STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the primary care provider was notified timely when weight gained and [MEDICAL CONDITION] occurred for 1 of 3 residents (R18) reviewed for [MEDICAL CONDITION]. R18's Admission Record printed 9/4/20, indicated R18's [DIAGNOSES REDACTED]. R18's Minimum Data Set ((MDS) dated [DATE], indicated R18 was cognitively intact, required limited assistance with bed mobility, transfers, dressing, personal hygiene, and required extensive assistance with toileting. R18's medical record indicated the following weights: On 8/12/20, weight was 117 pounds (lbs) On 8/17/20, weight was 116 lbs On 8/24/20, weight was 123.4 lbs (7.4 lbs. weight increase in seven days) On 9/3/20, weight was 125.5 lbs R18's medical record lacked indication the physician or nurse practitioner (NP) was notified on 8/24/20, at the time of R18's 7.4 lbs weight gain. On 8/27/20, a progress note indicated R18 had no [MEDICAL CONDITION]. On 8/29/20, two separate progress notes indicated R18 had [MEDICAL CONDITION] to the left foot and lower leg. On 8/30/20, a progress note indicated R18 had [MEDICAL CONDITION] to the left foot and lower leg. On 8/31/20, a progress note indicated R18 had [MEDICAL CONDITION] to the foot. On 9/1/20, a progress note indicated R18 had [MEDICAL CONDITION] in left foot. R18's progress notes lacked indication the MD was notified of R18's [MEDICAL CONDITION]. On 9/1/20, at 9:45 a.m. the top of R18's left foot and toes were observed to be swollen. R18 stated she told licensed practical nurse (LPN)-C her left foot was swollen, she was gaining weight, and requested to have a diuretic (medication that removes excess fluid) ordered. R18 stated she had gained over 7 lbs in a week, and was concerned her left foot and toes were swollen. On 9/2/20, at 7:30 a.m. R18's was observed propelling herself in the hallway in her wheelchair and R18's left lower leg was observed to be swollen. On 9/3/20, at 10:55 a.m. LPN-F stated she was unaware R18 had a weight gain of 7.4 lbs in a week prior to that day. LPN-F verified R18's medical record lacked indication R18's physician was notified of R18's 7.4 lbs weight gain, and [MEDICAL CONDITION] prior to 9/2/20. LPN-F stated a physician should be notified of a weight gain of five lbs or greater in a week. On 9/3/20, at 11:35 a.m. LPN-C stated she reviewed resident weights weekly. LPN-C stated she was aware of R18's weight gain the week of 8/24/20. LPN-C stated she did not notify the NP of R18's weight gain and [MEDICAL CONDITION] because R18 was already on the NP's schedule to bee seen on 8/24/20. LPN-C stated was unsure why R18 was not seen by the NP on 8/24/20, or 8/26/20. LPN-C stated she added R18 to the NP's schedule on 9/2/20, because of her weight gain. LPN-C stated the NP should have been notified immediately of R18's weight gain and [MEDICAL CONDITION], and further stated LPN-C should have followed up with the NP prior to 9/2/20. On 9/3/20, at 3:01 p.m. LPN-I stated she was responsible for keeping the NP rounding schedule. LPN-I stated the nurses would request a resident to be seen by the NP, and LPN-I would add the resident to the NP's schedule and the reason for the visit. LPN-I stated R18 was scheduled to be seen on 8/24/20, for an initial NP visit after her admission to the facility. LPN-I stated the NP was running out of time that day, and R18 was rescheduled to be seen on 8/26/20. LPN-I stated R18 was not seen by the NP on 8/26/20. LPN-I verified according the NP's schedule, the reason listed R18's was to be seen on 8/24/20, and 8/26/20, was for an initial visit, and weight gain was also listed. LPN-I verified the NP did not see R18 until 9/2/20. On 9/4/20, at 3:51 p.m. the director of nursing (DON) stated she expected the physician or NP to be notified of any weight gain over five lbs either by fax or phone the day the weight increase was discovered. The DON further stated a weight gain of 7.4 lbs would be a concern of changes in underlying medical conditions. The facility policy Change in Resident's Condition or Status revised 5/17, directed to promptly notify the resident's physician of changes in the resident's medical/mental condition and/or status.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a wheelchair was cleaned and in sanitary condition for 1 of 8 residents (R45) reviewed for environment. Findings include: R45's Admission Record dated 9/3/20, indicated R45's [DIAGNOSES REDACTED]. R45's annual Minimum Data Set ((MDS) dated [DATE], indicated R45 was cognitively intact. R45's MDS further indicated he had severely impaired vision, used a wheelchair, and required extensive assistance with transfers. R45's care plan dated 7/29/20, directed staff to clean equipment when visibly soiled and at least weekly. On 9/2/20, at 8:22 a.m. R45's wheelchair cushion was observed to have dried, yellow, and white crusted food debris on it. The food debris was approximately four inches (in.) by two in. Nursing assistant (NA)-G and NA-F were in R45's room. NA-G was observed to stand over R45's wheelchair and looked at the wheelchair cushion. NA-G then walked to R45's bathroom and NA-F was observed to also look at R45's wheelchair. NA-G and NA-F then transferred R45 to his wheelchair. R45 was seated directly on top of the soiled wheelchair cushion. On 9/2/20, at 10:25 a.m., R45 was observed being transferred, by NA-H, from his wheelchair to the bed. R45's wheelchair cushion remained soiled. On 9/2/20, at 10:30 a.m., NA-H was interviewed and confirmed R45's wheelchair cushion was soiled. NA-H stated, he believed it was egg residue on R45's wheelchair. NA-H stated he did not notice the residue when he got R45 up. NA-H stated wheelchair cleaning was completed weekly and when spills occurred. On 9/3/20, at 2:22 p.m., the director of nursing (DON) stated she expected staff to clean a wheelchair cushion when it was dirty. A wheelchair cleaning schedule was requested but not provided by the facility A policy on wheelchair cleaning was requested but not provided by the facility.
