STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW BRIGHTON A VILLA CENTER	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to immediately report to the state agency (SA) an allegation of potential neglect when a resident fell from a mechanical lift for 1 of 7 resident (R8) reviewed for accidents. Findings include: R8's annual Minimum Data Set ((MDS) dated [DATE], indicated R8 was cognitively intact with [DIAGNOSES REDACTED]. R8 required extensive assistance of 2 for most ADLs (activities of daily living) and required a full body mechanical lift for transfers. The MDS indicated R8's most recent weight was 269 pounds. R8's care plan dated 5/12/20, indicated R8 required assist of two with mechanical lift for transfers. R8's progress note dated 7/26/20, at 3:27 p.m. indicated staff nurses (registered nurses (RN)-A and RN-B were transferring R8 to bed with a mechanical lift when the lift, couldn't hold the patient weight therefore, mechanical lift stated tilting to the right side and all (sic) the sudden Res (resident) and the mechanical lift fell down to the right side. R8's progress note dated 7/26/20, at 10:14 p.m. indicated R8 was, calling out to go to hospital and complaining of hip pain. An x-ray was ordered. R8's progress note dated 7/27/20, at 10:51 a.m. indicated R8 was lethargic (sluggish) and had incoherent speech. An order was obtained to send R8 to the ED (emergency department) for evaluation and treatment. R8's progress note dated 7/31/20, at 12:23 p.m. indicated a review of the fall from the lift. Pt (patient) initially said ouch when he fell but when positioned in bed stated he had no pain upon assessment. Pt noted to have pain early next am. The progress note further indicated R8 went to the hospital and found to have no fractures. Head neck and left hip x ray showed nothing significant. R8's Post Fall Incident Investigation report indicated a witnessed fall to floor event occurred on 7/26/20, at 1:55 p.m. during a mechanical lift transfer. The report further indicated R8's provider and family member were both notified of the event and R8 was assessed and did not experience any injury. The report described the incident as follows: Pt (patient) was in w/c (wheelchair) next to bed with w/c brakes locked, Hoyer brakes unlocked, foot pedals removed, and Hoyer legs apart. Pt lifted. While w/c was being removed (sic) nurse 2 reminded pt to put arms across chest as pt had moved on arm outside of sling; Hoyer (mechanical lift brand name) made creaking sound; pt began thrashing and calling out; nurse 2 (RN-B) quickly moved around chair and supported pt head and shoulders as his movement made Hoyer tip and he fell on left buttock from aprox (sic) wheelchair height or slightly lower. The report further indicated the Hoyer lift was immediately taken out of service. The Hoyer was inspected on 7/27/20, with no findings of repair issues; Hoyer arm; base; and motor working as usual; no issues that would cause tipping with normal use: Pt is under 300 lbs. (pounds) and was using the 350 Hoyer. Hoyer serviced 4/30, 5/31 and 6/30 with no issues found and done timely by maint (maintenance) personnel. On 7/27/20, the DON (director of nursing) and maintenance services director (M)-A attempted to recreate the event using 200 pounds in the lift. No issues with lift performance was indicated. There was a noticeable noise during a certain point of the lift. The two nurses involved in the incident were suspended pending investigation. The administrator and corporate clinical advisor determined there was no error by either nurse and that they were, not negligently using lift. The care plan was being followed, the preventative maintenance on the lift was up to date, and there was no allegation of abuse. Therefore, it was advised and administration agreed that no reporting of event was necessary. When interviewed 8/20/20, at 1:25 p.m. the administrator stated that factors such as whether or not the care plan was followed or if there was an injury would determine if an event was reportable. The administrator further stated that the facility investigation concluded that this fall was not a result of negligence by staff. The corporate clinical advisor stated they also referenced the Care Provider's decision tree to determine if this was a reportable event. The administrator confirmed the two staff involved were immediately suspended, the lift was pulled out of service, and an investigation was started. Both nurses provided the same recollection of events. They concluded that the lift was just, very old, the oldest in the facility. Therefore, they decided to just replace it with a new one. The administrator further stated that the two nurses involved in the incident were required to retake the mechanical lift training prior to returning to work. The facility had completed an investigation prior to reporting, instead of reporting and then investigating. When interviewed on 8/20/20, at 2:50 p.m. RN-B confirmed involvement in the event. RN-B stated, As we started to lift it and pull (R8) from the chair we heard a creaky noise and it (the lift) started to tip. RN-B confirmed having training on mechanical lifts prior to and after this event. When interviewed on 8/20/20, at 2:53 p.m. M-A stated that he checked the lift after the incident and found, One bushing that was a little worn, but nothing not really anything wrong with it. M-A confirmed they tried to recreate the fall but were unsuccessful. M-A further stated, We just concluded that it was too old. M-A thought the lift was manufactured in 1999, but did not provide evidence of certainty. M-A further stated they disassembled the lift so it could not be used again. The Invacare Reliant lift manufacture's manual dated 2018, indicated the Invacare Reliant 450 weight capacity was 450 pounds. The facility provided Work History Report indicated the resident lifts were inspected every month over the past year. The report indicated a 12 step inspection process and indicated any item identified as poor condition should be removed from service. On 2/29/20 one lift required a new battery, otherwise no issues were noted. The facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 11/28/17, identified all suspected abuse allegations (abuse, neglect, exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) be reported to the State Agency (SA) in accordance with State Law. All alleged violations of abuse as described above were to be reported to the SA within two hours of the incident.
