DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y826

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00324

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245542**
2.STATE VENDOR OR MEDICAID NO.
(L2) **477605100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLEFORK MEDICAL CENTER**
(L4) **912 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2016**

6. DATE OF SURVEY **04/29/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 05/03/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/03/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/24/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/23/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2021

CMS Certification Number (CCN): 245542

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 20, 2021 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File
948

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2021

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: March 22, 2021

Dear Administrator:

On April 6, 2021, we notified you a remedy was imposed. On April 29, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 20, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 21, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 6, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 20, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y826

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(L5) **LITTLEFORK, MN** (L6) **56653**

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1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
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2 AOA 3 Other

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01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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FISCAL YEAR ENDING DATE: (L35)
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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Amy Charais, FNE - NE II 04/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/23/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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3. Both of the Above :

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04/24/1991
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
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(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 6, 2021

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: March 22, 2021

Dear Administrator:

On March 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 21, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 21, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 21, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 21, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Medical Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**912 MAIN STREET LITTLEFORK, MN 56653**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted from 3/15/21 to 3/22/19, during a recertification survey. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/15/21, through 3/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5542028C (MN62921) deficiencies were cited at F689 and F690. The following complaint was found to be UNSUBSTANTIATED: H5542029C (MN70961) H5542030C (MN53690) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 04/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a wheel chair to accommodate mobility needs for 1 of 1 residents (R33) reviewed for accommodation of needs. Findings include: R33's quarterly Minimum Data Set (MDS) dated 2/2/21, indicated he had moderate cognitive impairment and was independent with locomotion on and off the unit. The MDS indicated R33 did not have impairments to his upper or lower extremities. R33's care plan dated 8/5/20, indicated he was independent with propelling himself in his wheel chair. The care plan indicated R33 required assistance with mobility for long distances and directed physical therapy (PT) evaluation and treatment as needed. During observation on 3/15/21, at 5:44 p.m. R33 was seated in a Rock N Go Wheel chair (wheel chair that rocks back and forth with seat that tilts to an angle of 30 degrees). R33 was observed	F 558	1. R33 wheelchair was assessed for wheelchair mobility on 3/17/21, 3/18/21, 3/22/21, 3/30/21 and 4/7/21 by Physical Therapy. R33 has stated on multiple occasions during these evaluations that he likes the rock and go chair and is comfortable and able to propel. PT states that he has been able to maneuver the rock and go chair without difficulty. A thrust cushion was also ordered on 4/7/21 for a second potential option to place in a standard wheelchair. Will have PT evaluate once it arrives. 2. All residents who are independent in wheelchair mobility have the potential to be effected by the deficient practice. 3. Resident Bill of Rights and Individual Receiving Services Choice Policy were reviewed by DON and Administrator with no changes needed. 4. All nursing staff will be educated by the DON and/or designee to notify the charge nurses if any resident is observed having difficulties propelling their	4/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

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F 558	Continued From page 2 struggling to propel himself in the wheelchair, got stuck and could not move. On 3/16/21, at 9:04 a.m. R33 was observed to propel himself backwards in his wheel chair to get to his bedside table to eat breakfast. At 2:02 p.m. R33 attempted to propel himself from the dining room to his room. R33 bumped into the wall as he was unable to control the wheel chair. After staff assisted R33 to get un-stuck from the wall, R33 propelled himself backward to his room. On 3/17/21, at 8:03 a.m. R33 propelled himself out of his room then turned around to go back to his room. R33 was struggling to get his footing. At 10:59 a.m. PT-A approached R33 and asked him how he liked the Rock N Go chair. R33 replied, "I don't like it, I can't turn it." PT-A told R33 she would come and talk to him the next day. R33's Progress Notes identified the following: - 2/22/21, Staff reported that R33 looked uncomfortable in his wheel chair. When asked if he was comfortable R33 replied no. Will continue to trial chair for safety and discuss positioning with PT. - 2/23/21, Staff reported that R33 again complained of being uncomfortable and "hating" his new wheel chair. Director of nursing (DON) to request order for PT evaluation. - 2/24/21, Staff reported that R33 again complained of not liking his wheel chair. DON to	F 558	wheelchair. Charge nurses will be educated by the DON and/or designee to obtain an order for physical therapy to evaluate their wheelchair mobility. Physical Therapists will be educated by the DON and/or designee on timeliness of performing evaluations when orders are obtained. 5. Random observational audits will be completed by DON or designee of residents ability to self-propel their wheelchair without difficulty. Audits will be completed 3x/week x2 weeks, then once weekly thereafter. Auditing will begin on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 6. Completion date for F558 is 4/20/21. ***Review: CCP.QC.062 Individual Receiving Services Choice	

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F 558	Continued From page 3	F 558		

have PT eval ordered for appropriate chair.

- 2/27/21, R33 told writer, "I hate this." when asked what he was referring to R33 said "this damn chair." When asked why he hated the chair, R33 proceeded to attempt to wheel himself and was bumping into his table and dresser then stated "this." The note indicated R33 was able to self propel in the chair but "is very clumsy with this."

- 2/27/21, R33 "is very unhappy with the Rock N Go wheelchair that he is using at this time. He is having a hard time getting around, he does run into things with the chair. He is also having a hard time getting into his bathroom to brush his teeth."

- 3/17/21, PT-A wrote, It had been reported that R33 was placed in a Rock N Go chair since he had been sliding forward in a regular wheel chair. He then informed staff that he did not like the new chair.

- 3/17/21, PT-A wrote, asked R33 about the chair on this date and he stated he did not like it.

On 3/18/21, at 8:16 a.m. PT-A stated R33 had been sliding forward in his previous wheel chair so staff placed him in the Rock N Go chair over the weekend PT-A stated she was going to look into getting him a new cushion for his old chair. PT-A then stated R33 had actually been in the Rock N Go chair for a few weeks and stated she had not assessed him yet for appropriateness of the chair. PT-A stated when she asked R33 about the chair a few weeks ago he said he liked it.

During interview on 3/18/21, the DON stated R33 had been scooting around the facility on the edge

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F 558	Continued From page 4 of his chair and said she was not sure how he had stayed in the chair. The DON stated she had put R33 in the Rock N Go chair and he hated it. The DON stated PT-A had asked R33 if he liked the chair and he said he liked it and PT-A said he looked fine in the chair. The DON stated the usual process would be to send a request to occupational therapy for positioning. A facility policy related to accommodation of needs was not provided.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure accurate coding of skin conditions of the Minimum Data Set (MDS) for 1 of 4 residents (R39) reviewed for pressure ulcers. Findings include: R39's Physician's Orders dated 2/15/21, indicated re-admission to facility with new diagnosis of infected pressure ulcer stage III. Wound care ordered to right buttock, left buttock and left 4th and 5th toes. R39's undated Face Sheet, included a disorder of the skin and subcutaneous tissue and pressure ulcer of buttock stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Some slough may be present). R39's Video Visit note dated 2/18/21, indicated	F 641	1. MDS Coordinator will modify Section M for R39 MDS with ARD of 2/22/2021. The changes that will be modified will include: adding SDTI to left heel, Stage II pressure ulcers to left foot 4th toe and left 5th toe, and Stage II pressure ulcer to left lower buttock. The pressure ulcer to right lower buttock will remain coded as an unstageable pressure ulcer on the MDS with ARD of 2/22/2021 as wound nurse assessment identified inability to view the wound base on 2/18/21 due to covered in 100% slough. 2. All residents with pressure ulcers have the potential to be effected by the deficient practice. 3. The MDS 3.0 Assessment Policy was reviewed by the DON with no changes needed.	4/20/21

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F 641	Continued From page 5 R39 was recently hospitalized for sepsis and identified pressure injury to sacrum, pressure injury to right gluteal fold measuring 0.7 cm x 0.4 cm ,right buttock wound measured 5.2 cm x 4.0 cm. Pressure injuries to left 4th and 5th toes, eschar measures 2.6 cm x 2.6 cm. R39's significant change Minimum Data Set (MDS) dated 2/22/21, for assessment reference date 2/16/22 through 2/22/21, identified a stage I pressure ulcer (Intact skin with non- blanchable redness of a localized area, usually over a bony prominence) and an unstageable pressure ulcer (Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed) present on admission. R39's General Nurse's Observation dated 2/24/21, identified an assessment reference date of 2/22/21. The observation for bowel and bladder identified a stage III pressure ulcer on R39's buttocks. The skin assessment portion of the observation identified an unstageable pressure ulcer to right lower buttock, a Deep tissue injury (DTI) to left heel and lower buttocks stage II pressure ulcer. The MDS failed to identify the stage III pressure ulcer on R39's buttocks, DTI on left heel and stage II pressure ulcer on the lower buttock and an unstageable pressure ulcer on the toes. During interview on 3/18/21, registered nurse (RN) - D indicated she completed the MDS assessments. RN-D stated RN-C did the wound notes and she got the information from those notes. She saw the hospital notes that identified the wounds but she wasn't sure how to code	F 641	4. MDS Coordinator will be educated on coding Section M accurately on the MDS by the DON. DON will educate Wound Nurse and MDS Coordinator to do skin assessments together on residents who have pressure ulcers when in their ARD period. 5. All residents with pressure ulcers will have their Section M of their MDS reviewed going back three months for accuracy by the MDS Coordinator. Random MDS audits on Section M will be completed by DON or designee 3x/week x 2 weeks, then once weekly for coding accuracy. Auditing will begin on April 12th. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 6. Completion date for F641 is 4/20/21. Review: CCP.QC.001 MDS 3.0 Assessment	