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 an allegation of abuse to the stated agency (SA) for 1 of 2 residents (R7) reviewed for abuse. Findings include: R7's quarterly Minimum Data Set ((MDS) dated [DATE], indicated she was severely cognitively impaired, and required extensive assistance for bed mobility, and total assistance for transfers. On 8/6/20, an untitled facility document indicated around 6:40 p.m., a nursing assistant (NA) went to the unit, and as she approached the doors she heard a nurse in front of the medication cart facing R7's room yelling, (R7), shut up and go to bed, shut up and go to bed, (R7), its time to go to bed, just shut up. The document further indicated the NA reported the incident to two other nurses who told her to write a statement and place it in the DON's inbox. On 8/7/20, a facility report to the SA indicated a nursing assistant (NA) reported she was walking toward the wing four hallway, and could hear a nurse through the doors loudly telling at a resident to, Shut up and go to bed. The

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) report further indicated the incident occurred on 8/6/20, but was not reported to the director of nursing (DON) and the administrator until the following day. On 9/3/20, at 10:06 a.m. the administrator stated four staff members were aware of the incident, but it was not reported to him until the following day. The administrator stated it should have been reported to him immediately. The facility policy Abuse Prohibition Vulnerable Adult Plan dated 7/5/19, directed to ensure residents in the facility were not subjected to abuse by anyone. The policy further directed all staff were responsible for reporting any situation that was considered abuse or neglect, and to notify the administrator immediately of any allegations of abuse or suspected abuse. The policy directed suspected abuse shall be reported to the SA no later than two hours after forming a suspicion of abuse.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 of 6 residents (R111) reviewed for accidents. Findings include: R111's Admission Record printed 9/4/20, indicated R111 was admitted to the facility on [DATE], and [DIAGNOSES REDACTED]. A review of R111's medical record lacked a baseline care plan. On 9/4/20, at 1:50 p.m. licensed practical nurse unit coordinator (LPN)-C was interviewed and verified R111 did not have a baseline care plan. On 9/4/20, at 2:45 p.m. the director of nursing (DON) was interviewed and verified a baseline was to be developed within 24 hours of admission. A facility policy on baseline care plans was requested but not provided.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide nail care and remove facial hair for 3 of 8 residents (R21, R215, R45) reviewed for activities of daily living (ADLs) and who were dependent on staff for ADL assistance. Findings include: R21's Admission Record dated 9/4/20, indicated R21's [DIAGNOSES REDACTED]. R21's admission Minimum Data Set ((MDS) dated [DATE], indicated R21 was cognitively intact, and required one assist with personal hygiene needs. R21's care plan dated 6/30/20, directed staff to provide assistance of one for personal hygiene. R21's weekly skin inspections indicated R45 had not been shaved or had his nails trimmed since admission on 6/18/20. On 9/1/20, at 10:41 a.m. R21 was interviewed and stated he did not own clippers and has asked staff to trim his fingernails and beard. R21 was observed to have long, jagged fingernails on both hands, and long facial hair. On 9/2/20, at 7:26 a.m. R21 was observed in bed, and his nails and facial hair remained long and untrimmed. On 9/2/20, at 7:28 a.m. R21 put his call light on and asked nursing assistant (NA)-D if he could have his bath. NA-D stated R21's bath was scheduled for that evening. On 9/3/20, at 9:33 a.m. R21 was observed, and fingernails and facial hair remained long. R21 was interviewed and stated he did not get his bath as scheduled last evening. ON 9/3/20, at 11:03 a.m. licensed practical nurse (LPN)-F stated if a resident refused a bath, staff was to document refusals on a weekly skin inspection sheet, and report the refusal to the nurse. R21 reviewed R21's weekly skin inspection sheet dated 9/2/20, and noted a zero with a line drawn through, which indicated R21 did not get his shower. R21 further stated she heard staff did not have time last evening to give R21 his shower. LPN-F stated staff should try and get his shower completed that day. On 9/3/20, at 3:19 p.m. R21 was interviewed and stated he still had not been offered a shower, and it was important to him to get a shower, and have his fingernails and facial hair trimmed. On 9/3/20, at 3:20 p.m. nursing assistant (NA)-I verified R21 did not get a bath/shower last evening as scheduled. NA-I stated nail care and shaving was completed on bath/shower day and as needed. NA-I stated it looked like R21's had had not been shaved or nails trimmed in several weeks. On 9/3/20, at 3:56 p.m. the director of nursing (DON) stated residents should be offered to be shaved and nails trimmed on bath/shower day. The DON further stated if a resident declined cares, it was expected to reproach the resident three times, have a different staff member reproach, and if continued to decline, document the refusal. The DON stated if baths were unable to get done, it was expected to notify the nurse, ask for assistance, offer at a later time, and document on the weekly skin inspection sheet. R215's Admission Record dated 9/4/20, indicated R21's [DIAGNOSES REDACTED]. R215's admission MDS dated [DATE], indicated R21's cognition was moderately impaired, and required extensive assistance with personal hygiene. R215's care plan dated 8/28/20, indicated R21 was to be dressed, groomed, and bathed. R215's weekly skin inspection dated 8/28/20, indicated R21 received assistance with a bed bath, R21 was not shaved, and fingernails and toenails were not trimmed. On 8/31/20, at 5:39 p.m. R215 was observed to have dark facial hairs on the upper lip, and long jagged fingernails with a brown debris underneath and along the sides of the nails on both hands. On 9/2/20, at 12:47 p.m. R215 was observed in her room and had just finished with lunch. R21's fingernails remained long with a brown debris underneath fingernails. R215 continued to have dark facial hairs above upper lip. On 9/3/20, at 9:01 a.m. R215's nails remained long and dirty dirty, and facial hairs noted above the upper lip. R215 was interviewed and stated she preferred to have her nails shorter, and facial hair removed. On 9/3/20, at 3:26 p.m. licensed practical nurse (LPN)-F verified R215's facial hair to upper lip and fingernails were long and dirty. LPN-F asked R215 if she would like to have her fingernails soaked and trimmed, and her hair removed from her upper lip and stated R215 stated yes. On 9/4/20, at 3:56 p.m. the DON stated residents should be offered shaving and nail care each bath day and documented on the weekly skin inspections sheets. R45's Admission Record dated 9/3/20, indicated R45's [DIAGNOSES REDACTED]. R45's annual MDS dated [DATE], indicated R45 had intact cognition. R45's MDS further indicated he had severely impaired vision, and required extensive assistance with personal hygiene. R45's care plan dated 7/29/20, indicated R45 required extensive assistance grooming. R45's care plan directed staff to shave R45 as needed. Review of R45's weekly skin inspections dated 8/26/20, and 8/31/20, indicated shaving assistance was last documented on 8/26/20. On 8/31/20, at 5:13 p.m. R45 was observed to have long facial hair. On 9/2/20, at 8:22 a.m. nursing assistant (NA)-F and NA-G were observed to perform personal cares and transferred R45 to his wheelchair. An electric razor was noted on a table near R45's window. NA-F and NA-G did not offer to shave R45. On 9/2/20, at 2:25 p.m. R45 was interviewed and he stated his preference was to be clean shaven. R45 stated, I like [MEDICATION NAME] skin. R45 stated his preference was to be shaven every few days, and preferred to be shaven now. On 9/2/20, at 2:33 p.m. NA-I confirmed R45 needed staff assistance with shaving. NA-I stated R45 did not have the dexterity to shave himself. NA-I stated he believed R45 was legally blind. R45 was observed with NA-I, and NA-I confirmed the presence of facial hair. NA-I stated he believed the facial hair was present a day or two. On 9/2/20, at 2:51 p.m. NA-H was interviewed and stated R45 was blind, however, shaved himself. NA-H stated R45 required set up assistance, and staff placed a gown over him. NA-H stated R45 was very precise and particular. NA-H confirmed R45 had facial hair and stated it was a little longer than a five o'clock shadow. NA-H stated he was unaware when R45 was last shaven, and further stated R45 was shaved on shower days. On 9/3/20, at 9:28 a.m. LPN-B stated R45 needed staff assistance with shaving. LPN-B confirmed staff shaved R45, and stated he was blind. On 9/3/20, at 2:20 p.m. the director of nursing (DON) stated R45 needed staff assistance with shaving. The DON stated staff were expected to shave R45. The facility policy Monarch Healthcare ADL Assistance revised 5/18, directed based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be shaving males and females as needed, and fingernails and toenails to be clean and trimmed.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided for 4 of 4 residents (R111, R16, R28, and R45) reviewed for activities. Findings include: R111's Admission Record printed 9/4/20, indicated [DIAGNOSES REDACTED]. R111's care plan initiated 8/31/20, indicated R111 was at risk for increased depression and anxiety related to decreased socialization due to federal guidelines while managing Coronavirus-19. Interventions included assessments for risk of social isolation, and provide appropriate independent activities per resident likes and wishes. R111's care plan lacked identification of R111's specific activity needs and preferences. R111's Activity Participation Review dated 8/31/20, indicated R111 enjoyed one on ones with staff and his own independent activity