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** Based on observation, interview, and document review, the facility failed to comprehensively assess 1 of 6 residents (R32) reviewed for significant change in condition. Findings Include: R32's significant change Minimum Data Set ((MDS) dated [DATE], included severe cognitive impairment with [DIAGNOSES REDACTED]. The sections for Preferences for Customary Routines and Activities and Pain Assessment interviews had been left blank and not completed. Therefore, the Care Area Assessment for Pain management had not triggered, nor been completed. In addition, the section for prognosis had not been marked as having a condition or disease that may result in a life expectancy of less than six months. R32's Hospice IDG (interdisciplinary group) Comprehensive Assessment and Plan of Care Update Report identified a start of hospice on 5/26/20 and included, The Medical Direction/Hospice Team Physician listed above certifies that the patient's prognosis is six months or less if the disease runs its normal course. R32's terminal [DIAGNOSES REDACTED]. [MEDICATION NAME] (a narcotic [MEDICATION NAME]) was ordered at this time. R32's medical record failed to include a recent comprehensive pain assessment. The most recent documentation of any pain monitoring by a licenses nurse was on a Daily Skilled Nursing Evaluation form dated 6/3/20 and a progress note dated 6/6/20 with no pain identified. R32's nursing assistant pain documentation showed the most recent entry was on 6/16/20 with no pain. However a nurse aide entry on 6/10/20, indicated resident was in pain

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	(continued... from page 1) and a nurse was notified. R32's care plan dated 3/22/20, failed to identify R32 had potential for, or actual pain. Therefore, there were no goals for R32's pain, nor interventions placed to assist her. During observation on 8/17/20, at 3:00 p.m. R32 was lying in bed and crying out, I hurt, I hurt, over and over, R32's face was grimaced and she had tears in her eyes. At 3:20 p.m. R32 remained moaning and yelling out that she hurt. When interviewed on 8/19/20, at 1:23 p.m. nursing assistant (NA)-D stated R32, Seems to be in pain when she is crying out, some days she cries out all day. NA-D had reported this to nursing. When interviewed on 8/19/20, at 1:29 p.m. NA-E stated R32 has been crying out most days over the last few months and seems to be in pain, this had been reported to the nurses. When interviewed on 8/19/20, at 1:36 p.m. licensed practical nurse (LPN)-D stated when R32, screams out, they will assess for pain and administer the [MEDICATION NAME]. This had been increasing for the last few months. When interviewed on 8/19/20, at 1:46 p.m. the registered nurse (RN)-Z, MDS coordinator stated they had missed these sections on the MDS in error. A facility policy was requested, but not provided by the facility.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to revise a care plan for 1 of 2 residents (R26) reviewed for a decline in activities of daily living, and failed to have timely care conferences with 1 of 2 residents (R20) reviewed for care planning. Findings include: R26's annual Minimum Data Set ((MDS) dated [DATE], included moderate cognitive impairment, severe depression symptoms and [DIAGNOSES REDACTED]. R26 required extensive staff assistance for most activities of daily living. On 8/17/20, at 2:11 p.m. R26 was observed to have paralysis on the left side of his body. R26 stated he was weaker now than he used to be, so staff used a full body mechanical lift to move him in and out of bed, and also used a bed pan instead of a commode. R26 explained being weaker now, and having had falls because of the weakness. Additionally, R26 said staff had not performed range of motion on his left side for at least over a month. R26's care plan included a section for ADLs initiated 11/4/18, that noted left [MEDICAL CONDITION]. Interventions dated 2/19/20, required R26 to be transferred using a fully body mechanical lift. The care plan also included older interventions dated 4/8/19, for R26 to transfer using the full body lift when getting out of bed, but then needing only assist of one staff with a pivot transfer once up on the wheelchair to get onto a commode for toileting. An intervention dated 4/8/19, described R26 as using either bedside commode or bedpan for bowel movements. The care plan also included intervention dated 11/4/18, to perform passive range of motion to bilateral upper extremity and lower extremity joints of 10 repetitions twice daily for extension/flexion. R26's physician orders did not include an order for [REDACTED]. The care guide did not include any direction to perform range of motion services. R26's Villa Rehabilitation Screening Form was completed 8/3/20, by occupational therapy (OT). The reason for the screening was Fall. OT assessed neuromuscular function and functional abilities and found no change in abilities other than a decline in transfers. OT Evaluation and Plan of Treatment dated on 8/6/20, reason for referral was that R26 experienced increased falls with functional transfers indicating need for skilled OT assessment. Pt (patient) previously completing toileting tasks with SPT EOB<> BSC (standing pivot transfer from edge of bed to bedside commode). This has become an unsafe transfer technique for pt and staff, determined hoyer lift (full body mechanical lift) is a more appropirate (sic) technique to transfer pt at this time. Under the functional skills assessment section for toileting, Patient requires assistance, however, will not currently address in treatment plan (pt has had a decline in transfer status but is not appropriate for therapeutic intervention at this time and safe transfer techniques have been determined). Assessment summary risk factors noted: Fall risk has been reduced with recommendation for hoyer lift for transfers. R26's OT Treatment Encounter Note dated 8/6/20, included, Completed chart review and therapeutic evaluation of pt (.) Pt L LE (left lower extremity) and L UE (left upper extremity) flaccid indicating EZ stand (sit-to-stand mechanical lift) would not be an appropriate choice for fucntional (sic) transfers. Staff recently have been using hoyer lift (full body mechanical lift) 2/2 decline in function with SPT's (standing pivot transfers)-pt declined to participate in therapeutic strengthening tasks and reports 'the hoyer is working fine, I will just use that.' Further therapeutic intervention is not indicated at this time. On 8/19/20, starting at 8:08 a.m. R26's morning cares were observed. Range of motion was not offered. At 8:34 a.m. R26 stated his left hand had been paralyzed for [AGE] years, and the staff don't do range of motion. R26 stated he tried to perform range of motion on his left hand, by using his right hand. R26 said his hand hurts, and sometimes starts hurting, really bad for no particular reason, it just happens, and also reported random spasms in his left foot too. R26 did not think his hand had gotten worse, because it was still able to open, about the same as it used to. R26 did not think that the nurses or nursing assistants were supposed to perform range of motion, only occupational or physical therapists. On 8/19/20, at 8:52 a.m. nursing assistant (NA)-C carried a care guide that described how to care for residents. NA-C referred to the care guide for R26 and stated, this all needs to be changed, because it says EZ Stand, but he doesn't stand anymore, he is not safe with his bad side. The guide referred to use of a commode, and NA-C explained R26 did not use a commode anymore because it was not safe and staff had a hard time getting R26 on the commode. No range of motion exercises were identified on the care guide either. NA-C had never performed range of motion for R26. On 8/19/20, at 11:23 a.m. occupational therapist (OT)-C described evaluating R26 after a fall in August 2020. OT-C stated R26 wanted to use a pivot transfer to the commode, but that was becoming unsafe for him and staff. The sit-to-stand mechanical lift did not work because R26 was flaccid on one side. They decided the full body mechanical lift was good, and R26 did not want to work on getting stronger for transfers, he was fine with using the full body lift. OT-C thought that was a safe choice for R26 and staff. When asked about range of motion, OT-C said any range of motion would have been put in place prior to her August evaluation, as OT-C did not write an order for [REDACTED]. NA-C stated if he lets us, and explained R26 had a lot of pain on the left side, and did not let staff perform range of motion. NA-C stated any range of motion completed by nursing assistants was charted in care tracker. When interviewed on 8/19/20, at 12:40 p.m. medical records staff (MR)-A could not provide documentation of completion of range of motion services per R26's care plan, stating because there was no documentation. 