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F 641	Continued From page 6 them. RN-D stated she spoke with RN-C who told her how to code the MDS. On 3/22/21, at 10:24 a.m. the director of nursing stated it was questionable what the wounds were. The MDS 3.0 RAI Manual v1.17.1 dated 10/1/19, directed the staff completing the assessment "Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present." The pressure ulcer should be coded in terms of what was assessed during the ARD period.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine facial hair removal for 2 of 5 residents (R24, R33) who were dependent on staff for assistance with grooming and personal hygiene. Findings include: R24's annual Minimum Data Set (MDS) dated 1/13/21, indicated R24 was cognitively impaired, totally dependent on staff for personal hygiene and had functional limitation in range of motion to both upper extremities. R24's care plan dated 3/19/18, identified R24 had impaired mobility and was dependent on staff to	F 677	1. R33 had a new razor purchased and was shaved per care plan by NAR. R24 had her facial hair removed at the time of the survey and will continue to be assessed weekly on bath days. 2. All residents who are dependent on staff for grooming and personal hygiene have the potential to be effected by the deficient practice. 3. The Shaving/Hair Removal Policy was created by the DON and Administrator. All residents will have their facial hair removed according to their preference, following care plan. All residents dependent on staff will be assessed for their desired frequency for facial hair	4/20/21

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F 677	Continued From page 7 perform grooming including plucking facial hair. R24's medical record did not identify any refusals of shaving or plucking facial hairs from staff. During observation on 3/17/21, at 7:48 a.m. R24 was lying in bed and had facial hair which included three long visible white hairs, approximately 3/4 inch to 1 inch long, extending out and away from R24's lower left chin. - At 12:42 p.m. R24 was observed seated in her wheelchair by the dining room table. R24's facial hair remained on her lower left chin. On 3/18/21, at 8:45 a.m. during morning cares nursing assistant (NA)-A washed and dried R24's eyes and face. NA-A did not attempt or offer to shave or pluck the hairs from R24's chin. On 3/18/21, at 1:26 p.m. R24 was observed sleeping in her wheelchair in her room with NA-B present. NA-B stated residents were shaven on bath days and when needed. R24's bath day was on Fridays. NA-B was uncertain if R24 had a working razor in her room. NA-B searched for and found a razor and proceeded to shave the facial hair from R24's chin. She did not know how long the hairs had been on R24's chin and stated facial hair on women should be shaven or plucked on bath days or when they are noticed. During interview on 3/18/21, at 1:34 p.m. registered nurse (RN)-A stated residents were shaved on their bath days and as needed, and facial hair should be shaven or plucked as soon as it was noticed.	F 677	removal and care plan will be updated as needed by the Charge Nurses. All NAR staff will be re-educated on providing facial hair removal per care plan for those residents who are dependent on staff by DON or designee. 4. Random observational audits will be completed to ensure that facial hair removal is being completed per the care plan. Audits will be completed 3x/week x 2 weeks, then once weekly thereafter. Auditing will begin on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F677 is 4/20/21. Review: KHS Policies: Shaving Hair Removal (male female)	

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F 677	Continued From page 8	F 677		

R33's quarterly MDS dated 2/2/21, indicated he had moderate cognitive impairment and required extensive assistance from staff to complete personal hygiene.

R33's care plan dated 8/5/20, indicated he required assistance with grooming and personal hygiene. The care plan directed staff to shave R33's face daily.

During observation on 3/16/21, R33's face was unshaven with the appearance of several days growth on his beard. At 1:55 p.m. R33 was seated in the dining room. He remained unshaven.

On 3/17/21, at 8:03 a.m. R33 propelled himself from his room. R33's facial hair had not been shaved.

On 3/18/21, at 9:12 a.m. R33 stated he was unable to shave his own facial hair and stated staff had to do it for him. Staff shaved him, "when they get around to it." R33 stated he liked to be clean shaven.

During interview on 3/18/21, at 12:41 p.m. NA-D stated R33 did not have a decent razor. NA-D stated staff had to use a disposable razor with shave cream and indicated R33 did not like that. NA-D stated "I know he should be shaved every day. If we had the equipment we would do it." NA-D further stated she had told the social services designee (SSD) and she had gotten R33 a new razor but it was not effective. NA-D stated the SSD was told the razor did not work well and he needed a different one.

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F 677	Continued From page 9 At 2:33 p.m. the social services designee (SSD) stated she had not been aware the razor she purchased did not work well for R33. At 4:53 p.m. the director of nursing (DON) stated she would expect R33 to be shaved every day according to his preference. The facilities undated, Activities of Daily Living policy identified the purpose of the policy was to provide assistance to residents as needed and to improve quality of life. The policy identified activities of daily living to include: appropriate clothing, appropriate footwear and assistive devices. The care plan did not address grooming in the policy.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a soft brace was applied per provider order for 1 of 1 resident (R38) reviewed who had a fractured humerus. Further, the facility failed to obtain a blood pressure reading following complaints of dizziness after receiving a one time dose of blood	F 684	POC F684: 1. R38 currently has orders to apply brace to left arm when out of bed and PRN in bed for comfort. If R38 refuses brace, orders are to apply ACE wrap when out of bed and PRN in bed for comfort. R38 treatment record reflects these	4/20/21

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F 684	Continued From page 10 pressure reducing medication for 1 of 1 residents (R19) reviewed for hospitalization. In addition, the facility failed to ensure adequate wheel chair positioning for 2 of 2 residents (R6, R24) reviewed for positioning. Findings include: IMMOBILIZER: R38's admission Minimum Data Set (MDS) dated 2/18/21, identified R38 had intact cognition. R38 required extensive assistance with bed mobility, transfer, dressing and grooming and was total dependent for toileting and wheelchair mobility. R38 was unable to ambulate. Diagnoses included fracture of left humerus, congestive heart failure and diabetes. R38's care plan revised 2/13/21, identified R38 had a fracture to her left arm and an immobilizer on at all times. The care plan directed staff to inspect her skin daily with cares, encourage and assist resident to turn and reposition self at least every two hours and as needed for comfort and to encourage resident to get out of bed daily as tolerated. However, the care plan lacked any information related to non weight bearing to left upper extremity, to avoid abduction (movement of limb away from body) or tortion (the act of twisting)to the arm or how often and when the immobilizer could be removed. R38's Admission Observation dated 2/18/21, indicated R38 had sustained a fracture of the humerus of the left arm and had an immobilizer on her left arm at all times to stabilize the arm. R38's physician orders identified the following:	F 684	orders. Charge Nurse to review and revise care plan and NAR care guide as needed related to R38 brace to left arm. 2. All residents with immobilizers or braces have the potential to be effected by the deficient practice. 3. DON and Administrator developed a Splint, Braces, and Immobilizer Policy. All nursing staff will be educated by the DON and/or designee on this policy regarding following care plan/instructions for application of these devices for any resident. Licensed Nurses will be educated by DON and/or designee on transcribing orders for immobilizers/braces in resident ETAR for licensed nurses to apply by DON or designee. Charge nurses will also be educated on updating care plans and NAR care guides for immobilizers/braces by DON or designee. 4. Random observational audits for appropriate brace usage/placement per order will be completed by DON or designee 3x/week x 2 weeks, then once weekly thereafter. Auditing will begin on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F684 is 4/20/21 Review: KHS Policy: Splints, Braces and Immobilizer Policy	

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F 684	Continued From page 11 -2/11/21, directed staff to have no weight bearing and no lifting of upper left extremity and apply an immobilizer to left upper extremity at all times. - 3/18/21, indicated an order entered on 2/24/21, for ace wraps two times per day during the evening and night. Staff were to unwrap R38's left arm and re-wrap from her left hand to her armpit. - 2/23/21, directed staff to continue non weight bearing to the left upper extremity, rest it to gravity at the torso, and avoid abduction or tortion to the left arm. Staff were to apply a soft brace until a hard brace can be obtained and placed. During observation on 3/15/21, at 3:02 p.m. R38 was seated in a wheelchair in her room. R38 did not have a brace or wrap on her left arm. R38 indicated she was unable to move her left arm due to a recent fracture. During observation on 3/16/21 at 2:50 p.m. R38 was seated in her room in a wheelchair eating a cookie. R38 did not have a brace or wrap on her left arm. During interview on 3/17/21, at 4:44 p.m. R38 stated she had just returned from a doctor appointment. R38 was observed to have a white hard brace on her upper arm that secured around her neck with a strap. R38 stated she just received that brace that day. R38 stated she had an xray and her fracture was healing but was confused to why she was not wearing a brace before and was now. During interview on 3/18/21, at 8:59 a.m. physical	F 684	1. R19 was hospitalized on 3/15/21 until 3/18/21 for dx metabolic encephalopathy secondary to hypoglycemia, UTI, and left lower lobe pneumonia. 2. All residents who receive new or as needed medications have the potential to be effected by the deficient practice. 3. The DON and Administrator created the Side-Effect Monitoring Policy. DON or designee will educate all nursing staff on this policy, including monitoring residents for potential side effects from new or as needed medications. DON and/or designee will review all current residents who have received new medications or as needed medications since 4/1/21 will have their medical record review for potential side effects and MD and interventions will be implemented as needed. 4. Random audits regarding licensed nurses addressing any side effects from a new or as needed medication will be performed by DON or designee 3xweek x 2 weeks, then once weekly thereafter. Auditing will begin on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F684 4/20/21. Review: KHS Policy: Side-Effect Monitoring 1. Orders will be requested for R6 and R24 for PT evaluation for wheelchair positioning.	