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) in his room, and would participate in hallway activities of his choosing. R111's favorite activities, special accomplishments, and/or new interests included watching TV, exercises, the daily chronicles, short stories, trivia, and visiting with staff and his roommate. R111's activity-related focuses including needs, strengths and preferences was determined to remain appropriate and current as per R111's care plan. R111's Activity Participation Review did not address activities R111 had actually attended or participated in. The facility Activity Record of Participation undated, indicated R111 had been provided with the Daily Chronicle, but lacked documentation of any one to one visits, participation in any activities, and provision of independent activity materials, such as books or magazines. On 9/1/20, at 10:28 a.m. R111 was observed sitting in his room, a quarantine sign was hanging on his door, and no activity materials were visible in his room. R111's TV was turned toward his roommate. R111 stated there were no activities going on, and he got bored. On 9/2/20, at 2:35 p.m. R111 was observed to be sitting in his room with the door mostly closed. R111 had no activity materials, and the TV was on towards R111's roommate. On 9/2/20, at 2:45 p.m. R111 was sitting in his room, and said he had just returned from exercises. R111 stated there was nothing to do. R111 pointed at the quarantine sign on his door and asked, Do you know what I can do in here? R111 stated it was worse than being in prison. R111 stated he liked to read, but couldn't see very well. R111 had no reading materials in his room. On 9/3/20, at 10:23 a.m. R111 was in his room, talking on the phone, with no individual activity materials in sight. On 9/4/20, at 1:12 p.m. nursing assistant (NA) -G stated R111 had been in quarantine, and she had not seen him doing anything. NA-G stated she was not sure what activity staff do for residents. On 9/4/20, at 1:43 p.m. licensed practical nurse (LPN)-F stated R111 had not done any activities, but had been in therapy. LPN-F stated R111 went outside with therapy staff earlier that day, and was happy about that. LPN-F stated no staff do activities with any residents, other than dropping off a flier in their rooms. On 9/4/20, at 2:45 p.m. the director of nursing (DON) stated activities should do one-to-one activities, but was not sure what was happening. The DON stated activity staff try to think of ways for residents to participate. The facility policy Activity Programs revised 6/18, directed the activities program was provided to support the well-being of the resident, was based on the comprehensive resident-centered assessment and resident preferences, and included facility-organized group activities, independent individual activities and assisted individual activities. The policy indicated activity programs were designed to meet the needs and interests of the residents and activity participation was to be documented in the resident's medical record. R16's significant change MDS dated [DATE], indicated he was severely cognitively impaired, and required extensive assistance for all activities of daily living (ADLs). The activity preference section of R16's MDS was not completed. R16's Care Area Assessment (CAA) for Activities dated 8/30/20, indicated R16 showed little interest or pleasure in doing things. The CAA indicated R16 was dependent on staff for setting up and engaging him in activities, and indicated R16 was confined to his room related to infection. The CAA further indicated staff were to provide one to one room visits, and indicated R16 liked watching television, listening to classical music, and liked the window open for fresh air. R16's care plan dated 8/30/20, indicated he was dependent on staff for setting up and engaging in activities due to cognitive deficits and physical limitations. The care plan directed staff to converse with R16 while providing care, and open the window for fresh air. The care plan also indicated R16 liked to watch television, converse with family on the IPad, and listen to classical music. R16's care plan further indicated a risk for increased depression and anxiety related to decreased socialization. R16's Activity Participation Review dated 8/11/20, indicated R16 enjoyed the Daily Chronicles, short stories, tons of puns, and staff reading to him. On 9/1/20, at 9:07 a.m. R16 was observed lying on his back in bed with no television or radio on in his room. At 10:14 a.m. R16 remained in bed with his eyes open and no television or radio on. At 10:16 a.m. activity aide (AA)-A was in another resident room handing out the Daily Chronicles. AA-A left the unit without stopping in R16's room. On 9/2/20, at 8:33 a.m. R16 was observed laying on his back in bed with no television or radio on in his room. At 9:39 a.m. R16's television was on, R16 was laying on the bed with his eyes closed, and not engaged in the program. On 9/3/20, at 8:28 a.m. R16 was again observed lying in bed with no television or radio on. Staff had awakened R16 prior to 7:30 a.m. R16 was shifting around in the bed and appeared restless. Facility documents titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following: 7/17/20, R16 watched television 7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television, visits with staff and Daily Chronicles, 10 minutes. The log lacked any indication the activities were completed. 7/22/20 - 7/27/20, pre-filled activity log indicated the same as 7/21/20. 7/28/20, activity log was left blank. 7/30/20 and 7/31/20, the pre-filled activity log was again provided but no indication activities were completed. 8/1/20 - 8/19/20, no activity attendance was provided. 8/20/20, R16 had a one to one visit talking about the weather, and current events were read to him. 8/24/20, indicated Daily Chronicles were read to R16. 8/27/20, staff sat with R16 and talked about the day. 9/1/20, R16 had a visit from family. 9/2/20, indicated daily chronicles. The activity logs lacked evidence of weekend activity programming. On 9/3/20, at 11:28 a.m. nursing assistant (NA-)-J stated R16 watched television and had an IPad if he wanted to use it. NA-J stated sometimes R16 got up in his chair, and sometimes not. R28's admission MDS dated [DATE], indicated he was severely cognitively impaired, and he required assistance from staff to transfer. The MDS indicated locomotion off the unit had not occurred during the assessment period. R28's MDS further indicated it was somewhat important to do his favorite activities, go outside and get fresh air, and listen to music. R28's care plan dated 7/17/20, indicated R28 displayed little or no activity involvement, and indicated he would participate in one to one activity with staff. The care plan directed staff to inform R28 of scheduled activities, and praise efforts for attendance of hallway activities. A facility document titled Wing 3 dated 7/17/20 - 9/2/20, included a list of residents on the unit and identified the following: 7/17/20, no activity identified. 7/21/20, activity log was pre-filled out on a computer and indicated independent activity, watching television and one to one, Daily Chronicles 10 minutes. There was no indication the activities were completed. 7/22/20 - 7/24/20, and 7/27/20, Pre-filled attendance log provided, but no indication the activities were completed. 7/28/20, copy of chronicle, R28 was not interested in library cart but showed him items and he accepted three different items. 7/30/20, 7/31/20, pre-filled attendance sheet provided with no indication activity was completed. 8/1/20 - 8/17/20, no activity attendance was provided. 8/18/20, Daily Chronicles. 8/21/20, Daily Chronicles. 8/24/20, Daily Chronicles. 8/27/20, Enjoying television, provided chronicles but R28 was tired and declined further interaction. 8/29/20, Daily Chronicles. 