8/20/20, at 11:08 a.m. R26 stated it has gotten too hard to stand up. R26 confirmed staff do not help him with range of motion, and did not feel they should. R26 described leaving his left hand alone, unless it hurt, in which case he used his right hand to do some range of motion exercises. During interview on 8/20/20, at 2:50 p.m. licensed practical nurse (LPN)-C stated R26 first came to the unit from transitional care with range of motion in his care plan. Back at that time, R26 was refusing the service, so range of motion was removed from his orders. LPN-C thought the care plan needed to be updated to remove range of motion. LPN-C was asked about the care plan describing multiple modes of transportation, such as the sit-to-stand lift, and using the commode, even though staff reported this was unsafe for R26. LPN-C stated R26's transfer status depended on how R26 was feeling that week. LPN-C explained R26 used to transfer using the full body lift, but he did not like it, but also was not a candidate for sit-to-stand lift because R26's legs were not strong enough. R26 did work up to the sit-to-stand lift for a while, but then had an incident where he almost fell , and was not strong enough to stand anymore and pivot to the commode. LPN-C felt staff had to anticipate how strong R26 was going to be for transfer, and try the appropriate mode of transfer. LPN-C stated staff always used the full body lift to transfer R26 in and out of bed, but once out of bed staff might be able to use a sit-to-stand lift. LPN-C stated it was very confusing, staff had to anticipate how R26 would do, and what he would agree to. LPN-C stated stand by assist was not a safe option because R26 was not strong enough, as his leg gave out sometimes. LPN-C updated care plans, but stated, it could be hard to keep up on changes. LPN-C planned to look at the care plan and nursing assistant care guide to ensure they matched what was right for R26. A policy was requested, but not provided by the facility. R20's annual MDS dated [DATE], included intact cognition, and did not exhibit any behaviors. [DIAGNOSES REDACTED]. R20's quarterly and annual MDS were completed on 3/4/20, and 5/27/20, respectively, and lacked documentation indicating a care conference had occurred that included R20 or his responsible representative, and whom from the facility interdisciplinary team had participated. R20's care plan dated 1/25/18, identified R20 had an actual psychological well-being problem and directed staff to, provide opportunities for resident and family to participate in care and to increase communication between resident/family/caregivers about care. When interviewed on 8/17/20, at 4:23 p.m. R20 stated he had not been able to be included in decisions about his care and had not had a care conference in a long time. He stated he was able to express his needs, but did not feel staff really listened to him. When interviewed on 8/18/20, at 3:24 p.m. the director of social services (DSS) reviewed R20's medical record and found progress note dated 3/7/20 and 6/9/20 indicating a care conference

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) had been held for R20, and R20 had been invited. However, there was no indication R20 had actually attended the care conference or which interdisciplinary team staff had participated, or if R20 had input into his care plan. The DSS stated R20 was to have a care conference on 9/2/19, but that one had not occurred at all, she was the only social worker at the facility and had done an audit to see if there had been any missed and this one was missed altogether. When interviewed on 8/18/20, at 3:42 p.m. the administrator stated she had attended a care conference for R20 on 12/11/29, but none since then. On 8/20/20, 3:00 p.m. a care conference policy was requested, however the administrator stated they did not have a policy.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure interventions assessed to reduce the risk of pressure ulcer formation were implemented for 2 of 5 residents (R32 and R66) reviewed for pressure ulcers. Findings include: R32's significant change Minimum Data Set ((MDS) dated [DATE], identified R32 was cognitively impaired and required extensive assistance of two for transfers, bed mobility, and ADLs (activities of daily living). Further, R32 was at risk for pressure ulcers and did not have a current pressure ulcer. R32's care plan dated 3/22/20, indicated R32's potential for a pressure ulcer, with a goal to have intact skin through the review date, and an intervention to float heels while in bed for pressure ulcer prevention. R32's nursing assistant (NA) care guide sheet dated 8/13/20, directed staff to float R32's heels when in bed and to use soft blue boots at all times. R32's Order Summary Report dated 8/4/20, included an order for [REDACTED]. On 8/18/20, at 1:38 p.m. R32 was observed transferred to bed while being positioned onto back and did not have blue boots on feet. When observed on 8/18/20, at 2:34 p.m., 2:42 p.m., and 3:13 p.m. R32 was lying on back and did not have blue boots on feet. When observed on 8/18/20, at 3:33 p.m. R32 was lying on left side and did not have blue boots on feet. When observed on 8/19/20, at 7:05 a.m. R32 was lying on right side and did not have blue boots on feet. When interviewed on 8/19/20, at 7:08 a.m. nursing assistant (NA)-D stated the blue boots were placed on R32 feet this morning after the nurse manager supplied them to the staff. NA-D verified R32 did not have the blue boots on the date of 8/18/20. NA-D indicated not being aware of the need for R32 to wear the blue boots while in bed. When interviewed on 8/19/20, at 7:10 a.m. NA-C stated R32 was to wear the blue boots while in bed, however, R32 did not have the blue boots available in the room this morning until the nurse manager supplied them to the staff. When interviewed on 8/19/20, at 7:12 a.m. licensed practical nurse (LPN)-D verified R32 did not have the blue boots on the date 8/18/20 due to the blue boots needing to be washed, and another pair was not available. When interviewed on 8/19/20, at 8:52 a.m. LPN-C nurse manager verified R32 did not have the blue boots on the dates 8/17/20 and 8/18/20, and indicated R32 wore the blue boots a week prior. LPN-C nurse manager indicated the NA's would know to place the blue boots on R32 feet per the care guide sheet and verified R32 should have soft blue boots on at all times while in bed. On 8/19/20, at 8:58 a.m. R32's heels were observed with LPN-C, R32 had no open areas, however, both heels were, soft and prone to breakdown. R66's admission MDS dated [DATE], indicated R66 had moderately impaired cognition and required two person extensive assistance with bed mobility and transfers. R8's [DIAGNOSES REDACTED]. R66's care plan dated 6/5/20, indicated R66 had actual impairment to skin integrity on right heel and left outside of foot. The interventions were listed as, Evaluate and treat per physicians orders, and Evaluate resident for s/sx (signs and symptoms) of possible infection. On 8/19/20, at 7:16 a.m. licensed practical nurse (LPN)-F went in to assist R66. R66 was moaning and stated, My body hurts. LPN-F stated she would bring R66 pain medication. R66 yelled in pain as LPN-F attempted to place the Prevalon boots on R66. R66 stated, Both ankles are hurting me. LPN-F stopped and told R66 she would put the boots on later after pain medication administration. When interviewed on 8/19/20, at 7:27 a.m. LPN-F stated R66 should have had the boots on while in bed. On 8/19/20, at 8:22 a.m. R66 was yelling in pain and stated, Ankle hurt me all night. LPN-F placed both boots on R66. LPN-F stated, (R66) always yells out in pain, that is his norm. Even with normal cares. We give him scheduled pain meds. On 8/19/20, at 8:52 a.m. R66 was not yelling in pain at this time. When interviewed on 8/19/20, at 1:15 p.m. nursing assistant (NA)-B verified and stated that the nursing care sheet indicated R66 should have the blue boots on at all times. When interviewed on 8/19/20, at 1:19 p.m. LPN-F stated R66 has had orders for the Prevalon boots to be worn at all times since prior to going to the hospital. LPN-F further stated, (R66) did not have them on this morning when I first went in. I do not know how long they had been off. When interviewed on 8/20/20, at 9:33 a.m. LPN-C stated, The boots should be on all the time to protect (R66's) heels. (R66's) heels are painful so he needs them on so they don't bump into anything. R66's provider orders included Prevalon boots (pressure relieving heel protectors) on at all times except when ambulating or transferring. Nursing to ensure that heel lift boots are on at all times. Review of Twin Cities Physicians post hospitalization visit dated 7/30/20, indicated assessment and plan Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin: c/w (continue with) heel lift boots -on at all times. Review of Nursing Care Sheet for Group two indicted R66 blue boots to be worn at all times. A facility policy titled, Skin Management Guideline dated 11/28/17, indicated an intervention of elevated heels for residents unable to turn and reposition, for pressure ulcer prevention.