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F 684	Continued From page 12 therapist (PT)-A stated she was working with R38 for strengthening and walking. PT-A indicated R38 was non weight bearing on her left arm so they only did a little bit with it to keep it from getting to tight. She did not train the nursing assistants on how to get her dressed or apply her immobilizer. At first she was in a immobilizer and she quit wearing it when she went in for a follow up visit and a new brace was ordered. She had it wrapped when she came back from that visit but she did not have any orders to have it wrapped. PT-A stated they should get involved to help with application of braces. On 3/18/21, at 9:18 a.m. R38 was observed sitting in her wheelchair fully dressed, in her room. She did not have a brace or wraps on her left arm. R38 stated "I guess they don't know how to do it". During interview on 3/18/21, at 9:26 a.m. NA-C stated it was easy to get R38 dressed. She was able to lift her arm a little bit so they could wash her armpits and put deodorant on. When assisting her to stand using the stand lift, R38 would grab the lift with her left arm and then as she stood she would grab the lift with her left arm as well. NA-C indicated she was not aware if R38 had any restrictions for her left arm. R38 used to have an immobilizer but had not had it for awhile. She was told in report today that R38 had a new brace but did not like it, as it was hard and uncomfortable. NA-C stated she was not shown how to apply the brace. During interview on 3/18/21 at 9:55 a.m. NA-B stated she did not do anything with R38's brace as the nurse took care of it. NA-B stated R38 used to have an immobilizer but had not had it for	F 684	2. All residents who utilize wheelchairs for mobility have the potential to be affected by this deficient practice. 3. DON reviewed the Adaptive and Positioning Equipment Policy. All Nursing staff will be educated by the DON or designee on following policy regarding notifying charge nurse if residents are observed or identified with having positioning and mobility problems. Charge nurse will be educated on requesting order for physical therapy evaluation for wheelchair positioning right away. DON and/or designee will review all residents who utilize wheelchairs for mobility proper positioning or mobility problems. Orders will be requested for PT evaluation of for wheelchair positioning as needed. 4. Random audits of observing for proper wheelchair positioning, including following care plan for positioning devices, will be performed by DON or designee 3xweek x 2 weeks, then once weekly thereafter. Auditing began on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F684 is 4/20/21. Review: KHS Policy: Adaptive and Positioning Equipment Policy	

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awhile. NA-B indicated she did not know when it was stopped and R38 did not have anything for her arm after that.

During interview on 3/18/21, at 10:00 a.m. NA-D stated she had worked with R38 for two days the week before. NA-D indicated R38 had ace wraps (an elastic bandage used to reduce swelling) when she worked with her.

R38's undated nursing assistant care sheet in use on 3/18/21, indicated R38 used a wheelchair for devices. The care sheet lacked any information related to restrictions of movement or positioning devices for R38's left fractured arm.

R38's treatment records for February and March 2021, identified an order had been added on 2/24/21, to unwrap R38's left arm and rewrap with ace wrap from the left hand to armpit two times a day. The order was initialed every evening and night from 2/24/21 through 3/18/21, with no refusals noted. The treatment records lacked any information related to an immobilizer or brace to the left arm.

During interview on 3/18/21 at 12:09 p.m. registered nurse (RN)-C indicated she was not aware when the immobilizer to R38's left arm was stopped. R38 returned from an appointment on 2/23/21, with an ACE wrap on her left arm. The nursing assistants would get the information that a resident needed a brace, wrap or immobilizer in report. Putting the information on the treatment sheet would be the best way to track that sort of thing, however, the facility has never tracked application of braces or immobilizers. RN-C indicated there was no way to know whether R38 had been wearing the immobilizer to her left arm

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as ordered as the facility did not document that.

During interview with the director of nursing (DON) and RN-A on 3/18/21, at 1:09 p.m. the DON stated immobilizer and brace orders should be put on the resident's treatment record. The staff that passed medications could then check off the treatment as complete. The NA's did not chart on braces or behaviors. They were to tell the nurses if a resident refused and the nurses were to complete the charting. RN-A indicated the ACE wrap was the soft brace that had been ordered. RN-A stated she was sure R38 had worn her immobilizer when it was ordered but it was never put on the treatment record to monitor.

The facility's undated Ace Bandages policy indicated ACE bandages were applied to support and immobilize a joint. Documentation for the ACE bandage would occur on the treatment record, the resident care plan and resident nursing notes to include pertinent information such as pressure or absence of edema, color, movement, and sensation of the extremity.

The facility's undated Adaptive and Positioning Equipment Policy indicated the RN would document equipment use in the resident's care plan and the NA care sheets. Therapy or nursing would in-service staff on proper use of equipment as needed.

BLOOD PRESSURE MONITORING:

R19's quarterly Minimum Data Set (MDS) dated 1/12/21, identified R19 had intact cognition. R19 was independent with bed mobility, transfers and ambulation. R19 required supervision with

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dressing, grooming and toileting. Diagnoses included metabolic encephalopathy, diabetes and hypertension.

R19's care plan revised 7/21/20, identified R19 was at risk for falling due to he received psychotropic medications and had a history of falls. The care plan directed staff to assist R19 to ambulate with gait belt and four wheeled walker and to ensure wearing appropriate footwear at all times.

R19's progress notes identified the following:

- 3/15/21, at 5:12 a.m. indicated R19's vital signs were checked at 4:00 a.m. and elevated blood pressures were noted. The physician was contacted and ordered Clonidine (a medication to treat high blood pressure) to be administered stat and to recheck the blood pressure in one hour. The medication was administered at 4:20 a.m. and the blood pressure was improved when rechecked.

- 3/15/21, at 7:19 a.m. indicated R19's blood pressure was within normal range. R19 complained of feeling dizzy. He was assisted to sit in a recliner and brought breakfast. Nursing was to continue to monitor resident. No subsequent monitoring of R19's blood pressure was identified

- 3/15/21, at 11:35 a.m. indicated R19 had been found on the floor in his bathroom, covered in feces. His blood glucose was checked and was 42. Resident was unresponsive and was given glucagon (a medication to raise blood sugars) . An ambulance was called and R19 was transported to the emergency room. However,

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his blood pressure was not checked at the time?

R19's monitoring sheet indicated R19's blood pressure was checked at 8:00 a.m., however the progress notes indicated the blood pressure had been checked at 7:00 a.m. The monitoring sheet identified R19 was seated in a recliner in the television room at 8:30 a.m. At 9:00 a.m. R19 ambulated to his room. R19 was observed in his room again at 9:30 a.m. and 10:00 a.m. No further, monitoring of blood pressures were obtained even after R19 complained of being dizzy at the time.

During interview on 3/22/21, at 10:30 a.m. RN-C stated R19 was being monitored through out the night and she thought he was monitored through out the morning as well. RN-C observed R19 eat his entire breakfast in the recliner in the dining room, he then got up and went to his room after he was done with breakfast. RN-C indicated she did not see R19 again until she evaluated him when he fell at 10:45 a.m. and his blood pressure was 104/68. However, no one monitored his blood pressure from the time he complained of dizziness until her fell.

During a telephone interview on 3/22/21, at 10:54 a.m. pharmacist (PH)-A stated a dose of clonidine could last for a 24 hour period. Clonidine would lower the blood pressure and could cause dizziness. If someone moved quickly or with ambulation they could get dizzy after having taken a new medication dose of clonodine. This would be transient and wear off within four to six hours.