9/2/20, Daily Chronicles. The activity logs lacked evidence of weekend activity programming. On 9/1/20, at 9:01 a.m. R28 was sitting up in his wheelchair in his room with the television on. At 10:16 a.m. AA-A was on the unit handing out the Daily Chronicles. AA-A left the unit without stopping in R28's room. On 9/2/20, at 7:45 a.m. R28 was in his room laying in bed. At 9:09 a.m. R28 remained in his bed, no staff had entered room or engaged him in any way. He remained laying in bed at 10:03 a.m. On 9/3/20, at 11:26 a.m. NA-J was interviewed and stated staff assisted R28 to get up in his chair, and stated he watched television and looked outside. NA-J stated R29 did not come out of his room. NA-J further stated the nursing staff did not provide any activities to residents, only the activities staff did activities. NA-J stated R28 got papers from activity staff, but did not know if he participated. On 9/3/20, at 2:54 p.m. the administrator stated the activity director was new. The administrator stated when she started, someone from another facility developed the guide based on previous assessments (the guide referred to the activity log that was pre-filled out). The administrator stated the direct care staff did activities with residents, but they were probably not documented. The administrator stated when the activity director first started she did most of the activities, but stated since COVID-19, most of the activities were one to one visits. The administrator stated the Daily Chronicles was a hand out that described what activities were occurring each day, and sometimes had other things like a word search. The administrator stated the activity department handed them out to residents, and went over it with them. The administrator stated R16 had an IPad set up with things, and had a bird feeder outside his window. The administrator stated activities staff would go in and chat with R16 in his room, and said it was difficult to have him outside his room due to infection control concerns. The administrator stated he did not know R28 well, but said if something was written down for an activity, it was probably done. R45's Admission Record dated 9/3/20, indicated R45's [DIAGNOSES REDACTED]. R45's annual MDS dated [DATE], indicated R45 had intact cognition, had severely impaired vision, and had highly impaired hearing. R45's activity self-assessment indicated he enjoyed being around animals, time outdoors, and keeping up with the news. R45's activity self-assessment lacked indication he enjoyed listening to music and reading books, newspapers or magazines. R45's care plan reviewed 7/29/20, indicated R45 was dependent on staff for activities, cognitive stimulation, social interactions, and well-being. R45's care plan further indicated he independently pursued activities, and he liked to listen to a transistor radio or the

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) television. R45 refused to go outside or attend group activities. R45's Care Conference form dated 8/3/20, indicated R45 relied on staff for activities, and participated in one-on-one activities with staff. The form further indicated R45 did not have interest in activities due vision and hearing loss. R45's July 2020 activity log indicated the following activities were documented: - Delivered mail and talked a bit on one occurrence. - Watched television on one occurrence. - Listened to transistor radio on eight occurrences. - No other activities were documented. R45's August activity log indicated the following activities were documented: - Visited with staff and current events on one occurrence. - The Daily Chronicles on five occurrences. - Visited by staff about his needs on one occurrence. - Chatted about fall and reviewed today's events on one occurrence. - Verbal interactions through day on one -R45 refused to walk on one occurrence. - No other activities were documented. On 8/31/20, at 4:44 p.m. R45 was observed sitting in a wheelchair in his room. R45 had a bedside table in front of him, and the lights were off in the room. R45 was facing forward toward a wall. The television was noted to be off, and no radio was observed in R45's room. R45 stated he used to enjoy fishing, reading, and watching television. On 8/31/20, at 6:00 p.m. R45 was observed sitting in a wheelchair in his room. R45 was eating dinner. R45 was facing forward toward a wall. The television was noted to be off. On 9/2/20, at 8:22 a.m. NA-F was observed to assist R45 with morning cares, transferred him to a wheelchair, and placed a bedside table in front of him. The TV was noted to be off. At 8:47 a.m. activities assistant (AA)-B entered R45's room and placed a mug on his bedside table. AA-B then exited the room. From 9:29 a.m. to 10:17 a.m., R45 was seated in a wheelchair and facing forward toward a wall. R45's television remained off. At 12:43 p.m. R45 was seated in a wheelchair facing forward toward a wall. R45's television remained off. At 1:03 p.m. AA-A was observed to walk past R45's room and entered several resident's rooms and offered them an opportunity to attend an exercise activity. AA-A did not enter R45's room. At 1:42 p.m. At 2:14 p.m. R45 was observed lying in bed and appeared to be awake. NA-I entered R45's room and stated R45 he was just kind of laying around. On 9/2/20, at 2:25 p.m. R45 stated, I don't do anything. R45 stated he was bored and tried to keep himself comfortable by lying in bed most of the time. The television was noted to be off. On 9/3/20, at 8:37 a.m. R45 was observed to be eating breakfast in his room. At 8:52 a.m. R45 was observed to be facing toward a wall. R45's television was noted to be off and no radio was observed in the room. On 9/3/20, at 8:54 a.m. NA-D stated R45 liked to listen to the radio, but not often. NA-D stated he did not know if there was a radio in R45's room right now. NA-D stated he did not know if R45 attended activities. NA-F stated in the past, staff assisted R45 to play bingo. NA-D stated staff provided a daily sheet and was pretty sure they read it to him. NA-D stated R45 listened to his roommates television. NA-D stated R45 found peace with peace and quiet. NA-D stated R45 barely talked. When asked what types of activities were provided to R45, NA-D stated restorative therapy walked him. On 9/3/20, at 08:52 a.m. R45 was observed to be in his room facing forward toward a wall. R45's television was noted to be off. On 9/3/20, at 9:12 a.m. NA-E stated R45 didn't have much going on. NA-E stated R45 was unable to see and had hearing issues. NA-E stated there was not much for R45 to do due him being blind and hard of hearing. NA-E stated he believed music was provided in the past, and R45 was just living day-to-day. When asked about R45's activity participation, NA-E stated restorative staff provided R45 with exercises. On 9/3/20, at 9:41 a.m. AA-B entered R45's room and offered him the Daily Chronicle. On 9/3/20, at 9:46 a.m. AA-B stated R45 was unable to hear well at all, and he did not engage with television or music. AA-B further stated R45 doesn't see and staff cannot give him word searches or other paper activities. AA-B stated she was unsure if other sensory stimulation activities had been offered to R45. AA-B stated activities staff would talk with R45 about his life. AA-B stated R45 wants to be in bed and he likes to sleep. AA-B stated restorative staff does some stuff with him but was unsure of the frequency provided when asked about other activity participation. On 9/3/20, at 10:19 a.m. LPN-C stated R45 was a very quiet man and didn't like to attend activities. LPN-C stated R45 liked to lay down, and used to listen to the radio but was too hard of hearing now. LPN-C stated, I don't know what they do to engage him, and further stated, I can't say I have seen activities over here talking with R45 in the last 2 weeks. LPN-C stated restorative therapy walked with him. On 9/3/20, at 2:17 p.m. the DON stated R45 was in restorative therapy, and stated, I guess you could call that an activity. The DON stated she would have to ask the activities department about other activities R45 was in. The DON stated she would expect staff to offer R45 activities.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure Ace wraps and heel boots were applied for 1 of 2 residents (R17) reviewed for quality of care. Findings include: R17's Admission Record dated 9/4/20, indicated R17's [DIAGNOSES REDACTED]. R17's care plan dated 7/10/20, indicated R17 had a history of [REDACTED]. R17's care plan further directed blue boots to be put on when up in the wheelchair and in bed for cushion. R17's treatment administration record (TAR) dated 9/4/20, directed Ace wraps to legs to be applied in the a.m. and off in the p.m. The TAR further directed blue boots to both feet while in bed, and when up in the wheelchair. On 9/2/20, at 8:13 a.m. R17 was observed sitting in her wheelchair watching television, and was not wearing Ace wraps to her legs or blue boots. On 9/3/20, at 9:00 a.m. R17 was observed sitting in her wheelchair, and did not have Ace wraps or blue boots on. On 9/3/20, at 11:01 a.m. licensed practical nurse (LPN)-F stated R17 was to have her Ace wraps on during the day, and her blue heel boots on while in bed and in the wheelchair. LPN-F further stated the nurses apply the Ace wraps in the morning, and the nursing assistants apply the blue boots. On 9/3/20, at 1:29 a.m. nursing assistant (NA)-P stated resident care was directed by the resident's care plan. NA-P verified R17 was supposed to have blue boots on when up in the wheelchair and in bed. On 9/3/20, at 2:51 p.m. LPN-F stated she did not put R17's Ace wrap on that morning, and planned to put them on later in the day. LPN-F verified she signed R17's TAR and indicated she had put R17's Ace wraps and blue boots on, and they were not on. On 9/4/20, at 4:41 p.m. the director of nursing (DON) stated she would expect staff to follow the resident's plan of care, and further stated treatments should be signed off on the TAR after the treatment was completed, and not before. The DON further stated the concern for heel protectors and Ace wraps not being applied as directed could lead to worsening [MEDICAL CONDITION] and pressure injuries. The facility policy Care Planning revised 6/19, directed each resident will have a person centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs.