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R32) reviewed for activities of daily living (ADLs) was transferred and assisted to eat safely. Findings include: R32's significant change Minimum Data Set ((MDS) dated [DATE], included severe cognitive impairment with [DIAGNOSES REDACTED]. R32 required extensive assistance with eating and extensive assistance of two persons for transfers. R32's Comprehensive Nutrition assessment dated [DATE], indicated R32 required a regular diet with chopped meats and thin liquids and was totally dependent upon staff for feeding. R32's care plan dated 3/22/20, included at nutrition risk due to failure to thrive. Staff were directed to report any symptoms of dysphagia (difficulty swallowing), pocketing food, choking, or coughing to the nurse. The care plan did not identify any specific positioning needs for meal times. R32's care plan dated 3/22/20, also identified a risk for falling and directed staff to utilize a Hoyer (brand name mechanical full body lift) with two persons to transfer, provide general supervision, and to provide a safe environment. R32's nursing assistant (NA) care guide sheet dated 8/13/20, directed staff to use a full body mechanical lift and two staff for transfers. There were no directions for eating assistance or positioning. During observation on 8/17/20, at 6:52 p.m. R32 was seated in a Broda chair (brand name wheeled chair that can be placed upright or reclined), the chair was reclined 30 degrees and R32's head was back and chin in up position. Nursing assistant (NA)-D was feeding pudding to R32. During observation on 8/18/20, at 1:09 p.m. R32 was seated in a Broda chair and tilted back thirty degrees. NA-J assisted R32 to eat pureed food and chocolate milk. R32 ate 25% of meal. When interviewed on 8/18/20, at 1:34 p.m. NA-J verified R32 was seated in a reclined position while being assisted to eat; and stated R32 should have been seated upright to prevent choking. During observation on 8/18/20, at 1:38 p.m. NA-J and NA-D pulled a mechanical lift in front of R32, hooked the loops of sling into the arms of the mechanical lift, NA-J raised R32 up into the air while NA-D guided R32's body. Once up in the air, NA-D left R32 and went around to the other side of the room to adjust R32's bed sheets. As NA-D was walking away, R32's body swung around and her feet bumped into the the metal bar on the lift. R32 cried out, Ouch, that hurt my toes. NA-D and NA-J finished assisting R32 into bed and did not check her feet for injury. When interviewed at 2:22 p.m. NA-D stated R32's feet often get bumped on the metal bar during transfers and would not report it to a nurse unless it was, a really big bang. When interviewed on 8/18/20, at 2:24 p.m. licensed practical nurse (LPN)-D stated R32 had been seated reclined while eating and should have been upright to prevent choking or aspirating. If a resident bumped their feet on the metal bar of the lift, LPN-D expected the nurse aides to report that so they could assess for any injuries. When interviewed on 8/18/20, at 2:27 p.m. the nurse manager LPN-C stated they had checked R32 for any injuries from the incident. R32 showed no current injuries, but they would continue to monitor for bruising or pain over the next 72 hours. LPN-C stated staff should always report any incident in which a resident could be injured so the situation could be assessed and interventions placed to prevent reoccurrence. When interviewed on 8/18/20, at 3:38 p.m. the director of nursing (DON) stated residents should be seated upright while eating to prevent choking and aspirating on food/fluids. R32 did not have a history of choking or aspirating. The nursing assistants should not have left a resident dangling in the air during a lift; a two person transfer was required so that one person could guide the resident to protect them while the other maneuvered the machine. The nursing assistants should have reported the incident where R32 bumped her feet on the metal bar so that a nurse could complete an assessment of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) resident and investigate what happened to prevent incidences like it in the future. A mechanical lift policy was requested, but not provided by the facility.
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** Based on observation, interview, and document review the facility failed to comprehensively assess and develop interventions to reduce incontinence for 1 of 2 residents (R1) reviewed for bowel and bladder. Findings include: R1's significant change Minimum Data Set ((MDS) dated [DATE], included moderate cognitive impairment with [DIAGNOSES REDACTED]. R1 required limited assistance with toilet use and supervision with personal hygiene. R1 was frequently incontinent of urine and was not on a toileting program. The undated Urinary Incontinence Care Area Assessment (CAA) included, resident needs limited assist with toileting, due to after care and barrier cream application. Resident is able to change brief, but often doesn't clean skin after incontinency. Resident is frequently incontinent of bladder. The CAA identified that urinary incontinence would be addressed in the care plan. R1's Nursing Evaluation dated 7/25/20, identified, continent of bladder; independent use of toilet, able to use call light for assistance. R1's care plan dated 12/30/19, included, Potential for bladder incontinence r/t (related to) [MEDICAL CONDITION], urinary urgency, chronic incontinence, h/o (history of) incontinence, h/o UTI independent. Staff were directed to provide incontinent products and assist in cleaning peri-area. Staff were also directed to monitor and report signs or symptoms of urinary frequency. During observation on 08/17/20, at 12:19 p.m. R1 was seen walking out of room with visibly wet buttocks area from the back of her slacks/sweat pants from upper buttocks to back of knees. R1's brief was visibly bulging out from her pants, heavily saturated with urine. During observation on 08/18/20, at 1:13 p.m. R1 was observed seated outside smoking. R1 finished her cigarette, stood up and had visible wetness centered in the middle portion on her buttocks on of the back of her pants as she walked back to return to the facility. During interview on 08/19/20, at 10:27 a.m. nursing assistant (NA)-A stated R1, is soaking wet in the mornings referring to R1's bed sheets, brief, and clothing on her lower extremities. NA-A indicated R1 was able to be prompted or redirected to go to the bathroom during the day and was able to remove/dispose of her brief independently. NA-A reported R1 being wet, at least once per day and not on a toileting program. During interview on 8/19/20, at 10:41 a.m. NA-B stated she changed R1's bed sheets, every single day, her bed is always soaked, she wears her pull-up, she should be wearing diapers. NA-B stated this had been going on for over a month. Sometimes her whole back is wet, we go in there and it smells terrible and I've told the nurse. During interview on 8/19/20, at 10:45 a.m. licensed practical nurse (LPN)-S stated they were responsible for the bladder assessments and did not know why R1's July bladder assessment indicated she was continent. R1 had been incontinent of urine for some time. R1 was not on a toileting program and not care planned to be checked at night for incontinence. R1's Point of Care history (POC) documentation from 8/8/20 to 8/19/20, indicated R1 had been incontinent several times each day. Bowel and Bladder Management facility policy dated 11/28/17, directed procedure of incontinent residents, Will have 3 days of elimination monitoring evaluating bowel and bladder patterns upon admission, re-admission, reviewed quarterly and re-evaluated with a significant change in elimination patterns.