling catheter. R1's undated Facesheet identified diagnoses of chronic kidney disease and urinary retention. R1's care plan dated 6/11/24, identified R1 had a catheter and included interventions to manage the catheter; however, the care plan failed to identify if R1 was on EBP and when EBP was to be used. On 7/29/24 5:32 p.m. R1 was observed lying in bed and had a catheter leg bag attached to his right leg and was draining yellow urine. The was no personal protective equipment (PPE) cart in or outside R1's room and there was nothing on the door or elsewhere identifying R1 was on EBP. On 7/30/24 at 9:46 a.m., R1 was seated on the bed and nursing assistant (NA)-D was observed emptying the leg bag to the catheter. NA-D was wearing gloves; however, did not have a gown on. NA-D finished emptying the catheter, cleansed the port with alcohol, emptied the urine, removed their gloves and sanitized their hands and exited the room. During interview on 7/30/24 9:48 a.m., NA-D could not state if they were to wear a gown when emptying the catheter for R1 and would have to ask. R69's quarterly MDS 6/20/24, identified R1 had moderate cognitive impairment and had and indwelling catheter. R69's undated Facesheet identified a diagnosis of urethral stricture. R69's care plan dated 5/30/24, identified R69 had a catheter and included interventions to manage the catheter; however, the care plan failed to identify if R69 was on EBP and when EBP was to be used. On 7/29/24 12:52 at p.m. R69 was observed seated in his wheelchair and had a catheter leg bag attached to his right leg and draining yellow. The was no PPE cart in or outside R69's room and there was nothing on the door or elsewhere identifying R69 was on EBP. On 7/30/24 at 10:36 a.m. R69 was not in his room and there continued to no PPE cart in or outside R69's room and there was nothing on the door or elsewhere identifying R69 was on EBP. On 7/30/24 at 11:32 a.m. NA-E was observed placing a PPE cart outside R69's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/30/24 at 11:32 a.m. NA-E stated she was placing the cart for EBP outside R69's room as R69 was supposed to be on EBP because he had a catheter. There had not been PPE carts for R69 or R1 and none of the staff had been wearing gowns while providing care for the R69 and R1 while in their rooms. During interview on 7/30/24 at 11:36 a.m. registered nurse (RN)-B, who was also the facility infection preventionist, stated her understanding was EBP was more of a suggestion and then all of a sudden it was implemented. Other residents in the facility had EBP however, RN-B could not explain why R1 and R69, who resided on the memory care unit, did not have the EBP implemented. RN-B stated EBP was to be used with any residents that had an external line like a catheter and with chronic wounds. When interviewed in 7/30/24 at 11:40 a.m. stated R1 had a catheter for some time and R69 had got a new indwelling catheter placed a couple weeks ago. RN-B could not identify why EBP were not implemented for R1 and R69. The facility policy Enhanced Barrier Precautions dated 3/28/24, identified EBP was a strategy in nursing homes to decrease the transmission of multi drug resistant organisms (MDR)). EBP would be used for residents actively infected or colonized with an MDRO along with those with an indwelling medical device and or chronic wounds requiring a dressing would be required to use EBP. EBP should be used during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/toileting, indwelling medical care device including central line/urinary catheter/feeding tube/tracheotomy/ventilator and with any chronic wound care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 4 of 5 residents (R3, R13, R70, R72) reviewed for immunizations. Findings include: R3's admission Face Sheet dated 4/22/24, identified R3's age of [AGE] years. Diagnoses included cerebral infarction (stroke), thrombocytopenia (low platelet count that could cause bleeding), endocrine disorder and malignant neoplasm of prostate (cancer)/ R3's Minnesota Immunization Information Connection (MIIC) report dated 12/15/23, identified R3's immunizations. R3 received the pneumococcal polysaccharide vaccine (PPSV23) 11/13/06, the pneumococcal vaccine Prevnar 13 (PCV13) on 7/1/15. R3's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended pneumococcal conjugate (PCV 15 or PCV 20) had been offered in conjunction with their providers recommendation. R3's electronic medical record (EMR) lacked evidence R3 had been given information or offered the newer recommended PCV15 or PCV20 vaccination. R13's admission Face Sheet dated 3/2/23, identified R13's age of [AGE] years. Diagnoses included Alzheimer's disease, diabetes, and kidney failure. R13's MIIC report dated 3/1/23, identified R13's immunizations. R13 received the PPSV23 on 5/11/07, and PCV13 on 8/29/17. R13's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation. R13's EMR lacked evidence R13 had been given information or offered the newer recommended PCV15 or PCV20. R70's admission Face Sheet dated 12/21/23, identified R70's age 74. Diagnoses included Stage four pressure ulcer, atrial fibrillation, kidney disease, heart failure and kidney disease. R70's MIIC report dated 7/31/24, identified R70's immunizations. R70 received the PPSV23 on 4/16/07, 10/31/07, and 8/30/17 and the PCV13 on 10/14/15. R70's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation. R70's EMR lacked evidence R39 had been given information or offered the newer recommended PCV15 or PCV20 vaccination. R72's admission Face Sheet dated 7/18/23, identified R72's age 90. Diagnoses included dementia, polymyalgia rheumatica, obesity, heart disease and cerebral infarction (stroke). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R72's MIIC report dated 7/31/24, identified R72's immunizations. R72 received the PPSV23 on 12/18/13, and the PCV13 on 12/18/14. R72's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation. R72's EMR lacked evidence R39 had been given information or offered the newer recommended PCV15 or PCV20 vaccination. When interviewed on 7/31/24, at 1:36 p.m. registered nurse (RN)-B stated she was aware the residents were due for the updated pneumonia vaccinations but had not yet offered it to them. RN-B had R3, R13, R70 and R72 on her list to offer the new PCV20 vaccine but had not gotten around to offering it to them yet. RN-B had recently gotten back in to the position of infection preventionist and was trying to get a number of things caught up, including offering the PCV15 or PCV20 vaccination to residents. During interview on 7/31/24, at 2:59 p.m. the director of nursing (DON) stated she was not aware the PCV20/PCV15 was not being offered to residents and it should have been offered. The Centers for Disease Control (CDC) Pneumococcal Vaccination: Summary of Who and When to Vaccinate dated 9/22/23, identified for adults [AGE] years or older with immunocompromising conditions, the PCV15 or PCV20 should be given at least five years after the last pneumococcal vaccine. The facility policy Pneumococcal Vaccines for Residents dated 3/18/22, identified the facility would provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to Center for Disease Control (CDC) recommendations. The policy identified the CDC recommended PCV15 or PCV20 to adults who had never received PCV13 if they were [AGE] years or older with certain chronic medical conditions. The facility had failed to update their policy to reflect the new CDC recommendations.