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 an appropriate smoking assessment was completed for 1 of 1 residents (R30) reviewed for smoking. Findings include: R30's Admission Record indicated [DIAGNOSES REDACTED]. R30's quarterly Minimum Data Set ((MDS) dated [DATE], identified intact cognition, and required total assistance for activities of daily living (ADLs) including locomotion on and off the unit. The MDS further identified R30 had upper extremity impairment to both sides. R30's care plan dated 7/13/20, identified R30 had a self care deficit related to limited mobility. R30's care plan for smoking dated 8/31/20, indicated he currently smoked at the facility. The care plan indicated R30 had a device used to assist with smoking, and had been assessed to smoke independently with assistance only to light the cigarette. On 5/5/20, a progress note indicated R30 had been outside smoking, and when the nursing assistant (NA) went outside to get him, she found that R30 had caught his cigarette on the adaptive device he had rigged to try to smoke, and could not get it off. The progress note indicated, if NA had not gone outside he (R30) could have burnt himself. R30's Smoking Evaluation dated 5/6/20, indicated he was currently smoking, and identified cognitive loss and a dexterity problem. The assessment indicated R30 required the use of a cigarette extension/holder, and indicated writer observed R30 smoking. R30 needed adaptive equipment that the activities department was going to pick up. The assessment further indicated R30 needed staff to light the cigarette, then could use his arms, hands and adaptive equipment to smoke independently. R30's Smoking Evaluation dated 8/31/20, indicated he was currently smoking, and had a cognitive loss and a dexterity problem. The assessment identified the use of a cigarette extension/holder, and indicated R30 required staff to light the cigarette and was then able to use his arms, hands and adaptive equipment to smoke independently. On 8/31/20, at 4:18 p.m. R30 was observed outside smoking a cigarette independently. R30's right hand was wrapped in a bandage, and a stylus was sticking out the top of the bandage. The stylus was used to aide R30 in use of his phone and tablet. On the left

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	245495	A. BUILDING _____ B. WING _____	09/04/2020

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) side of R30's right hand, a yellow plastic clothes pin was sticking out of the bandage. The clothes pin was stained a dark brown and appeared burnt. On 9/2/20, at 12:46 p.m. R30 was observed outside smoking a cigarette. When R30 finished his cigarette, he was observed to drop the still lit cigarette butt on the grass next to his chair. On 9/3/20, at 8:35 a.m. nursing assistant (NA)-A was interviewed and stated a few days prior, R30's family member had called the facility because he had told her staff were not checking on him when he was outside. NA-A stated R30 needed staff to assist him with lighting his cigarette, stated staff took R30 outside, and R30 had this thing on his hand, and we light the cigarette and he does it that way. NA-A stated R30 could ask when he wanted a cigarette, and would call the facility if he needed something when he was outside, but could not get himself in or out of the building independently. NA-A stated she thought they checked on R30 every hour when outside following the phone call from his family member. On 9/3/20, at 1:51 p.m. the director of rehabilitation (DOR) stated R30 had a universal cuff to use his phone and his IPad with a stylus, and used a clothes pin to smoke. The DOR stated R30 was able to use the clothespin to get the cigarette to his mouth, and when he was done he could get rid of the cigarette. The DOR stated R30 disposed of his cigarette on the ground. The DOR stated they had ordered something different to assist R30 with smoking and it had arrived the previous day but had not been implemented yet. The DOR stated he had been outside when R30 was smoking, but had not assessed him, and stated it was up to nursing to determine if residents could smoke safely. At 9:45 a.m. the director of social services (DSS) stated she would typically go out and see if residents were safe to smoke, whether or not a smoking apron was needed, or if assistance to light the cigarette was needed. The DSS stated R30 needed assistance to light a cigarette and was able to ash the cigarette appropriately, but disposed of his cigarette butts on the ground. The DSS stated a new smoking device had been ordered and said we don't like that clip he's using, it's plastic and it could melt. The DSS further stated R30 was supposed to be checked on every 30 minutes while outside, because he felt once he was out there staff did not check on him. At 1:37 p.m. registered nurse (RN)-A stated initially she did not think R30 was safe to smoke. RN-A stated physical therapy rigged up the clothes pin that was connected to R30's hand. RN-A stated R30 was not able to dispose of his cigarette in an ashtray. RN-A further stated she usually completed the smoking assessments and said in regard to R30, I did not rig up the clothespin, they (therapy) did so . At 2:19 p.m. the DOR confirmed that the therapy department did rig up the clothes pin so R30 could smoke, but stated therapy did not complete a formal assessment. At 3:32 p.m. the director of nursing (DON) stated the nurse manager or social services department watched residents to make sure they were safe to smoke independently. The DON stated the criteria for safe, independent smoking included being able to hold a cigarette, not drop hot ashes, and properly dispose of the cigarette in the canister. The DON stated she had not observed R30 smoking. The facility policy Resident Smoking Agreement undated, directed the purpose of providing residents with the safest smoking environment possible, and to provide the smoking supervision each resident requires. The policy identified three smoking categories: able to smoke independently without an apron, requirement of an apron to smoke safely, and resident requiring smoking supervision to be safe. The policy did not identify the criteria for the smoking categories.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to effectively provide pain management for 1 of 3 residents (R260) reviewed for pain. This resulted in actual harm to R260 when her pain was not relieved. Findings include: R260's Admission Record printed on 9/3/20, indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. R260's admission Minimum Data Set (MDS) completed on 9/1/20, indicated R260 was severely cognitively impaired. R260's MDS indicated she received as needed pain medications (PRN), had pain present almost constantly, the pain made it difficult to function, and limited her day to day activities. R260's MDS indicated she rated her pain a nine on a scale of one to ten. R260's Care Area Assessment (CAA) dated 8/30/20, indicated pain as a potential problem. Staff were directed to administer medications as ordered, to monitor for effectiveness of PRN pain medication, and document in the Medication Administration Record [REDACTED]. R260's care plan initiated on 8/17/20, indicated staff should use pain medication as ordered by the medical doctor (MD), document effectiveness of pain, and encourage the resident to verbalize discomfort. R260's Order Summary Report with active orders through 9/3/20, indicated R260 had an order for [REDACTED]. The NAs asked R260 if she could sit up, she agreed, but when they attempted to move her from lying in her bed to sitting on the edge of her bed, R260 resisted, saying it hurt too much. NA-K and NA-L layed R260 back down on her bed sideways. R260 stated, It's the fracture, and said she had forgotten that she had a fracture. The NAs rolled her side to side, and placed a lift sheet under her. During repositioning, R260 said she was in lots of pain, and described the pain as sharp and shooting. R260 did not want to get dressed or have any cares completed after attempting to get out of bed. -at 1:18 p.m. NA-K and NA-C entered to dress R260 for a clinic appointment. R260 kept repeating, Ow and It hurts. R260 resisted attempts at dressing and getting out of bed, and layed back down on the bed. NA-K and NA-C let her rest briefly, and continued dressing her. NA-K and NA-C had R260 stand up, and transferred her quickly to the wheelchair. During the transfer, R260 continued to say Ow. -at 1:49 p.m. NA-K was interviewed. NA-K stated R260 usually complained of pain when going from laying to sitting in bed. NA-K stated she informed registered nurse (RN)-C about R260's pain. -at 1:59 p.m. RN-C was interviewed. RN-C stated the NAs had informed her R260 was in pain in the morning, and did not want to get up or get dressed. RN-C stated she had given R260 scheduled [MEDICATION NAME] (Tylenol), and she tried not to give confused residents narcotics. RN-C stated she should have pre-medicated R260 prior to her clinic appointment this afternoon. -at 2:39 p.m. R260 was observed crying out in pain as she was assisted from the wheelchair back into her bed following her return from the clinic. R260 stated she had been in pain since she left for the appointment. R260 stated once she was back in bed, the pain was less. -at 3:04 p.m. RN-A was interviewed, and stated she did not see R260 when she returned from the clinic. RN-A stated, She is always like this when you want her to do something. RN-A stated she would expect staff to complete a pain assessment on R260 every shift. On 9/2/20, the physician's note from orthopedic clinic visit indicated the resident was alert, confused, in a lot of pain, and refusing meals. On 9/3/20, at 9:49 a.m. R260 was resting in bed, and stated she was hurting today. -at 10:05 a.m. NA-A was interviewed. NA-A stated when she was assisting R260 with cares in the morning, R260 had called out Ow, ow. NA-A stated she could only get R260 to sit on the edge of the bed, and stand long enough to pull up her pants. NA-A had planned to get R260 out of bed, but could not accomplish this because of R260's pain. NA-A stated she informed the nurse of R260's pain, and also told the nurse R260 would not get out of bed. NA-A was told by the nurse to try again later. -at 10:34 a.m. licensed practical nurse (LPN)-D was interviewed. LPN-D did not know when R260 was last medicated for pain. LPN-D stated she had not completed a pain assessment on R260, and had not seen R260 move yet today. LPN-D stated she would need to see R260 move to complete a pain assessment. -at 1:50 p.m. R260 was observed trying to get out of bed. LPN-D went to get another staff to help get R260 back into bed. R260 stated, Oh I hurt so bad. LPN-D stated R260's last PRN pain medication was given on 9/3/20, at 12:27 a.m. -at 2:30 p.m. the director of nursing (DON) was interviewed. The DON stated she would have expected staff to pre-medicate R260 prior to her clinic appointment on 9/2/20. On 8/20/20, progress note by nurse practitioner indicated resident's pain was controlled with [MEDICATION NAME]. The facility policy Pain Assessment and Management revised 3/15, defined pain management as the process of alleviating the resident's pain to a level that is acceptable to the resident, and is based on his or her clinical condition and established treatment goals. The care process included the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; The policy indicated the resident should be observed during rest and movement for physiological and behavioral (non-verbal) signs of pain. Resisting care was described as a behavior to monitor, as were limitations in his or her level of activity due to the presence of pain, guarding, rubbing or favoring a particular part of the body, difficulty eating or loss of appetite.