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure ongoing nutritional assessments and weight monitoring for 1 of 5 residents (R66) reviewed for who were at risk for nutritional status. Findings include: R66's admission Minimum Data Set ((MDS) dated [DATE], indicated R66 had moderately impaired cognition and required two person extensive assistance with bed mobility and transfers. R8's [DIAGNOSES REDACTED]. R66's care plan dated 6/5/20, indicated R66 had, nutritional problem or potential nutritional problem r/t (related to) swallowing difficulty, pain with compression fx (fracture), malnutrition. R66's care plan interventions included monitor and record intake with every meal, provide supplements as ordered, obtain and monitor weight weekly and as needed. R66's Comprehensive Nutrition Assessment (CNA) dated 6/8/20, indicated R66 required a general diet with pureed texture and honey thick consistency liquids. The CNA further indicated R66 required nutritional supplements. The CNA included R66's most recent height as 76 inches on 6/8/20, at 4:09 p.m. The most recent weight was blank. The CNA further indicated the nutritional needs were estimated using an undated hospital weight of 141 pounds. On 8/17/20, at 4:00 p.m. R66 was observed lying in bed with exposed shoulders and upper back. R66 appeared thin with bony protuberances at shoulder and shoulder blades observed. Record review in PCC (point click care - the documentation platform for the electronic medical record) did not include any weights documented for R66 since admission. When interviewed on 8/19/20, at 10:36 a.m. nursing assistant (NA)-B stated (LPN-C) set out a weight sheet on the nurse's station desk when either a daily or monthly weight was needed that day. The aides weighed the residents when they needed a weight and wrote it on the sheet. Then the nurses documented the weights in PCC. When interviewed on 8/19/20, at 11:00 a.m. NA-C stated if any weights needed to be done they would be on the weight list. The nurses also had it on their MAR (medication administration record). They are pretty good about telling us in the morning if we need to get one. When interviewed on 8/19/20, at 11:03 a.m. NA-B stated if we had one (a weight) to do today there would be a slip out that (LPN-C) put out. NA-B looked on the desk, I don't see one. NA-B stated being aware of only one weight due. NA-B confirmed and stated R66 was not due for a weight. RN-B further confirmed R66 was not listed on the North Weights schedule. When interviewed on 8/19/20, at 11:07 a.m. LPN-C stated the process for identifying and obtaining resident weights was pretty routine. LPN-C stated that the nurses would see that a weight was due on their MAR and they would tell the aides. Then the nurse would enter the weight through the MAR in PCC. LPN-C further stated that due to COVID, the facility had not weighed residents in the scale room for a month or so, so some residents were missing weights in May. LPN-C further stated any residents that missed an ordered weight would have the reason documented in a progress note by the registered dietician (RD). When interviewed on 8/19/20, at 11:33 a.m. RD-A stated R66 has had a decrease in intake and received protein supplements using magic cup desserts three times a day. RD-A further stated that R66 was listed on the at nutritional risk report. I have not done anything since he got back (from the hospital). I did speak with the nurse practitioner and made sure his orders were the same as when he went to the hospital. RD-A further stated R66 was due for a weekly nutritional assessment the next day. Weekly nutritional assessments included looking at intake, acceptance of nutrition supplements and weight changes for the prior week. RD-A further stated R66 should have been weighed upon admission, but that could have been during the timeframe when weights were halted due to Covid. When asked about R66's weight trends, RD-A looked in PCC and stated, Since admission his weights have been running RD-A stopped mid-sentence. I cannot give you that answer right now. RD-A searched PCC and confirmed R66 had no documented weights in PCC since admission. RD-A again searched in PCC and confirmed R66 did not have a nutritional assessment completed since the admission assessment. RD-A verified and stated R66 should have been on weekly assessments and weights since his arrival in June and he had been receiving nutritional supplements since admission. When interviewed on 8/19/20, at 11:52 a.m. director of nursing (DON) stated nurses had the orders to obtain a weight that they would see it on the MAR. The nurse would coordinate with the NA to have it done. Nurse managers and dieticians reviewed daily weights together every day Monday through Friday, but weekly weights were the responsibility of the nurse manager. When interviewed on 8/19/20, at 1:01 p.m. LPN-C stated she had not been reviewing weekly weights or reminding anyone of weekly weights. Maybe that is something new coming. But it does come up on the nurses' MAR. When interviewed on 8/20/20, at 9:24 a.m. LPN-C stated I have a bunch of scattered papers with resident names and weights on that I need to enter (into PCC). LPN-C further stated, I did find two weights on (R66) but that is all. LPN-C further stated, I weighed (R66) myself yesterday. R66's Order Summary Report indicated the following orders: Weekly weights every day shift every Wednesday. Start date: 7/29/20. No end date. Weights every day shift every 7 days for 3 weeks. Start date: 8/18/20 End date: 9/8/20. Weights one time only for 1 day. Start date: 8/11/20. End date: 8/12/20 R66's MAR (medication administration record) for July 2020, indicated weekly weight every day shift every Wednesday. The MAR further indicated no documented weights and an X mark on every day of the month. An X mark indicated not done. A checkmark indicated done. No checkmarks were noted. The facility Baseline Vitals Guideline dated 11/28/17, indicated all baseline vital signs and weights should be determined prior to admission. The guideline further indicated vital signs and weights should always be documented in the weight/vitals tab in PCC so they could be used in comparison to baseline admission values.

F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**

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	245164	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Based on observation, interview, and document review, the facility failed to ensure prescribed narcotics and controlled substance reconciliation was completed in a manner to allow rapid detection of potential diversion in 3 of 3 med carts, and this had the potential to affect 15 of 15 residents (R5, R10, R12, R24, R38, R40, R54, R66, R68, R69, R71, R72, R75, R229, R328) identified to have narcotics and/or controlled substances stored on the carts. Findings include: On 8/19/20, at 2:05 p.m. the TCU (transitional care unit) Team two medication cart was reviewed with licensed practical nurse (LPN)-A. The cart contained a separate drawer locked with a physical key which housed narcotics and/or controlled substance medications. LPN-A explained the narcotics were counted with every change of shift and recorded in a white colored binder. The front of the binder had a document attached which indicated, Please ensure you are signing this book each time the narcotic drawer is counted. The binder contained a, shift to shift controlled substance verification log sheet dated August 2020 and was used to record the oncoming and off-going nurses' signature for each shift. The book had 180 opportunities to document the narcotic count so far in the month of August 2020, however, it had only been signed out 56 times. LPN-A verified the number of times counting narcotics was not signed as being completed. On 8/20/20, at 8:44 a.m. the LTCU (Long-term care unit) Team one medication cart was reviewed with LPN-F. The cart contained a separate drawer locked with a physical key which housed narcotics and/or controlled substance medications. LPN-F explained the narcotics were counted with every change of shift and recorded in a white colored binder. The binder contained a shift to shift controlled substance verification log sheet dated May 2020 through August 2020. LPN-F verified the log had 116 times in which counting the narcotics was not signed by anyone. On 8/20/20, at 9:06 a.m. the TCU Team one medication cart was reviewed with LPN-E. The cart contained a separate drawer locked with a physical key which housed narcotics and/or controlled substance medications. LPN-E was unable to find any sign out verifying the narcotics were being counted on this cart. When interviewed on 8/20/20, at 9:46 a.m. director of nursing (DON) stated, The nurses are expected to count narcotics at the beginning and end of their shift to prevent diversion. DON expressed the process was for the oncoming nurse to look at the narcotics and the off-going nurse to look at the narcotic book and complete count together and then sign the controlled substance verification log to indicate all narcotics were being accounted for. When interviewed on 8/20/20, at 10:13 a.m. consulting pharmacist stated they normally check the narcotic tracking system with rounds, but due to COVID-19, they had not done that since 1/28/20. The controlled substance storage policy dated August 2019, indicated at each shift change, or when keys were transferred, a physical inventory of all controlled substances, including refrigerated items was conducted by two licensed nurses and was documented.