R19's medical record was reviewed and lacked any evidence that potential side effects related to the as needed (PRN) dose of Clonidine had been

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F 684	Continued From page 17 assessed or interventions for R19's complaints of dizziness were implemented. The facility policy Medication Administration reviewed 5/20/19, did not address the monitoring of potential side effects from new or as needed medications. WHEELCHAIR POSITIONING: R6's quarterly MDS dated 3/8/21, indicated R6 had severe cognitive impairment and was totally dependant on staff for bed mobility, transfers and locomotion. The MDS identified impairments to upper and lower extremities on both sides. R6's care plan dated 3/11/21, identified a deficit related to neck positioning. The care plan directed staff to place a neck pillow daily when up in the wheel chair. Further, the care plan identified R6 was non- ambulatory exhibited by stiffness in her extremities and identified the use of a Tilt N Space wheel chair and the staff were to monitor R6 for positioning in their wheel chair. During observation on 3/16/21, at 1:37 p.m. an unidentified staff member approached R6 and placed a pillow on her left side in her wheel chair. R6's head was tilted to the left side. R6 continued to lean to her left side with her head resting on a square pillow between her left arm and the wheel chair.	F 684		

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On 3/17/21, at 11:26 a.m. nursing assistant (NA)-D assisted R6 to the dining room in her wheel chair. R6 was leaning far over to her left side and had a pillow in the chair. NA-D made an adjustment to the pillow but R6 continued to lean far over to her left side. At 11:47 a.m. R6 remained at the table in the dining room. R6's neck was bent to the left at and angle, almost touching her left shoulder. At 12:06 p.m. NA-D assisted R6 to eat. R6's head remained bent to the left at almost a 90 degree angle. NA-D made no attempt to reposition R6 during the meal.

On 3/18/21, at 7:06 a.m. R6 was again observed seated at a table in the dining room with her head bent at a 90 degree angle toward her left shoulder. R6 had two covered cups with straws in front of her but was unable to drink independently. At 7:52 a.m. an unidentified staff member asked R6 if she was done eating her cereal and her milk which were both in the covered cups. At 8:07 a.m. unidentified staff member assisted R6 away from the table and placed her in front of the television off to the side of the dining room. R6's head remained at an angle and was leaning to her left side with pillows between her side and the wheelchair arm.

During interview on 3/17/21, at 12:32 p.m. nursing assistant (NA)-D stated R6 had a neck pillow for eating but she did not always like it. NA-D stated she was not sure why R6 leaned to her left. NA-D stated R6 was able to sit up in the chair but throughout the day staff would find her leaned over and would place pillows on her left side.

During interview on 3/18/21, at 8:16 a.m. physical

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therapist (PT)-A stated R6 had a neck brace for her wheel chair but stated it was not on the chair. R6 did not like things by her neck and head. Further, R6 had not been assessed for wheel chair positioning in "quite a while." PT-A stated R6's wheel chair was not an appropriate fit and stated facility staff had not notified her R6 needed to be assessed for wheel chair positioning.

On 3/18/21, at 4:24 p.m. registered nurse (RN)-D stated she completed the activities of daily living (ADL) section of the MDS. RN-D stated when she completed the assessment she would talk to the NA's and ask what they did for the residents. If residents were on a restorative program she looked at the program. RN-D stated if there were positioning concerns a referral would go to therapy for an evaluation.

On 3/18/21, at 5:00 p.m. the director of nursing (DON) stated on 6/15/20, (nine months earlier), PT-A completed an ADL assessment for R6 and had not recommended any changes.

On 3/22/21, at 5:06 p.m. the administrator stated the RN's completed the assessments for ADL's and stated they should be identifying positioning and mobility problems and requesting therapy evaluations.

R24's annual MDS dated 1/13/21, identified R24 had severe cognitive impairment, and included diagnoses of progressive neurologic condition and dementia. R24 utilized a wheelchair, required total dependence of staff for transfers and locomotion on/off unit. The MDS further indicated R24 had functional limitations in range of motion

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on both sides of their upper and both lower extremities.

R24's care plan last reviewed 2/19/19, directed staff to use a rock and go wheelchair and a lateral wedge cushion (a cushion device used to increase the user's stability and positioning) in R24's wheelchair.

During observation on 3/16/21, at 8:31 a.m. unidentified staff was wheeling R24 out of her room and towards the dining room. R24 was seated in her wheelchair, with her upper body leaned to right side and her right arm hanging over right side of the wheelchair. The unidentified staff left R24 in the dining room and R24 did not have the lateral support, and staff did not reposition R24.

-At 8:34 a.m. unidentified staff returned to where R24 was seated in the dining room. Unidentified staff assisted R24 with drinking, and did not offer or attempt to reposition resident to sit upright in her chair.

On 3/17/21, at 12:42 p.m. R24 was observed seated in her wheelchair at a dining room table. A blue lateral support was now in place behind R24's right side; however, R24's right arm was still hanging over the right side and resting on the wheel of her wheelchair.

During interview on 3/18/21, at 8:45 a.m. NA-A and NA-C stated when seated in her wheelchair R24 would lean over to the right side and her arm would hand down over the wheelchair arm rest and her arm at times would turn purple and would feel cold to the touch. NA-A further stated prior to yesterday (3/17/21) R24 did not have a wedge

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F 684	Continued From page 21 cushion to help her sit upright in her chair. - At 9:13 a.m. the DON stated R24 tended to lean to the right side and was supposed to have a wedge cushion behind her when sitting in her wheelchair. R24 did not have a wedge cushion placed behind her while in her wheelchair earlier in the week as care planned and she expected staff to reposition residents as soon as they noticed a resident was not seated comfortably and properly positioned. The DON had placed a cushion on 3/17/21, but had not referred R24 to therapy for a wheelchair assessment for positioning of the arm in the wheelchair. - At 12:29 p.m. NA-C stated prior to yesterday (3/17/21) there was not a wedge cushion in R24's room. The undated facility policy Adaptive and Positioning Equipment indicated an RN would contact the provider for referral to occupational therapy (OT) or PT for wheelchair positioning, seating assessment or other adaptive equipment recommendation. OT or PT would conduct the assessment and make recommendations for wheelchair modification and/or equipment and communicate these recommendations to nursing. The RN would document equipment use in the care plan and on the nurse aide care sheets. Nursing and/or therapy would observe appropriateness of continued use of the equipment.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		4/20/21

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F 686	Continued From page 22 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess facility acquired pressure ulcers, consistently implement identified interventions, reassess nursing interventions to promote healing when the pressure ulcer deteriorated and communicate with the medical provider regarding current treatment and pressure ulcer status for 1 of 4 residents (R10) reviewed for pressure ulcers. This caused actual harm to R10 who's pressure ulcer worsened to an unstageable pressure ulcer and warranted physician and surgeon recommendation for below the knee amputation. In addition, the facility failed to ensure the medical provider's orders for a pressure reducing cushion was processed and implemented for 1 or 4 residents (R39) reviewed for pressure ulcers. Findings include: The National Pressure Ulcer Association define the following pressure ulcer stages and wound descriptions as follows: Stage I: An observable, pressure-related	F 686	1. R10 discharged from the facility. R39 was provided with new gel cushions for recliner and wheelchair per physician order. 2. All residents at risk for pressure ulcers have the potential to be effected by deficient practice. 3. All licensed nursing staff will be educated by the DON or designee on the Skin Ulcer Protocol including evaluating a resident□s clinical condition for possible risk factors for developing pressure ulcers, implementing interventions to prevent pressure ulcers or to promote healing for any present pressure ulcers and to evaluate the effectiveness of interventions and to revise as needed, including updating physician with any changes, and processing physician orders related to skin interventions. Wound Nurse will reassess all residents with pressure ulcers to ensure appropriate skin interventions are in place. Resident care plans and NAR care cards will be reviewed and updated as needed.	

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F 686	Continued From page 23 alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). Slough: Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in	F 686	4. Random audits of residents at risk for pressure ulcers or with current pressure ulcers will be completed to insure interventions are in place for prevention or to promote healing, that these areas are care planned, and interventions followed. Audits will be completed 3x/week x 2 weeks, then once weekly thereafter. Auditing began on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F684 is 4/20/21. Review: Guidance Policies-Skin: Skin Ulcer Protocol Updated 7-1-20	

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color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

R10's admission Minimum Data Set (MDS) dated 12/17/20, identified R10 had no cognitive impairment and required extensive assistance for bed mobility, transfers and toileting. Further, R10 was at risk to develop pressure ulcers, however his skin was dry and intact with no pressure ulcers or skin concerns present. The MDS included diagnoses of cerebrovascular accident (blood flow to the brain is stopped and cells die) (CVA) and hemiplegia (paralysis on one side of the body).

R10's Admissions Observation Assessment dated 12/14/20 through 12/18/20, identified R10's skin was dry and intact. R10 was at risk for altered skin integrity related to incontinence of bladder. R10 utilized a wheelchair for mobility.

R10's admission progress note dated 12/10/20, indicated R10 had some trace edema in his lower extremities and no significant skin issues were noted.

R10's care plan dated 12/14/20, identified R10 was at risk for skin breakdown due to incontinence. Several interventions were listed including to observe skin daily with cares, encourage fluid intake, encourage and assist R10 to turn and reposition at least every 2 hours, and observe skin-especially lower extremities for edema. On 12/22/20, the care plan identified a pressure ulcer to R10's right heel with a goal for the ulcer to heal without signs and symptoms of infection. Several interventions were listed to

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help R10 meet this goal, including float heels when in bed, blue booties while in bed, pressure reducing mattress, and trial removal of R10's foot board. The care plan did not address pressure relieving interventions when out of bed.