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 insulin pens were labeled with current MEDICATION ORDERS FOR [REDACTED]. In addition, the facility failed to ensure topical treatments ointments and creams were stored separately to prevent cross contamination for 9 residents (R38, R261, R33, R34, R20, R23, R44, R112, and R16) reviewed for medication storage. Findings include: R37's Admission Record printed 9/3/20, indicated R37's [DIAGNOSES REDACTED].=2 units; 200-249=4 units; 250-299=6 units; 300-349=8 units; 350+=10 units, subcutaneously three times a day. On

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) 8/31/20, at 5:40 p.m. registered nurse (RN)-D prepared to administer insulin [MEDICATION NAME] to R37, and dialed up 5 units on the insulin pen, per the orders on the Medication Administration Record [REDACTED]. RN-D verified the pharmacy label did not match R37's current medication orders on the MAR. RN-D stated she would go by the orders on the MAR, as they were the current orders. RN-D stated R37's insulin pen should have a change-in-directions sticker on it to alert nurses of the change in orders, and proceeded to return R37's insulin pen to the medication cart without applying a change-in-directions sticker on the insulin pen. On 9/3/20, at 2:50 p.m. licensed practical nurse (LPN)-F verified R37's insulin [MEDICATION NAME] pen did not have a change-in-directions sticker on it and the pharmacy label directions did not match the physician orders [REDACTED]. On 9/3/20, at 3:15 p.m. director of nursing (DON) verified a change-in-direction sticker should have been placed on R37's insulin pen when there was a change in directions. DON verified there was a risk for giving the wrong dose of insulin when the pharmacy label did not match the physician orders [REDACTED]. [REDACTED]. -insulin [MEDICATION NAME] solution pen injector; inject per sliding scale: if 201-250-2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-600=MD call provider, subcutaneously four times a day, dated 8/5/20. -insulin detemir solution pen-injector; inject 44 units subcutaneously in the morning for diabetes, dated 8/27/20. On 9/3/20, at 7:23 a.m. LPN-G was observed during administration of insulin to R58. R58's insulin [MEDICATION NAME] pharmacy label was noted to direct administration of 14 units three times a day with meals and per sliding scale. R58's physician orders [REDACTED]. In addition, R58's [MEDICATION NAME] pharmacy label was noted to direct administration of 40 units subcutaneously daily, and R58's physician orders [REDACTED]. On 9/3/20, at 3:36 p.m. LPN-H verified R58's insulin pharmacy labels did not match the physician order [REDACTED]. LPN-H stated she looked at the MAR for the correct medication orders when administering medications. LPN-H wrote see MAR indicated [REDACTED]. R38's Admission Record printed 9/3/20, indicated R38's [DIAGNOSES REDACTED]. R38's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME] ointment 0.1% (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions to right hand topically twice daily for psoriasis.) On 9/2/20, at 7:39 a.m. R38's door was closed, a contact precautions for special [MEDICATION NAME] precautions sign was posted on R38's door. R261's Admission Record printed 9/3/20, indicated R261's [DIAGNOSES REDACTED]. R261's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME] cream to infection area topically as needed for infection; and [MEDICATION NAME] cream 0.1% to rash topically as needed three times daily. R33's Admission Record printed 9/3/20, indicated R33's [DIAGNOSES REDACTED]. R33's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME] gel [MEDICAL CONDITION] in the morning on the 10th of each month, Asper-Flex Cream 10% ([MEDICATION NAME]) to knee topically as needed for knee pain, to be kept in resident room for nurse to apply; [MEDICATION NAME] cream 1% (antifungal medicated cream) to rash topically three times a day to rash; [MEDICATION NAME] cream to feet topically twice daily for dry skin; and silver [MEDICATION NAME] cream 1% to [DEVICE] site topically in the morning. R33's undated Pocket Care Plan indicated R33 was on contact and droplet precautions related to a resistive organism in the sputum. R34's Admission Record printed 9/3/20, indicated R34's [DIAGNOSES REDACTED]. R34's Order Summary Report with active orders as of 9/3/20, included orders for menthol-zinc oxide ointment 0.44-20.6% to [DIAGNOSES REDACTED]tous (reddened) areas topically twice daily; and [MEDICATION NAME] cream 0.025% to facial rash as needed until clear. R20's Admission Record printed 9/3/20, indicated R20's [DIAGNOSES REDACTED]. R20's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME] cream 0.1% (reduces the swelling, itching, and redness related to skin conditions) to skin rash topically every 12 hours as needed. R23's Admission Record printed 9/3/20, indicated R23's [DIAGNOSES REDACTED]. R23's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME]-[MEDICATION NAME] cream 1-0.05% to rash topically twice daily as needed; and [MEDICATION NAME] cream to dry skin as needed for dry skin. R23's undated Pocket Care Plan indicated R23 was on contact precautions due [MEDICAL CONDITION] in her wounds. R44's Admission Record printed 9/3/20, indicated R44's [DIAGNOSES REDACTED]. R44's Order Summary Report with active orders as of 9/3/20, included orders for [MEDICATION NAME] gel for insertion [MEDICAL CONDITION] changing every month, [MEDICATION NAME] ointment 0.44-20.6% to decubitus regions topically three times daily; [MEDICATION NAME] cream 1% to skin topically twice daily for yeast; [MEDICATION NAME] cream 13% (zinc oxide) to bottom topically every 6 hours prn rash and skin irritation; Menthol-[MEDICATION NAME] Ointment to skin topically every 6 hours as needed for joint and muscle pain four times daily; Vicks [MEDICATION NAME] ointment 4.7-1.2-2.6% ([MEDICATION NAME]-eucalyptus-menthol) to fingernail/toenails topically every 12 hours as needed for pain; and zinc oxide ointment 40% to bottom topically every 6 hours as needed for skin irritation four times a day. R112's Admission Record printed 9/3/20, indicated R112's [DIAGNOSES REDACTED]. R112's Order Summary Report with active orders as of 9/3/20, included orders for barrier cream to skin surrounding feeding tube, [MEDICATION NAME] cream 1% (used on the skin to treat swelling, itching and irritation) to feeding tube side topically one time daily; [MEDICATION NAME] gel 2% to coccyx topically as needed for moderate pain three times daily, and [MEDICATION NAME] cream to feeding tube site topically two times daily for site breakdown. R112's undated Pocket Care Plan indicated R112 was on contact precautions [MEDICAL CONDITION] in her sputum. R16's Admission Record printed 9/3/20, indicated R16's [DIAGNOSES REDACTED]. R16's Order Summary Report with active orders as of 9/3/20, included orders for A&D ointment to G tube site topically twice daily and to rash/back/side topically as needed for rash twice daily, and [MEDICATION NAME] cream 0.025% to [MEDICAL CONDITION] topically twice daily. R16's undated Pocket Care Plan indicated R16 was on contact and droplet precautions for Carbapenem-resistant pseudomonas aeruginosa (CRPA) in his sputum. On 9/3/20, at 3:15 p.m. both medication carts were checked for medication storage and revealed several topical treatment tubes/containers were stored together in a drawer, without any separation. Topical treatments stored together in the first cart included: -R38's [MEDICATION NAME] -R261's [MEDICATION NAME] and [MEDICATION NAME] -R33's sports cream (Asper-cream) and silver [MEDICATION NAME] cream -R34's [MEDICATION NAME] -R20's [MEDICATION NAME] -R23's Asper-cream and [MEDICATION NAME] Topical treatments stored together in the second cart included: -R44's [MEDICATION NAME], antifungal spray, A&D, clotrizole cream and R112's and R16's topical treatments were in baggies, but in contact with R44's topical treatments. On 9/3/20, at 3:36 p.m. RN-A verified the risk of cross-contamination due to storing topical treatments together that go into each resident's rooms during application. On 9/3/20, at 4:14 p.m. the DON verified the risk of cross-contamination with topical treatments being stored together. A policy for labeling of medications was not provided. The facility policy for Topical Application of Ointment and Cream dated 11/19, lacked directives for storing them separately to prevent cross-contamination.