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to routinely prime insulin pens prior to administering insulin for 1 of 2 residents (R12) observed for insulin administration. Findings include: On 8/17/20, at 6:31 p.m. licensed practical nurse (LPN)-B was observed to set-up R12's insulin pen. LPN-B was observed opening one of the lower drawers of the medication cart, and retrieved R12's insulin pens inside a plastic bag. LPN-B took the cap off the [MEDICATION NAME] KwikPen 100 units and stated, R12's blood sugar was 240 and was to receive 4 units per the sliding scale, plus 18 units which were scheduled, which totaled 22 units. LPN-C took the cap off the insulin pen, applied a pair of gloves, and cleaned the rubber [MEDICATION NAME] on the insulin pen with an alcohol wipe. LPN-B obtained an Auto Shield needle, applied it to the Kwikpen, dialed 22 units of [MEDICATION NAME] insulin, and never primed the Kwikpen with two units of insulin to pre-fill the needle. -At 6:33 p.m. LPN-B approached R12 in his room and told him she was going to give the insulin and was observed give the 22 units of [MEDICATION NAME]on the left upper abdomen. On 8/17/20, at 6:42 p.m. when asked if the pens were supposed to be primed LPN-B stated I don't know about priming the pen. On 8/19/20, at 1:51 p.m. the director of nursing (DON) stated she expected the nurses to use the insulin pens correctly per the manufacturer guideline which included priming the pens. The Insulin [MEDICATION NAME] Injection KwikPen Instructions for Use revised 2/2020, instructed to, Prime before each injection. The instructions explained that, Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview, and document review, the facility failed to ensure opened vials of [MEDICATION NAME] (solution injected under the skin to test for [MEDICAL CONDITION]) were dated when opened to ensure potency and prevent administration after expiration. The remaining potentially expired solution had the potential to affect approximately 10 of 10 existing or future residents who could receive these injections. In addition, the facility failed to ensure opened insulin flex-pens were dated when opened to ensure potency and prevent administration after expiration which had the potential to affect 2 of 2 residents (R27 and R228) whom could receive these injections. Findings include: On [DATE], at 4:54 p.m. the facility central station medication room was reviewed with licensed practical nurse (LPN)-G present. A single refrigerator was placed on the counter which was inspected. Inside, the following was found: A total of two opened vials of [MEDICATION NAME] solution. Both vials had a white label affixed to them from the pharmacy which did not have a fill date present. There was no writing or indication on each opened vial demonstrating when they had been opened. On [DATE], at 5:04 p.m. LPN-G verified the above findings and indicated typically the vials were dated when opened with a marker to ensure they were discarded timely, and not used after they expired as the vials were only good for 30 days after being opened. LPN-G reviewed each vial and indicated one vial had two doses remaining and the other vial had three doses remaining which could be used for residents and/or employees. The opened vials had been used for residents two-step [MEDICATION NAME] test upon admission, but could not tell if they had the test with expired solution or not as it was not dated. On [DATE], at 6:05 p.m. the facility TCU (transitional care unit) medication room was reviewed with registered nurse (RN)-E present. A single full sized refrigerator was inspected. Inside the following was found: One opened vial of [MEDICATION NAME] solution. The vial had a white label affixed to it from the pharmacy which did not have a fill date present. There was no writing or indication on the vial demonstrating when it had been opened. The opened vial had been used for resident two-step [MEDICATION NAME] test upon admission. On [DATE], 6:10 p.m. RN-E verified the above findings and indicated typically the vials are dated when opened to ensure they were discarded timely, and not used after they expired as the vials are only good for 30 days after being opened. RN-E reviewed the vial and indicated the vial had five doses remaining which could be used for residents and/or employees. On [DATE], at 9:46 a.m. the director of nursing (DON) stated the [MEDICATION NAME] solution vials should be dated when opened to prevent giving the mediation after expiration. The package insert, [MEDICATION NAME] Purified Protein Derivative (Mantoux) [MEDICATION NAME] indicated on line 262, a vial of [MEDICATION NAME] which has been entered and in use for 30 days should be discarded. The Medication Storage in the Facility policy dated [DATE], indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. On [DATE], at 2:05 p.m. the south team 2 medication cart was reviewed with LPN-A present. R228 insulin [MEDICATION NAME] were removed from the medication cart and reviewed with LPN-A. There were two Admelog [MEDICATION NAME] which had a white label affixed to them from the pharmacy which identified one had been filled on [DATE] and the other on [DATE]. However, there was no writing or indication on the [MEDICATION NAME] demonstrating when they had been opened. LPN-A verified the above findings and indicated typically the [MEDICATION NAME] are dated when opened to ensure they were discarded timely, and not used after they expired as the [MEDICATION NAME] are only good for 28 days after being opened. On [DATE], at 9:06 a.m. the TCU team 1 medication cart was reviewed with LPN-E present. R27's 2 insulin [MEDICATION NAME] were removed from the medication cart and reviewed with LPN-E. The two Admelog [MEDICATION NAME] had a

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) white label affixed to them from the pharmacy which identified both had been filled on [DATE], however, there was no writing or indication on the [MEDICATION NAME] demonstrating when they had been opened. R27 Tresiba (a man-made insulin used to control high blood sugars) [MEDICATION NAME] had a white label affixed to them from the pharmacy which identified the [MEDICATION NAME] had been filled on [DATE], however, there was no writing or indication on the [MEDICATION NAME] demonstrating when they had been opened. R27 Basaglar [MEDICATION NAME] had a white label affixed to them from the pharmacy which identified the [MEDICATION NAME] had been filled on [DATE], however, there was no writing or indication on the [MEDICATION NAME] demonstrating when they had been opened. LPN-E verified the above findings and indicated typically the [MEDICATION NAME] are dated when opened to ensure they were discarded timely, and not used after they expired as the [MEDICATION NAME] are only good for 28 days after being opened. On [DATE], at 9:46 a.m. the director of nursing (DON) indicated that vials should be dated when opened to prevent giving the mediation after expiration. The package inserts for the Admelog, Basaglar, and Tresiba [MEDICATION NAME] indicated all should be dated when opened and disposed of after 28 days. The Medication Storage in the Facility policy dated [DATE], indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the necessary coordination of services between the hospice agency and the facility for 1 of 2 residents (R32) reviewed for hospice services. Findings include: R32 significant change Minimum Data Set ((MDS) dated [DATE], did not indicate R32 was on hospice care on section O. Indicated R32 was severely cognitively impaired and required extensive assist of two for transfers and bed mobility. R32's Order Summary Report dated 8/4/20, did not indicate an active order for hospice care. The document did however indicate, ok for hospice care which was discontinued on 11/11/19. R32's facility care plan initiated 10/03/2017, did not identify R32 as receiving hospice care. The care plan lacked any evidence or outline as to the frequency of skilled nursing visit(s). Further, the care plan lacked any information on additional services provided by the outside hospice agency including hospice health aide visit(s), spiritual counselor visit(s), and social worker visit(s). R32's Hospice IDG (interdisciplinary group) Comprehensive Assessment and Plan of Care Update Report, dated 5/26/20, indicated R32 was admitted to hospice services with a hospice [DIAGNOSES REDACTED]. The document indicated the hospice nurse to evaluate R32 and develop a plan of care to be signed by the physician. No hospice care plan was found in the medical record. R32's information on the nursing assistant care guide titled Group Four, did not include any evidence of hospice care. During an interview on 8/19/20, at 10:59 a.m. licensed practical nurse (LPN)-D indicated the hospice staff come everyday to see R32, then stated, I don't know for sure. LPN-D indicated the hospice plan of care and visit schedule was located in a separate binder at the nurse station available for staff to review to be aware of when hospice comes into the facility and what hospice