During observation on 3/15/21, at 3:17 p.m. R10 was wheeling his wheelchair backwards down the hall, while visiting with staff. R10 was pushing the wheelchair with his left foot and his right foot was dragging on the hallway floor. R10 had socks on both feet and was not wearing shoes.

On 3/15/21, at 5:47 p.m. R10 stated he had a sore on his foot he obtained at the facility. He did not have the right equipment on his wheelchair and was dragging his foot and ended up wearing a hole in his heel. R10 did not know he was dragging his foot but had noticed a trail of wet on the floor. He then looked at his heel and "it was a mess." R10 did not know how long he was dragging his foot as he could not feel it dragging. He notified staff and they bandaged the heel up. R10 stated he should have went to the doctor right away but did not go until things started going sour with it and by the time he was seen by the doctor, they could not do anything with it. The heel was kind of a hole with a big scab on it. The dressing was being changed two times daily and he was meeting with a surgeon the following day. R10 indicated it was almost a necessity to take the foot off because he had an infection in it a couple times already and so the foot needed to come off. R10 stated his last infection was about 2 weeks ago.

On 3/17/21, at 7:24 a.m. nursing assistant (NA)-B entered R10's room and assisted R10 with his am cares. After completing dressing and grooming,

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R10 was assisted to his wheelchair with a stand lift. NA-B offered to put a Prevalon (a pressure relieving foam) boot on R10's right foot. R10 declined the boot and was observed to place his right foot on the wheelchair pedal with his right heel resting on the top edge of the wheelchair foot pedal and the remainder of his foot hanging over the pedal. The foot was wrapped from mid foot to heel with stretch bandaging wrap (kerlix). R10 notified NA-B the surgeon was going to amputate his leg because of the shape the heel was in, he would always have an infection in it and it would never heal. NA-B moved R10's wheelchair in front of the television as they talked and placed the bed side table in front of the wheelchair in preparation for breakfast. R10's foot was observed to slip off the foot pedal during the repositioning of the wheelchair and bedside table. NA-B lowered her self under the bedside table and repositioned R10's right heel back on the top edge of the pedal with 3/4 portion of the foot hanging over the pedal, due to his long legs. NA-B stated there were no other positioning devices for R10's right foot when sitting in the wheelchair except for the foam boot.

On 3/17/21, at 11:13 a.m. R10 was observed seated in his wheelchair. R10's right foot was resting directly on the floor, well past the foot pedal. Trained medication aide (TMA)-A and registered nurse (RN)-C entered the room to assist R10 into bed for his dressing change. RN-C stated the treatment had been to use an antiseptic wound cleanser (Dakins solution) to clean the wound but had been switched to use a betadine (a providone-iodine disinfectant solution) wet to dry dressing about a week ago. R10 stated the pressure ulcer had either occurred when his foot jumped and came down on his foot

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board at the end of his bed or when he had drug it around when seated in his wheelchair.
- TMA-A lifted R10's right leg as RN-C removed the ACE bandage and kerlix dressing. The dressings appeared tight around R10's foot and ankle when the ACE wrap and Kerlix wrap was removed. Edema (swelling) was identified on the top of the right foot and the dressing marks and ridges were visibly apparent on R10's skin. R10's upper 3/4 portion of his right heel was covered in black tough eschar tissue which was surrounded by slough tissue on the mid and bottom portion of his heel. No odor or drainage was noted. RN-C cleansed the wound and patted the wound dry. She then applied the betadine as ordered and re-wrapped R10's right foot with kerlix wrap and ACE wrap as ordered.
- R10 requested to sit up in his wheelchair for lunch and was assisted back into his wheelchair using the stand lift. RN-C put the right foot rest onto the wheelchair, placed the Prevalon boot on the top of the foot rest and positioned R10's right leg and foot on top of the Prevalon boot and elevated the foot rest. R10 stated he liked the boot under his foot on the wheelchair pedal, and staff had never done it before, and stated, "but now I think I will."

R10's skin condition/wound progress note(s) identified the following:

-12/18/20, A new blister was identified on R10's right heel that measured 7.8 centimeters (cm) X 6.4 cm. Skin was assessed and was macerated. An ABD (sterile abdominal pad) pad was applied and secured with roll gauze. Treatment would continue for one week. R10 did agree not to wear his shoes until the blister healed and would wear grippy socks instead. The medical doctor

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(MD) or nurse practioner (NP) was notified via fax communication of the deterioration noted in the site and pressure relieving devices were in place on the bed surface. The likelihood of healing was good.

-12/22/20, serosanguinous (thin drainage, usually with a pink or red tinge) drainage was weeping through the dressing. R10 was dragging his foot across his floor. He was encouraged to use his heel protector even when in he wheelchair and encouraged the nursing assistant staff to keep his foot on the foot pedal. R10 complained of pain with the dressing change. Therapy was notified. MD was notified of the present status of the ulcer and deterioration noted in the wound. No recent changes were made to the treatment orders for the wound. A pressure relieving mattress was on the bed and a foam Prevalon boot was being used. Likelihood of wound healing due to overall condition was identified as fair.

-12/31/20, Unable to accurately stage ulcer due to slough and eschar (dead skin tissue) covered. The ulcer was identified as being present on admission; although it developed after admission. The pressure ulcer measured 9.4 cm by 10.6 cm. The MD was updated on the wound status and recent changes for treatment had been ordered. The note identified a pressure reducing mattress on the bed, a Prevalon boot was used, a turn and repositioning program was being implemented and a heels up pillow was in use on the bed.

-1/5/21, Unable to accurately stage due to slough and eschar covered. The affected area had pitting edema. Recent changes were made to the treatment of the pressure ulcer. Pressure reducing devices were being used on the bed, a

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chair cushion was being used, and a Prevalon boot was used. R10 did not have his foot elevated on the heels up pillow and was encouraged to do this. R10 was informed of the risks associated with refusing the treatment recommendations. R10 signed an informed consent for refusing to comply with elevating his heel on the heels up pillow when in bed; however, did not idenify interventions to try if R10 refused.

-1/11/21, Pressure ulcer remained unstageable. The affected area has non-pitting edema. Wound improvement was noted and measured 8 cm X 9.6 cm. No odor was present. Drainage was minimal.

-1/18/21, Unstageable wound measured 6.2 cm X 8.8 cm. The ulcer was identified as being present on admission; although it developed after admission. No change noted in the wound. No recent changes in treatment orders. Pressure reducing devices were in place and unchanged. Likelihood of wound healing due to overall condition was fair.

-1/23/21, R10 was seen via virtual visit this morning, accompanied by his daughter. MD referred to another physician who traveled to the area to perform a sharp debridement of the pressure ulcer. MD ordered ACE wrap to right extremity from toe to knee. MD stated to continue with twice per day dressing changes, however an ABD pad did not need to be placed during the day to avoid extra cost but to put in place at night.

-1/26/21, Pressure ulcer measured 7 cm x 8.5 cm. No odor was apparent. Dressing was changed with son present. Stable eschar

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remained. Sanguineous drainage was present. R10 had pitting edema in right lower extremity. Pressure reducing devices and interventions remained unchanged

-2/4/21, Pressure ulcer measured 5.8 cm x 8.8 cm. No odor was apparent and minimal drainage was present. The ulcer was identified as being present on admission; although it developed after admission. The wound had improved a great deal since last assessed. No changes were made to plan of care. R10 had an appointment with podiatry scheduled for 2/10/21. Pressure reducing devices and interventions remained unchanged

-2/9/21, Pressure ulcer measured 6.6 cm x 7.9 cm. No odor was apparent. Continued to have stable eschar. Soft edema was observed in the pedal area. Deterioration of the wound was identified. No changes were made to the treatment orders. R10 had an appointment with podiatry on 2/10/21. Pressure reducing devices and interventions remained unchanged

-2/14/21, Pressure ulcer measured 6.7 cm x 7.9 cm. Scant drainage was present. No odor was identified. No change in the wound was identified. Recent changes were made to the treatment ordered. Pressure reducing devices and interventions remained unchanged

-2/18/21, Pressure ulcer measured 6.7 cm x 8.1 cm. Minimal drainage was present and no odor was apparent. Wound improvement was identified. No recent changes were made to the treatment ordered. Pressure reducing devices were in place and remained unchanged. A multi-vitamin was initiated and was being

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administered.

-2/26/21, Pressure ulcer measured 6.5 cm x 8.2 cm. Minimal drainage was noted. A moderate odor was apparent. Deterioration in the wound was noted and the MD was notified. Recent changes were made to the treatment order and antibiotics were ordered. Pressure reducing devices and interventions remained unchanged. Likelihood of wound healing due to overall condition was fair.

-3/3/21, Pressure ulcer measured 6.4 cm x 8 cm. A moderate odor was noted as well as a large amount of drainage. Pressure reducing devices and interventions remained unchanged. Likelihood of healing due to overall condition was changed to be noted as poor.

-3/6/21, Pressure ulcer measured 6.2 cm x 8 cm. The ulcer was identified as being present on admission; although it developed after admission. A faint odor was apparent and a moderate drainage was present. Deterioration was observed in the wound. No recent changes were made to the treatment orders. No antibiotics were prescribed. Pressure reducing devices and interventions remained unchanged.