F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean by ensuring ceiling tiles over the food preparation area and the oven hood and its components were free of dust and debris to prevent food contamination. In addition, the facility failed to ensure dirty dishware was not in close proximity to a clean dish drying rack, and the ice machine was free from rusted bolts. Findings include: On 8/31/20, at 3:01 p.m. during the initial kitchen tour with the culinary services director (CSD)-A, three carts of dirty dishes were parked within three feet of the clean dish drying rack. At 3:05 p.m. a staff member was observed bringing additional dirty dishes into the kitchen, and stacking them atop a rolling cart near the clean dish drying rack. The drying rack held various clean items including glasses, meal trays, and a water carafe. The drying rack was made of metal, and had multiple worn areas with considerable rust. CSD-A confirmed the presence of rust, and confirmed the dirty and clean areas were too close in proximity to each other. The lid of the ice machine was noted to have a rusty screw on the underside, with a visible orange drip line leading down from the screw into the area that held the ice. No rust was observed on the ice. CSD-A stated the ice machine was cleaned once per month. CSD confirmed the presence of the rusty screw and orange drip and stated, It looks like rust. During kitchen tour, copious amounts of dust were observed on the oven hood and the sprinkler system, directly above the stovetop where food was being prepared. Dusty accumulation was observed on the electrical box above the oven hood and its piping. CSD-A stated the oven hood was professionally cleaned once every 6 months, and cleaned by maintenance every month. CSD-A confirmed the presence of dust and stated, I see a little dust, not a lot, it was done in March so they should be coming. CSD-A confirmed the presence of dust on the ceiling tiles and fire sprinkler directly above the food preparation area and stated, Looks like dust. Food was being prepared directly below the dusty ceiling. On 8/31/20, at 5:59 p.m. dried orange and brown food was observed splattered on the ceiling tile immediately outside the kitchen doors. On 9/1/20, at 11:32 a.m. dust remained on the ceiling tiles and fire sprinkler directly above the food preparation area. On 9/2/20, at 9:17 a.m. the paper towel

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	245495	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE EMERALDS AT GRAND RAPIDS LLC	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) dispenser was empty, and a roll of paper towels had been placed on one of the empty clean drying rack poles. Dietary aide (DA)-A used these paper towels to dry her hands after washing. The dust remained on the ceiling tiled and sprinkler directly above the food preparation area. Food was being prepared directly below this area. At 09:49 A.M. dried food remained on the ceiling tile immediately outside of the kitchen doors. On 9/2/20, at 1:20 p.m. the DCS-A confirmed the presence of dust on the ceiling and sprinkler above the food prep area and stated, There is still dust up there, it can fall in the food. The DCS-A also confirmed food splatter on the ceiling outside of the kitchen doors and stated, I am not sure what that is or how it even got up there. The facility policy Food Receiving and Storage revised October 2017, directed food services, or other designated staff, will maintain clean food storage areas at all times.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure proper retention of medical records for 3 of 5 residents (R11, R23, R33) reviewed for unnecessary meds. Findings include: R11's Admission Record printed 9/4/20, indicated R11's [DIAGNOSES REDACTED]. R11's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/19. R11's consultant pharmacist Summary Report dated 12/19, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. A consultant pharmacist Prospective Medication Review dated 2/14/20, indicated R11 had a physician order [REDACTED]. R11's Prospective Medication Review had a hand written note by the medical records staff, indicating the original potassium order at this dose was written on 4/23/18. R11's medical record lacked evidence of a review of R11's potassium order by a physician by 2/15, at 11:59 p.m. as directed by the consultant pharmacist. R11's consultant pharmacist Summary Report for 4/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 5/20, indicated no irregularities were identified. R11's consultant pharmacist Summary Report for 6/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations, or evidence of the physician's follow-up to the irregularities. R11's consultant pharmacist Summary Report for 7/20, indicated irregularities were identified. R11's consultant pharmacist Summary Report for 9/20, indicated irregularities were identified. The facility was unable to provide the consultant pharmacist's Consultation Report with identification of the specific irregularities and recommendations. On 9/4/20, at 2:50 p.m. director of nursing (DON) verified they were unable to locate the remaining recommendations and physician follow-up for residents for whom records were requested. The facility policy Medication Regimen Reviews revised 5/19, directed the consultant pharmacist would provide a written copy of all medication regimen reports, which would be maintained as part of each resident's permanent record, along with the physician responses. The facility Records Retention Schedule updated 11/14, directed Medical records to retain consultant reports for 2 years in the medical record. R23's Admission Record printed on 9/4/20, indicated R23's [DIAGNOSES REDACTED]. R23's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, and 11/2019. R33's Admission Record printed on 9/4/20, indicated R33's [DIAGNOSES REDACTED]. R33's medical record lacked evidence of consultant pharmacist reviews for 9/19, 10/19, 11/19, and 2/20. In addition the 3/20, consultant pharmacist review identified irregularities, no report was found. On 9/4/20, at 4:06 p.m. the administrator was interviewed and verified the facility was required to keep medical records for a specified time period. On 9/4/20, at 4:15 p.m. the consultant pharmacist was interviewed and verified there should have been monthly medication reviews in R23's record. He stated that he took over the role of consultant pharmacist in December of 2019.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to perform hand hygiene after direct contact with residents and high touch environmental surfaces in quarantined residents rooms and subsequently passing meal trays for 6 of 25 residents (R48, R56, R59, R211, R2100, and R21) reviewed for dining. Further, the facility failed to ensure their comprehensive infection prevention and control program (IPCP) included surveillance of all potential infections; ongoing, comprehensive analysis of all collected surveillance data; and, demonstrated investigation(s) of developed infections to help prevent potential recurrence and/or spread within the facility. This had the potential to affect all 64 residents residing in the facility at the time of the survey. Findings include: R46's Admission Record printed 9/3/20, indicated R46's [DIAGNOSES REDACTED]. R57's Admission Record printed 9/3/20, indicated R57's [DIAGNOSES REDACTED]. R110's Admission Record printed 9/3/20, indicated R110's [DIAGNOSES REDACTED]. R R11's Admission Record printed 9/3/20, indicated R11's [DIAGNOSES REDACTED]. R11's care plan initiated 6/10/20, indicated R11 was on contact precautions for [MEDICAL CONDITION]-Resistive Staphylococcus Aureus (MRSA-organism resistive to some antibiotics). R111's Admission Record printed 9/3/20, indicated R111's was admitted on [DATE], and [DIAGNOSES REDACTED]. R111 was on quarantine precautions related to new admission to the facility, and room door had a quarantine sign posted on it. R12's Admission Record printed 9/3/20, indicated R12's [DIAGNOSES REDACTED]. R12's room door had a quarantine sign posted on it. On 8/31/20, at 5:45 p.m. nursing assistant (NA)-M was serving meal trays to each room, from a cart with individual trays. On 8/31/20, at 6:06 p.m. nursing assistant (NA)-M was serving meal trays to each room, from a cart with individual trays. NA-M had gloves and a faceshield on. NA-M brought a tray into R46's room, left the room, did not remove gloves and/or sanitize hands, got another tray from the cart and served it to R110, moved a glass for R110, and left the room, without removing gloves and/or sanitizing hands. NA-M got another tray from the cart, brought the tray into R57, positioned R57 in his wheelchair up to the tray table, and with the same gloves, knocked on R11's door, brought in a tray from the cart, without wearing a gown, left R11's precautions room without sanitizing or changing gloves. NA-M picked up another tray from the cart without sanitizing or changing gloves, delivered it to R12. After passing a tray to R12, when questioned, NA-M verified she had been wearing the same gloves from room to room, touched resident's environment, and went into R11's precautions room without wearing a gown, or changing gloves, and went right into R12's room to deliver a tray and touched his belongings. During the same time, NA-N picked delivered fluids to each room. NA-N changed gloves between each room, but did not sanitize between glove changes. On 8/31/20, at 6:13 p.m. NA-M and NA-N verified they should have been sanitizing between glove changes, between each resident. On 9/3/20, at 4:14 p.m. director of nursing (DON) verified there was a risk of cross-contamination when gloves aren't changed and hands are not washed or sanitized between each resident while passing meal trays. The facility policy and procedure for Handwashing/Hand Hygiene revised 8/19, directed staff to use an alcohol-based hand rub or soap and water before and after assisting a resident with meals, handling food, after removing gloves, before and after direct contact with residents or contaminated equipment. On 9/1/20, at 12:03 p.m. nursing assistant (NA)-B delivered meals to residents R48 and R56, exited the room, and without performing hand hygiene took another meal from the cart and delivered it to R59. NA-B then delivered a meal to R211, who was in quarantine. Without performing hand hygiene, NA-B delivered a meal to quarantined resident R210. NA-B touched and moved items on R210's bedside table including a water glass and soda can. NA-B exited the room, did not perform hand hygiene, and pushed the food cart down the hall, and brought a meal tray into R21's room, who was quarantined. On 9/1/20, at 12:30 p.m. NA-B was interviewed and stated she did not sanitize her hands while passing meal trays. NA-B stated, I must have spaced it, I am usually really good about hand hygiene. On 9/3/20, at 10:23 a.m. licensed practical nurse (LPN)-A was interviewed and stated if staff were going in and out of rooms they should be using hand sanitizer properly and they should should be doing proper hand hygiene. On 9/3/20, at 2:17 p.m. the DON stated when staff was going from resident to resident rooms she would expect they would perform hand hygiene. On 9/3/20, the last twelve months infection control line listings were requested for review from the infection control preventionist/registered nurse (RN)-B. The provided information was reviewed and identified the following data separated by each month. The facility Antibiotic Tracking Sheets, dated 6/4/20, to 6/25/20, and 7/2/20, to 7/31/20, identified line