does for R32. LPN-D went to nurse station to retrieve the hospice binder and found no evidence of the plan of care or visit schedule. LPN-D verified without the plan of care or schedule the facility staff would not know when hospice would visit or what cares hospice provided during their visits. During an interview on 8/19/20, at 11:17 a.m. nursing assistant (NA)-B stated the nurse aides find out about hospice visits and what hospice does for residents on their care guide group sheet. NA-B verified there was no information on hospice care for R32. NA-B stated nurse aides do not have access to the main care plan or look at any hospice charts. During an interview on 8/19/20, at 11:29 a.m. health information coordinator (HIC)-H verified the hospice care plan and schedule for visit(s) was not located at the desk, then stated it should be located in the hospice chart. During an interview on 8/19/20, at 11:35 a.m. nurse manager LPN-C verified the hospice care plan and schedule for visit(s) should be in the hospice chart. However, when LPN-V reviewed the hospice chart, there was no hospice care plan available. During an interview on 8/19/20, at 11:40 a.m. the director of nursing (DON) reviewed the hospice chart and verified neither the hospice plan of care nor the schedule of hospice visit(s) were in the chart. DON verified the hospice chart is how the facility and the hospice staff communicate and without the information in the chart the staff would not know how to coordinate care with hospice. During an interview on 8/20/20, at 8:34 a.m. the hospice registered nurse (RN)-F indicated the facility does not supply access to the electronic medical records (EMR). RN-F indicated without access to the EMR it's difficult to coordinate care with the facility staff and have good communication about R32 care. RN-F revealed the only information received is verbally from the current shift during the visit. RN-F indicated a clear picture of R32 pain and condition was not possible to attain without having access to the EMR. A facility policy for hospice services was requested and not received.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure a communal blood glucose machine was disinfected between resident use for 2 of 2 residents (R21 and R15) observed to have blood sugar checked. The facility also failed to follow appropriate hand hygiene and gloving practices for 3 of 7 residents (R9, R19, and R56) observed during cares. In addition, the facility failed to ensure insulin pens were stored separately to prevent the cross contamination of blood borne pathogens in 1 of 3 medication carts on the first floor. Findings include: Glucometer On 8/17/20, at 12:02 p.m. licensed practical nurse (LPN)-A was observed into R15's and R21's room carrying a small tote which contained diabetic supplies and a communal glucometer. Upon entering the room, LPN-A approached R21's side of the room and stated to R21 she was going to check her blood sugar. LPN-A set the tote on R21's bedside table without a barrier, then after she applied gloves, she picked up the bottle of glucometer strips, took one strip out then set the bottle on the table still with no barrier; applied it into the glucometer, then picked a lancet and punctured R21's right middle finger, squeezed a drop of blood into the strip and got the blood glucose reading. LPN-A set the glucometer on the bedside table with no barrier, picked up the bottle of strips with same gloves closed it and dropped it into the tote. LPN-A then pulled the strip out of the glucometer, removed her gloves inside out and tossed them into the trash, picked the glucometer and dropped it on top of the rest of the supplies in the tote without cleaning it, then went to the sink and washed her hands. On 8/17/20, at 12:07 p.m. still in the same room, LPN-A came back to R21's side of room and grabbed the tote with the diabetic supplies with the glucometer and went to R15's side of the room. LPN-A set the tote next to the sink without barrier, applied a pair of gloves, approached R15 and cued her she was going to check her blood sugar. LPN-A punctured R15's left middle finger and got a reading of 112. LPN-A took the blood sugar strip with blood off the glucometer, set the glucometer on top of the diabetic supplies without cleaning it, then removed gloves. Without washing her hands, LPN-A picked up the tote and piece of paper off the bedside table. As she left the room, R15 asked if she would move R21 out of the way so she would be able to access the bathroom. -At 12:10 p.m. LPN-A set the tote on R21's bedside table with no barrier, and as she wheeled R21 to the hallway she realized the floor on R21's side had a spill of root beer pop. So, after she stationed R21 in the hallway she came back to the room, went to the sink area grabbed paper towels, then wiped the floor using the paper towel with her bare hands. LPN-A tossed the wet soiled paper towels in the garbage, then picked the tote with diabetic supplies without washing her hands and left down the hallway to the medication cart before using hand sanitizer to cleanse her hands. On 8/17/20, at 12:17 p.m. LPN-A acknowledged she was supposed to clean the glucometer between residents before she put it back with all the other clean diabetic supplies. LPN-A verified this was a communal glucometer. LPN-A also stated she was supposed to wash her hands after removing gloves, after she had wiped the floor, and before she continued to assist R21. Hand hygiene and gloving: When observed on 8/19/20, at 10:08 a.m. nursing assistant (NA)-A and NA-B assisted R9 from wheel chair to bed with a mechanical lift. NA-B applied gloves and pulled down R9's pants, unfastened R9's incontinent product and performed peri-care. NA-B picked up a clean incontinent product with the same gloves. NA-A with gloves on assisted R9 to turn to the side and removed stool from R9's buttocks. NA-B applied a barrier cream. NA-B then removed gloves and applied a clean pair without washing hands. NA-A, without removing the soiled gloves or washing hands took a tissue and used it to wipe the side of R9's mouth. On 8/19/20, at 10:33 a.m. NA-A and NA-B were interviewed together and they acknowledged they had not removed gloves and washed hands before proceeding to finish cares when going from dirty to clean. Both NAs stated they were supposed to change gloves and wash hands between dirty and clean areas. On 8/20/20, at 11:05 a.m. during an interview with registered nurse (RN)-C and the cooperate clinical consultant RN, both stated the facility had identified infection control as an area of focus however the survey team had entered the facility the week training was to begin. RN-C who was the infection control preventionist (ICP) stated staff were supposed to wash their hands when going

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NEW BRIGHTON A VILLA CENTER	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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** - Some	(continued... from page 6) from dirty to clean. RN-C also stated all residents were supposed to have individual glucometers, but if a communal glucometer was being used, it was supposed to be disinfected according to the manufacturer's guidelines, which was to be done between residents. On 8/18/20, at 2:12 p.m. NA-F was observed during incontinence and toileting cares of R19. NA-F was observed to perform hand hygiene, don gloves, and wipe R19's peri area after toileting. NA-F then doffed gloves, applied soap to hands, lathered for 3 seconds, rinsed under running water for 2 seconds, and dried with paper towel. R19 turned the water faucet off. NA-F then donned gloves, applied barrier cream to R19's peri area and doffed gloves. NA-F then handed Oxygen tubing and nasal cannula to R19. NA-F turned on the water faucet, applied soap to hands, lathered for 3 seconds, rinsed under running water for 3 seconds, dried hands with paper towel, then turned water off with an ungloved hand. NA-F arranged water cups on R19's bedside table, straightened personal items on the counter, picked up the garbage bag, and exited R19's room to place garbage in the soiled utility room. At 2:23 p.m. NA-F stated she was trained on proper hand hygiene which included washing hands with soap and water for 20 seconds. On 8/19/20, at 8:01 a.m. NA-C was observed performing Activities of Daily Living (ADL's) and incontinence care for R56. After performing cares, NA-C doffed gloves, turned on water, applied soap, lathered hands under running water for 5 seconds, then dried hands and turned water off with a paper towel. NA-C then picked up garbage and linens, took them into the soiled utility room, and performed hand hygiene with alcohol-based hand rub. When interviewed on 8/19/20, at 8:25 a.m. NA-C stated she had received hand hygiene and infection control training. NA-C further stated NAs should wash hands for 20 seconds, but was unsure if