-3/11/21, Pressure ulcer measured 6 cm x 7.8 cm. The ulcer had a moderate odor with thick moderate drainage present. Ulcer was redressed as ordered, which had been changed back to a betadine wet to dry dressing. Deterioration was observed in the wound. Recent changes were made to the wound treatment. Antibiotics were prescribed. Pressure reducing devices and interventions remained unchanged. Likelihood of healing due to overall condition was continued to

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be documented as poor.

R10's medical record lacked a comprehensive assessment to determine the causative factors of the development of R10's pressure ulcer as well as reassessment of nursing interventions when wound deterioration was noted. The record also lacked evidence the pressure reducing/relieving devices were evaluated for consistent use and effectiveness or elevation of R10's leg was being performed as ordered when the pressure ulcer was identified to worsen.

R10's Physical Therapy Module Evaluation dated 12/11/20, lacked evidence R10 was assessed for positioning in his wheelchair in regards to his foot pedals in relation to the length of R10's legs.

R10's physician communication form dated 12/17/20, identified R10 was reporting problems with jumpy legs, more dominant on the right and they were concerned about his right foot flopping inward with inability to control the foot. An order was written to have physical therapy evaluate and treat right foot and to schedule to be seen on next rounds to address restless legs.

R10's medical record lacked evidence the therapist was notified of concerns related to R10's wheelchair, evaluation of R10's wheelchair to ensure proper pressure relief was in place or notification of the order to evaluate and treat R10's right foot.

R10's Hospital Discharge Summary dated 12/31/20, indicated R10 was admitted to the hospital for progressive right foot/heel wound. Imaging demonstrated he should have sufficient arterial flow to heal his right heel ulcer. Would

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recommend offloading pressure at all times and keep clean and dry. Follow up recommendations were for Prevalon heel boots to offload and to wear at all times except with transfers and to follow up with wound clinic in 2-3 weeks.

R10's progress note dated 1/5/21, indicated R10 had signed an informed consent for non-compliance with elevating the right heel using a heels up pillow and heel protector when in bed. The risk associated with refusal of treatment was that it could increase the pressure to the right heel and could increase friction to the area; however, did not identify interventions to reduce pressure when R10 refused.

R10's physician office visit note dated 2/10/21, indicated since the ulceration was unstageable, debridement was not necessary unless signs of infection arose. The ulcer did not seem to be acutely infected and conservative treatment was advised. R10 was to limit activities, minimize weight bearing, and use sterile dressings to cover the ulcer. Discussed control of peripheral edema and offloading were the keys to healing the ulcer. R10 must wear offloading boot at all times while in wheelchair or bed. Dressing order placed for betadine, exufiber, abdominal pads (ABD) and kerlix dressing to right heel twice daily.

R10's physician order dated 2/24/21, directed staff to wash R10's right heel ulcer with soap and water twice daily. Cover the entire wound with a dakins moist gauze. Pad with a dry 4x4 dressing and secure with a kerlix wrap. Have him wear the Prevalon boot at all times other than when ambulating or transferring. Avoid all pressure to the right heel at all times. Elevate the right leg as much as able.

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R10's physician rounds note dated 2/25/21, indicated R10 was seen on rounds in his room. Wound care would continue with Dakins moist gauze twice a day, Prevalon boot and protection.

On 3/17/21, at 12:54 p.m. RN-C stated she thought the ulcer on R10's heel started when he was hitting his heel on the foot board of his bed, so they removed the foot board. The physical therapist was who would evaluate wheelchair fit and positioning but they did not automatically evaluate this when they saw a resident. Interventions of a foot pillow and heel boot were implemented in bed to reduce pressure on the foot on 12/22/20. Family wanted him sent to the ER on 12/26/20 and he was admitted and sent to Duluth to be seen by a specialist. RN-C was unable to find communication to physical therapy for the 12/16/20 order for PT evaluate and treat right foot.

On 3/17/21, at 1:50 p.m. NA-C indicated R10 had a Prevalon boot or a foot pillow. NA-C stated R10 was usually ok with using the foot pillow but would refuse the Prevalon boot. She had never elevated R10's right leg and he had never asked her to elevate it. She had never been instructed R10 needed to have his leg elevated, but she did not feel R10 sat in his wheelchair for very long periods of time. The nursing assistants were suppose to apply the ACE (an elastic bandage used to control swelling) wrap to R10's right leg with morning cares until the nurse could do his dressing. NA-C stated she had not been trained to apply ace wraps.

R10's nursing assistant assignment sheet dated 3/17/21, lacked any direction to use positioning

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devices or elevate R10's right leg in or out of bed.

On 3/18/20, at 8:46 a.m. physical therapist (PT)-A stated she did look at wheelchair positioning when she did resident evaluations and felt R10 was positioned adequately in his wheelchair. PT-A stated she had put the longest leg extension she could find on the wheelchair and if you stretched his leg out you could get his leg on the foot pedal and then you had to rest the ball of his foot on the foot pedal. PT-A stated she had not been notified of the 12/10/20, order to evaluate and treat R10's right foot. An order was not placed for longer foot pedals to accommodate R10's long legs and relieve the foot from pressure.

On 3/18/21, at 12:48 p.m. RN-C stated the nursing assistant assignment sheet did not direct the nursing assistants to position R10's foot with a pillow or Prevalon boot. There would not be any documentation in R10's record on 3/15/21, to indicate if R10 had refused to wear the Prevalon boot because a trained medication aide (TMA) had been working on the wing and they did not document in resident charts. RN-C stated she was disappointed R10's foot was not being positioned correctly in the wheelchair and the nursing assistants should be positioning it with the Prevalon boot.

On 3/18/21, at 1:09 p.m. RN-A stated if R10 refused the Prevalon boot, his foot should still be positioned on the foot rest to avoid any pressure to the heel, such as placing a pillow or something to float the heel and the leg should be elevated.

During telephone interview on 3/19/21, at 11:08 a.m. family member (FM)-A stated R10 was

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placed in the nursing home for some sub acute care and time to heal. R10 had everything back from his CVA except his right foot. Ten days after his admission, the nursing home had called and reported to FM-A R10 had a small blister on his foot. They mentioned maybe he had kicked the foot board on his bed because of his long legs or maybe his shoes had caused it. On 12/23/20, the nursing home called and informed FM-A R10's heel was pretty bad, the blister had busted and the heel was black in color. When FM-A visited on 12/25/20, they were shocked as the wound on his heel had went from a tiny blister to that. FM-A could smell the stench of the pressure ulcer when FM-A walked into the room. FM-A took pictures and sent them to several doctors. All three doctors told them the wound was a pressure ulcer and was completely preventable. The doctor told FM-A they needed to get R10 into the ER. FM-A called and told the facility they wanted him sent to the ER to be evaluated. FM-A wished they had seen it earlier, but nobody had told them it was a pressure ulcer, it was always a blister.

On 3/19/21, at 1:14 p.m. RN-A stated she had done the initial admission skin assessment for R10 and did not find any skin concerns. A week later a blister was found on his right heel. In February the facility reached out to the wound clinic and got orders to use the Daikins solution. RN-A stated, "We started seeing some improvement in the wound. The eschar [dead skin tissue] and slough was coming off. The following week he was seen by the podiatrist who changed the treatment back to the former betadine wet to dry dressing." RN-A indicated an updated med list, the treatment record and the physician order sheet was sent with residents to all appointments. RN-A did not write an update to

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the podiatrist for that appointment and did not clarify if the podiatrist was aware of the Daikins ordered treatment that had made improvement in the wound or verify the change in treatment was a purposeful change in treatment back to the old dressing orders. RN-A stated R10 would frequently refuse the Prevalon boot because it was to hot or to tight. The nurse aides were informed today (3/19/21), if R10 refused his boot they were to put a pillow under it and they should elevate the leg and foot.

During an interview with the administrator and the DON on 3/22/21, at 4:44 p.m. the DON stated the registered nurses should be identifying wheelchair positioning problems and issuing the order for therapy to evaluate it. When the facility identified a pressure ulcer, the process should include an evaluation of the resident's positioning. The facility is working on improving their assessment process. The DON indicated she had called the wound specialist and had gotten a new treatment order to use the Daikins solution to the wound instead of betadine. It looked like the Daikins solution was working and there might be some hope but then R10 went to the podiatrist and the order was changed back to betadine. The podiatrist would have known about the new treatment of Daikins because the order sheet was sent with the resident; however, a nursing update was not sent with R10 to his appointment. The administrator indicated the doctor needed to have some responsibility to look at the residents order sheet.

The undated facility policy Adaptive and Positioning Equipment indicated an RN would contact the provider for referral to occupational therapy (OT) or PT for wheelchair positioning,

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seating assessment or other adaptive equipment recommendation. OT or PT would conduct the assessment and make recommendations for wheelchair modification and/or equipment and communicate these recommendations to nursing. The RN would document equipment use in the care plan and on the nurse aide care sheets. Nursing and/or therapy would observe appropriateness of continued use of the equipment.