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) listings used to record infections within the facility. The data collected included various items tracked including, but not limited to, resident names, room numbers, infection types, symptoms, onset dates, laboratory or organism results, antibiotic usage and if transmission-based precautions were needed/used. Healthcare Associated Infection Summary Report by Resident Days dated June 2020, and July 2020, tracked a breakdown of specific infections (respiratory, urinary tract infections (UTIs), skin, gastrointestinal, bloodstream, other, and ventilator associated pneumonia) and resident days, which when calculated indicated the month's total infection rate. The bottom of the form identified an area for Specific Trends and Actions Taken. JUNE 2020: The line listing (outlined above) identified a total of 12 resident infections between three listed units (unit 2, unit 3, and unit 4): - Unit 2 had an identified UTI which listed a urine specimen had been collected after symptom onset of 6/4/20, however, the tracking sheet did not identify the organism for which seven days of antibiotics had been administered. -Unit 3 had identified a single infection each for UTI, pneumonia, upper respiratory infection and skin infection, along with a single infection identified as, Other. The UTI listed a urine specimen had been collected after symptom onset of 6/17/20, however, the tracking sheet failed to identify the organism for which six days of antibiotics had been administered. The pneumonia infection sputum (coughed up mucus) culture obtained after symptom onset of 6/17/20 identified extended-spectrum beta-lactamase (ESBL, an enzyme that prevents certain antibiotics from being able to kill the bacteria). The upper respiratory infection listed a sputum culture was obtained for symptom onset of 6/23/20, however, failed to identify the organism for which seven days of antibiotics were administered. -Unit 4 had identified a single skin infection and five UTI. All five UTI were each identified to have different symptoms listed, however, urine cultures for two of the UTI identified proteus mirabilis (a bacteria) with symptom onsets of 6/4/20, and 6/19/20, respectively. Two of the other UTI identified escherichia coli (a bacteria), in which one further identified ESBL, with symptom onsets of 6/22/20, and 6/23/20, respectively. The line listing failed to indicate antibiotic end dates for three of the resident infections, results of reported wound cultures for the two skin infections, and further failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic treated infections (i.e. [MEDICAL CONDITION] infections, common cold symptoms). The infection summary report (outlined above) dated June 2020, identified a total of seven facility infections with a total of 1432.00 resident days. A series of equations were listed which identified the facility had an infection rate of 4.89 % (percent). The Specific Trends section listed: Unit 2- 1 UTI, Unit 4 - 5 UTI, Unit 4 - skin 1, Unit 3 - 1 pneumonia. The Actions Taken section listed: Hand washing audits in place for each wing. Different organisms. The infection summary report failed to show documentation of a comprehensive analysis of the infections for June 2020. JULY 2020: The line listing (outlined above) identified a total of 14 resident infections between three listed units (unit 2, unit 3, and unit 4): - Unit 2 had identified four UTI and one pneumonia. All four of the UTI were each identified to have different symptoms listed. One urine culture for symptom onset of 7/9/20, reported to be obtained per the resident's request with no other symptoms indicated, identified [MEDICATION NAME] avium (a bacteria) and another resident's urine culture obtained for symptom onset of 7/30/20, identified [MEDICATION NAME] faecalis (a bacteria). Another urine culture obtained identified escherichia coli with ESBL for symptom onset of 7/30/20. One urine culture failed to identify the organism result. The pneumonia infection indicated the resident was seen in the emergency department but the line listing did not indicate results of the x-ray report listed to have occurred on 7/27/20. -Unit 3 had identified one skin infection, one ear infection, one pneumonia, and one UTI, with a single infection listed as Other. The UTI listed a urine culture was completed for symptom onset of 7/22/20, however, failed to identify the organism for which three days of antibiotics were administered. -Unit 4 had identified one pneumonia infection, one UTI, and two infections listed as Other. One UTI indicated a urine culture obtained after symptom onset of 7/22/20, which identified the organisms to be escherichia coli and ESBL. A urine culture report dated 7/23/20, with a nurse practitioner note further indicated the resident diagnosed with [REDACTED]. This was not listed on the line listing form. The line listing failed to identify two of the residents tracked for UTI and Other had an antibiotic reassessment performed in regards to antibiotic stewardship processes. Further, the line listing failed to identify when all of the infections listed had resolved symptoms. The line listing did not indicate or identify any residents had been tracked for non-antibiotic treated infections. The infection summary report (outlined above) dated July 2020, identified a total of 11 facility infections with a total of 1729.00 resident days. A series of equations were listed which identified the facility had a infection rate of 6.36%. The Specific Trends section listed: no specific trends. The Actions Taken section listed: 11 total infections. 3 residents with pneumonia. 2 residents with [MEDICAL CONDITION]. 6 residents with UTI's. The infection summary report failed to show documentation of a comprehensive analysis of the infections for July 2020. The facility did not provide documented evidence demonstrating the facility had conducted a comprehensive analysis of the facility acquired infections to determine if any of the infections identified were potentially related and/or spread within the facility or respective unit(s), despite having had multiple infections with the same causative organisms throughout the facility. Further, there was no provided evidence the facility had correlated the resident' infection data with staff illnesses to determine if any of the infections were related. In addition, the facility did not provide documented evidence the facility had a system for tracking non-antibiotic treated infections. On 9/3/20, at 10:06 a.m. the DON and RN-B were interviewed. RN-B stated she reviewed the electronic health system dashboard each day she works, and monitors every resident who is on antibiotics, which she then adds to a monthly line listing. The DON stated at the end of the month the line listings are reviewed to see if there are trends and to see if staff education was required. Both the DON and RN-B denied a comprehensive analysis was documented prior to the infection data being brought to the facility monthly QAPI (Quality Assurance and Performance Improvement) committee. Any analysis completed during the QAPI committee was not kept with the infection control reports, however, was kept with the QAPI meeting minutes. Neither the DON nor RN-B offered to provide any analysis which may have been completed prior to or during the QAPI meetings to show support of a comprehensive infection analysis process. On 9/3/20, at 3:32 p.m. a follow-up interview was conducted with RN-B in which she stated the monthly line listings were only for those infections that required antibiotic treatment. RN-B explained non-antibiotic infections were placed on a 24 hour board in which nursing staff would chart on those residents. RN-B confirmed she did not track non-antibiotic infections. The facility Infection Prevention and Control Program policy dated 8/19/20, directed the scope of the plan was . comprehensive in that is addresses detection, prevention and control of infections among residents and personnel. The policy further directed surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Culture reports, sensitivity data, and antibiotic usage reviews are included in the facility surveillance activities, in which surveillance data and reporting information is used to inform the committee of potential issues and trends. The policy identified the infection preventionist collected data from the nursing units, categorized each infection by body site, and recorded the absolute number of infections. The policy lacked any direction or guidance on how identified infections would be investigated to reduce the risk of recurrence or when to ensure a comprehensive analysis was to be completed. Further, the policy lacked any information on how the program would track non-antibiotic treated infections or if/when investigations into the infections would be done.