she had done so. When interviewed on 8/19/20, at 8:36 a.m. licensed practical nurse (LPN)-D stated it would be her expectation that NAs would wash for 20 seconds with soap and water, as that was their training. When interviewed on 8/19/20, at 9:06 a.m. LPN-C, nurse manager, stated all staff were educated on infection control and proper hand hygiene. LPN-C further stated staff were expected to wash hands for 20 seconds if using soap and water. Insulin Pens When interviewed on 8/20/20, at 1:17 p.m. R127's family (FM)-K was interviewed and stated an insulin pen belonging to R47 was included in a bag with insulin pens sent home for R127 when discharged on [DATE]. When interviewed on 8/20/20, at 4:13 p.m. FM-L stated R127 was sent home with another resident's insulin pen. FM-L further stated she called the facility to let them know they had another resident's insulin pen. On 8/20/20, at 1:58 p.m. the director of nursing (DON) was interviewed and stated the nurse would be expected to check the medications being sent with a discharged resident against the orders to ensure they were correct. The DON further stated it was her expectation that the correct medications would be sent home with a discharged resident. Insulin pens should be stored separately for each resident. On 8/19/20, at 2:05 p.m. the TCU (transitional care unit) Team two medication cart was reviewed with licensed practical nurse (LPN)-A. LPN-A pulled out a clear plastic unlabeled bag which held seven insulin [MEDICATION NAME]. Four insulin [MEDICATION NAME] were labeled with R71 information, one with R228 information, and two with unreadable labels. LPN-A verified the insulin [MEDICATION NAME] should be in separate bags to prevent cross contamination. Further LPN-A indicated by having different residents' insulin [MEDICATION NAME] in the same bag a potential medication error could occur. On 8/20/20, at 9:46 a.m. director of nursing (DON) verified the facility protocol was for each resident to have a separate bag for the insulin [MEDICATION NAME] and bags should be labeled with resident name. DON expressed the protocol was in place to prevent the wrong medication being given which could cause a medication error or contamination. A policy was requested but not provided by the facility.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 6 of 8 rooms (rooms 100, 108, 109, 117, 118 and 121) were maintained in good repair and sanitary manner reviewed for environmental concerns. This had the potential to affect 9 residents (R20, R201, R9, R202, R203, R32, R204, and R18) who resided in the rooms. In addition, the facility failed to maintain a safe, and comfortable environment for residents, staff and the public in hallways and common areas of the facility. Findings include: When interviewed on 8/17/20, at 4:24 p.m. R20 stated there were holes in the walls in his room, he had reported it to the maintenance services director, who had completed some patching. My room here they don't clean it. Go to the bathroom it over flows and they just come clean here and there and leave. R20's bathroom had a strong musty smell of urine and feces. There was a toilet plunger located in the corner by the toilet, with brown matter plastered on it. The housekeeper manager (HM)-A came into the room at 4:40 p.m. and verified the bathroom was not clean. On 8/17/20, at 12:00 p.m. open ceiling tiles, water dripping into a bucket placed on the floor, and water stained ceiling tiles were observed near the respiratory care unit nurses station on the first floor. On 8/19/20, at 1:49 p.m. during an environmental tour, the MSD verified the concerns, and stated contractors were being contacted and they were working to get it fixed. On 8/19/20, at 1:51 p.m. the MSD verified multiple ceiling tiles in the hallway to the transitional care unit nurses station were observed to be water stained and sagging. MSD stated he could replace the ceiling tiles. On 8/19/20, at 1:56 p.m. during the environmental tour, the wallpaper was noted to be peeling up in the hallway near the door to room [ROOM NUMBER], exposing the drywall underneath, a non-cleanable surface. MSD verified the concern, and stated staff put in work order requests through the TELS system. MSD had not been notified of the peeling wallpaper, but would repair it. On 8/19/20, at 1:55 p.m. the edging around the lower portion of the first floor elevator was observed to be loose, exposing sharp plastic edges. MSD verified the concern regarding the edging around the elevator, stated it could be fixed, and further stated he would order a new piece to repair it. On 8/20/20, at 1:04 p.m. during the environmental tour with the corporate regional maintenance director and the facility maintenance services director (MSD), the following concerns were observed in room [ROOM NUMBER]: The laminate on the sink counter corner by the bathroom door was observed to be peeled off exposing the surface underneath not making it a cleanable surface. In addition, below the bathroom door wall the base trim had come off and the sheetrock was observed to have a gouges. Both staff verified the concerns in room [ROOM NUMBER], and the MSD stated he would fix the concerns. The MSD stated staff were supposed to let him know of any concerns in resident rooms by putting a work order in the facility work order system called TELS. The MSD also stated he would review the list and address the concerns. On 8/20/20, at 1:01 p.m. the following concerns were observed in room [ROOM NUMBER], and verified with nursing assistant (NA)-C: -Approximately 5 centimeter (cm) by 8 cm jagged edge and sharp ends hole was observed on the plastic bumper guard on the wall next to bed 2. The hole also exposed a steel railing underneath it. -Across from bed 2 the left cabinet door handle under the sink was broken and had a sharp edge of broken screw which was exposed. -The dark brown trim on wall by the bathroom was observed to be tearing off. -The telephone outlet on wall was falling off and exposed white piece of plastic and wires. -In the bathroom an approximately 3 cm by 4 cm caulking was observed missing and approximately 8 cm by 9 cm remaining caulking was noted to be brown to the back and base of the toilet and -Brown splattered stains were observed on the bottom of the privacy curtain between the two roommates in room [ROOM NUMBER]. When asked what the system was for reporting concerns to maintenance NA-C stated Honestly I don't see this things anymore. When I see them like this I write it down and report to the nurse who will send an e-mail to the maintenance. On 8/20/20, at 1:07 p.m. the MSD and corporate maintenance director verified the concerns in room [ROOM NUMBER]. The MSD stated he would be fixing the concerns. On 8/20/20, at 1:25 p.m. the following concerns were observed in room [ROOM NUMBER], and verified by MSD and cooperate maintenance director: -The wall by the bathroom door was observed with gouges and scraps and the paint was peeling off the wall. -The caulking around the toilet base was observed missing and brown matter was noted to the back -The caulking around the sink counter was observed cracked all around it making it not a cleanable surface. -The kick plate to the room door was observed cracked with jagged edges and bent at ankle level. On 8/20/20, at 1:27 p.m. the following concerns were observed in room [ROOM NUMBER], and verified by MSD: The laminated flooring in the bathroom was observed buckled, broken and was missing a transitioning strip between the room and bathroom. A resident residing in that room did go in and out of the bathroom. In addition, on the counter top wall the paint was peeling off and the caulking around the base of the toilet was missing and brown debris was noted all around the base. MSD acknowledged the buckled, broken laminate and missing transition strip were a fall hazard for the residents. On 8/20/20, at 1:19 p.m. the following concerns in room [ROOM NUMBER] were observed: The floor base boards by the bathroom were torn off the walls. Also along the walls were multiple scrapes, and the counter was warped by the sink countertop under the paper towel holder. MSD and cooperate maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	**08/20/2020**

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) director verified the concerns, and when asked what was causing the counter to warp stated, It's getting old. On 8/20/20, at 1:27 p.m. the MSD stated he did not previously know about the environmental concerns identified during the survey. The MSD also stated unless someone had put in a TELS order recently he did not know. Surveyor requested to see the TELS work orders in the last two months for the unit. During a review of the Work Orders list provided by the MSD, from 7/1/20, through 8/20/20, it was revealed none of the concerns surveyors identified during survey had been identified and included in the work order list.