R39's significant change MDS dated 2/22/21, indicated she had intact cognition and did not display rejection of care. The MDS indicated R39 required total assistance from staff for bed mobility, transfers and toileting, was occasionally incontinent of bowel and had an indwelling catheter. The MDS further identified a Stage I pressure ulcer and an unstageable pressure ulcer present on admission. R39's undated Face Sheet, identified diagnoses that included disorder of the skin and subcutaneous tissue and Stage III pressure ulcer to the buttocks.

R39's care plan dated 3/14/21, identified a risk for skin breakdown related to decreased mobility and at risk for developing additional pressure ulcers. The care plan directed staff to observe skin with cares and to encourage R39 to reposition every two hours and as needed for comfort. The care plan dated 2/8/21, identified a pressure ulcer to R39's buttocks along with the use of an alternating pressure mattress in bed and a pressure reducing cushion in her wheel chair.

On 3/15/21, at 3:25 p.m. was observed seated in her recliner chair with a dressing on her right heel

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and a Prevalon boot on her left heel. R39 stated the dressing was a precaution as she had a soft spot that could develop into a pressure area. R39 also stated she did have a pressure ulcer on her bottom.

R39's Physician Order dated 1/20/21, indicated: Pressure relieving device in recliner and on bed.

A facility communication form to the physician dated 1/25/21, indicated R39 had three new areas. One to her right buttock which appeared to be a "shearing injury", staged as an unstageable pressure ulcer. The area measured 8.8 centimeters (cm) long x 6.2 cm wide and was covered with eschar. The entire right buttock from the top of the gluteus maximus to the right gluteal fold was purple even after several minutes of offloading and was rock hard . The area had almost tripled in size since the writer saw it 6 days prior. The second "open area" on her left buttock measured at 1.2 cm x 1.2 cm x 0.1 cm and appeared to be from "friction". The third "open area" was on the right gluteal fold and measured 0.8 cm x 0.8 cm x 0.1 cm.

R39's hospital Discharge Summary dated 2/15/21, indicated R39 had an indwelling Foley catheter since January 2021, due to ongoing skin breakdown and sacral pressure ulcers. She was sent to the emergency department for increased temperature and increased confusion. R39 was found to have an infected appearing right buttock pressure ulcer as well as an urinary tract infection. They recommended a wound consult and indicated, "may need some debridement verses local wound cares."

R39's Physician's Orders dated 2/15/21, identified

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a re-admission to facility with a new diagnosis of an infected Stage III pressure ulcer. Wound care was ordered to the right buttock, left buttock and the left 4th and 5th toes.

R39's Video Visit note dated 2/18/21, indicated R39 was recently hospitalized for sepsis and an identified "pressure injury" to the sacrum, a "pressure injury" to right gluteal fold measuring 0.7 cm x 0.4 cm and a right buttock "wound" measured 5.2 cm x 4.0 cm.

During observation on 3/18/21, at 1:54 p.m. RN-C completed R39's dressing changes. RN-C measured R39's buttocks wounds, R39 had an area described by RN-C as a five inch line, deep, dark purple in color which RN-C stated was new. R39's buttocks was red and macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture) with induration (deep thickening of the skin resulting from inflammation) noted. R39 also had four shallow open areas in the gluteal cleft. At 2:26 p.m. RN-C observed the cushion in R39's wheel chair and described it as approximately a one inch regular foam cushion. A cushion was not observed in R39's recliner chair. RN-C stated R39 had never been assessed for a specialty cushion.

During interview on 3/22/21, at 10:24 a.m. the DON stated she was not aware what kind of cushion R39 had in her chair. The DON stated the nurses process orders which should then be entered onto the medication administration record and in the care plan. The DON stated one nurse entered the orders and there was not a second check system in place. At 10:49 a.m. the DON stated R39 did not have a cushion in her recliner

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F 686	Continued From page 41 as ordered by the nurse practitioner. At 1:45 p.m. nursing assistant NA-D stated R39 did not have a cushion when seated in her recliner chair. NA-D stated she had never received direction to place a cushion in the recliner chair. The undated facility policy Skin Ulcer Protocol indicated residents would not develop pressure sores or other skin ulcers unless it was clinically unavoidable and appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. The policy defined an avoidable pressure injury as having developed because one or more of the following were not done: a resident's clinical condition was not evaluated, risk factors were not identified, interventions were not implemented and/or effectiveness of interventions were not monitored or revised. An unavoidable pressure injury was defined as having developed even though the facility had evaluated the resident's clinical condition and risk factors, implemented proper interventions and monitored and revised interventions due to underlying disease process and ulcer developed. Staff were directed to obtain a physician's statement that the ulcer was unavoidable.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		4/20/21

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F 688	Continued From page 42 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review failed to assess for a splint and/or restorative nursing program for 1 of 2 resident (R7) reviewed for restorative nursing services. Findings include: R7's admission Minimum Data Set (MDS) dated 12/30/20, indicated R7 had moderate cognitive impairment and did not indicate any mood or behavior issues. Further, R7 did not have any limitations in the upper or lower extremities. R7's diagnosis included adult failure to thrive. R7's Admission Observation Assessment dated 12/24/20 through 1/4/2021, indicated no limitations or contractures in R7's upper or lower extremities. During an observation on 3/16/21, at 8:31 a.m. R7 was in the dining room and her middle finger, ring finger and little finger were clenched tight on her right hand. When R7 reached with her right hand for silverware, coffee cup or food she did not use any of those fingers.	F 688	1. R7 is receiving restorative services for passive range of motion for upper and lower extremities, including hands 3-6x per week initiated by PT. This is being completed by facility ROM program. She was also assessed for safe transferring and is assist of two with a gait belt and 4WW as recommended by PT. 2. All residents who enter the facility have the potential to be effected by the deficient practice. 3. DON reviewed the Restorative Nursing Program policy. Residents will be evaluated on admission, ongoing and at least quarterly to determine the need for restorative nursing services by the Restorative Coordinator or nursing designee and/or Contracted Therapy. Restorative Coordinator or Therapist (PT,OT,SLP) will provide a copy of their recommended treatment to the Restorative Coordinator, DON, MDS Coordinator and Charge Nurse. The Restorative Coordinator or nursing designee will develop the program(s), in	

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F 688	Continued From page 43 R7's care plan dated 12/25/20, did not identify a restorative nursing program or splint use. R7's progress notes identified the following: - 1/8/21, by occupational therapist (OT) indicated R7 followed cues to grip OT's fingers but did not follow though for a second time. R7 would benefit from further skilled OT services. - 1/22/21, by OT indicated R7 was very limited in her participation of therapy sessions, further skilled OT services were not appropriate and ended at this time. The note did not identify if R7 required a restorative nursing program or a splint. During a subsequent observation on 3/17/21, at 8:43 a.m. R7 was being assisted with morning cares by nursing assistant (NA)-E and R7's middle finger and ring finger on her right hand was clinched tightly. R7's right hand was not exercised and did not have a splint placed during morning cares. During an interview on 3/18/21, at 8:32 a.m. the physical therapist (PT)-A entered R7's room and assessed her hands for range of motion (ROM). PT-A stated R7's right hand was not previously clenched while in therapy. PT-A assisted R7 to open her hand and stated there was a range of motion issue in the middle and ring fingers with stiffness . R7 grimaced upon opening hand. PT-A stated the stiffness in R7's hands was arthritic in nature and she would benefit from a restorative nursing program to prevent contractures from forming. Once R7's hand was opened she was able to move it freely without pain.	F 688	collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). A Restorative Assessment will be completed by the RN Restorative Coordinator or by nursing staff under the supervision of the RNC. This will include identifying and care planning the residents need for restorative nursing services, goal(s), and interventions to meet the goal(s). Nursing staff will also be educated on notifying the Charge Nurse and/or Restorative Coordinator if a decline in physical functioning has been observed. The DON and/or designee will educate all nursing staff and contracted therapy on the care center process and policy for restorative nursing services. Restorative Coordinator will have a meeting with the restorative staff, charge nurses, a NAR representative from each unit, DON and PT to review all current residents level of functioning to ensure appropriate restorative programs are in place, with care plans updated as needed. 4. Random audits will be completed to ensure residents are being assessed for ROM services. Audits of new admissions, quarterly MDS reviews and discontinuation of therapy services will be completed 3x/week x 2 weeks, then once weekly thereafter. Auditing will begin 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI	

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F 688	Continued From page 44 During an interview on 3/18/21, at 9:23 a.m. the director of nursing (DON) stated it had been a challenge to keep the restorative nursing program going. They recently hired an RN to oversee the restorative program to ensure the residents received the services they need. The RN was still in training and had not started to expand the program yet. During interview on 3/18/21, at 9:58 a.m. registered nurse (RN)-B, the restorative therapy nurse, stated R7 did not have a restorative nursing program and was not receiving services. RN-B stated for a resident to receive restorative nursing services they would be assessed by physical therapy and they would recommend restorative nursing services and would place an order for the restorative nursing program. If the floor staff identified a concerns they would report it to licensed staff, and the licensed staff would place an order to the restorative nursing program. RN-B stated she would then go and assess the resident and determine what services were needed and develop a restorative program specific to the resident. She had not received an order and no concerns were brought to her attention for R7. RN-B indicated R7 would benefit from a restorative nursing program due to stiffness in her hand and needing assistance to get it open in the morning to move freely all day and prevent contractures. During an interview on 3/18/21, at 1:36 p.m. NA-E stated R7 had been clenching her hand a lot lately and did not remember seeing it unclenched. NA-E stated the last time she assisted R7 with a tub bath R7's right hand was clenched tight and it was difficult to open and wash inside of it. R7 did not show any signs of pain when attempting to	F 688	team will make recommendations for ongoing monitoring. 5. Completion date for F688 is 4/20/21 Review: CCP.QC.071 Restorative Nursing Program	

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F 688	Continued From page 45 open her hand and able to just open it far enough to clean it. She did tell the trained medication aide (TMA) working the med cart that evening, and did not know which TMA was notified. The facility's Restorative Nursing Program policy dated 4/6/20, indicated it would have a restorative nursing program which promotes a residents' ability to achieve and/or maintain there optimal function. The restorative nursing coordinator would develop the program for residents who are identified as having the potential to benefit from the program.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, per manufacturer's recommendation, the level of assistance required for use of the bath chair prior to use and failed to assess cause of injury and implement interventions to prevent subsequent injury while bathing for 1 of 1 resident (R39) reviewed for facility acquired lacerations while in the tub chair. This resulted in actual harm to R39 who sustained a second injury in the tub room resulting in a second laceration which required 16 sutures.	F 689	1. R39 is assigned to have assist of two people in tub chair when transferring and docking. 2. All residents who utilize the bath chair have the potential to be effected by the deficient practice. 3. The Bathtub Transfers policy was reviewed and revised by the DON. All nursing staff will be educated on the Bathtub Transfers policy by the DON or designee. All residents who utilize the mechanical lift will have assist of 2 with	4/20/21

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F 689	Continued From page 46 Findings include: R39's significant change Minimum Data Set (MDS) dated 2/22/21, indicated she had intact cognition and required extensive assistance for transfers. The MDS indicated R39 required physical assistance from two staff to complete bathing activity. In addition, R39's MDS identified a lower extremity impairment on both sides. Further, R39 was taking a blood thinning medication. R39's undated, Face Sheet identified diagnoses that included neuropathy, hypertension, osteoarthritis and abnormal coagulation. R39's care plan dated 3/14/21, indicated she was unable to transfer without assistance and directed staff to provide assistance from two staff for all transfers using a mechanical lift device. R39's care plan indicated she would receive three baths per week and directed staff to monitor for changes in abilities and provide supplies as needed. The care plan did not identify level of assistance needed or number of staff required. R39's medical record lacked an assessment related to bathing and the use of a mechanical bath chair. During interview on 3/15/21, at 3:27 p.m. R39 stated she had 16 stitches on the top of her foot from an incident that occurred in the tub room the previous week. R39's progress note(s) identified the following: -1/25/21, indicated staff came to get the nurse as R39 was bleeding excessively and had a large	F 689	tub chair. All other residents will be assessed for safe tub chair use by licensed nurse or will use a minimum of 2 people. Charge Nurse to update bathing care plans and NAR care sheets with any changes. Signs with the policy have been placed in the tub room, in the tub room book, and all nursing staff have been re-educated on this procedure. All accidents will be investigated per our Accidents/Incidents policy. Accidents will be reviewed at High Risk Committee to insure that proper investigation was completed and appropriate interventions are in place to prevent further incidents. 4. Random observational audits will be completed to insure safe tub chair transferring and docking is being performed appropriately per plan of care. A licensed nurse will perform audits to be completed 3x/week x 2 weeks, then once weekly thereafter. Auditing will begin 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F689 is 4/20/21. Review: KHS Policy: Bathtub Transfers Policy CCP.QC.002 Accident.Incident	

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pool of blood beneath her. R39 had sustained a superficial laceration to all four of her small toes. The lacerations required the use of a pressure dressing to stop the bleeding.

- 2/1/21, indicated areas on R39's 4th and 5th toes appeared to be a result of her toes being bumped on the bath scale on 1/25/21, while in the tub room. The note indicated on 1/25/21, R39 had excessive bleeding, the ends of her toes were soft and minor lacerations were noted.

- 3/12/21, indicated R39 had been transferred to the emergency departement for evaluation and wound care for right foot laceration with uncontrollable bleeding.

- 3/13/21, indicated R39 returned to the facility and ice was applied to her affected foot.

- 3/15/21, indicated review with R39 regarding laceration to foot resulting in R39 stating her foot hit a bolt on the shower chair. R39 reported while being lifted out of the tub the injury occurred. R39 also stated she did not have control of that leg and it "does what it wants." The outside of the tub was noted to have two hinges to hold the door closed. The hinges were colored in a bright color to draw attention to them.

- 3/17/21, indicated after interview with R39 and observation of the tub room equipment, R39's description of the incident was unclear. R39 was brought to the tub room and when she described the incident, nurse was unable to determine what caused the laceration. R39 stated she did not know what she hit her foot on. The bottom of the tub chair had two spots which appeared to be dried blood behind the right wheel of the chair.

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Still no conclusive understanding of the incident until staff member involved can demonstrate. Will remind staff to monitor body parts with use of equipment, especially when there are flaccid body parts.

R39's Incident Details Report dated 3/12/21, indicated R39 sustained a laceration during transfer to the top of her right foot. The report indicated R39 was transferred to the emergency department and required sutures. Wound measured 9.2 centimeters in length. The report lacked a follow up assessment or interventions to prevent further incident.

During a subsequent interview on 3/16/21, at 3:22 p.m. R39 stated when the incident occurred in the tub room on 3/12/21, nursing assistant (NA)-F had transferred her by herself and stated the facility had been short of help that day.

On 3/16/21, at 3:59 p.m. NA-F stated R39 had scraped her foot while in the bath tub lift chair. NA-F stated there was a "white part on the bottom where the wheels are at, her foot must have gotten caught on it." NA-F stated another NA had assisted her to place R39 in the tub chair using the ceiling lift but had left before R39 was in the tub.

On 3/19/21, at 12:05 p.m. the director of nursing (DON), administrator and corporate clinical consultant (CCC) were interviewed. The DON stated she had spoken to R39 about the incident and R39 told her she had cut her foot on a hinge on the door of the tub. The DON stated when she went in with maintenance she had seen something different and stated she had seen some spots of blood on the bottom of the bath

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chair. The DON said R39 later told her she may have hit her foot on the bottom of the chair. The DON stated she needed to talk to the NA that was working when the incident occurred but had not yet spoken to her. At 12:09 p.m. the administrator stated she had gone to the facility the evening after the incident occurred and talked to the NA that had performed the bath. The administrator stated NA-F told her she had made sure R39's feet were on the pedestal in the tub and went slowly, then saw the foot bleeding and stopped. The administrator stated she did not have documentation of her conversation with NA-F. The administrator stated they needed to re-enact the incident with NA-F to determine what had happened. The corporate clinical consultant (CCC), present during the interview, stated to the DON "the tub chair only needs one person and wouldn't you think your aides would let you know if they needed additional help?" The DON stated the facility did not use an assessment to determine safety when using the mechanical tub chair. The CCC again spoke to the DON and stated, "it's never happened before so you will have to assess."

At 12:19 p.m. when asked what the facility was doing to ensure a similar incident did not occur with other residents who used the tub chair the administrator said she had talked to staff the night of the incident and told them always to be careful when moving residents in the tub chair and to watch their limbs. The administrator stated she did not have documentation of the education.

At 12:29 p.m. the tub room was observed with the DON and the administrator who demonstrated the tub chair lift. The tub chair had the ability to be raised to a height that would allow a residents

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feet to hang down and still clear the base of the tub. During the demonstration the administrator stated, "when we find the cause, we will take care of it."

On 3/22/21, at 11:05 a.m. registered nurse (RN)-C stated when the first incident occurred on 1/25/21, staff were assisting R39 out of the tub and R39's toes scraped a wheel on the tub seat. RN-C stated she did not know if any interventions had been placed at that time to prevent further incident.

On 3/22/21, at 1:01 p.m. the DON stated there was no follow up after the incident occurred on 1/25/21. The DON stated an incident report should have been completed and the interdisciplinary team should have followed up. In regard to assessing a residents safety with regard to use of a mechanical tub chair, the DON stated she had never performed an assessment and stated the NAs were the ones who determined resident safety while bathing. The DON stated the NAs had training on how to use the tub chair and felt they would come to her if they had questions. The DON further stated now that there had been an injury everyone would be asessed.

At 5:12 p.m. during interview with the administrator and DON, the administrator stated in regard to assessments for safety with the tub chair, "I think it's one of those things missed in most care centers." The DON stated assessment for safety was re-active on the part of the facility.

The Cascade Patient Transfers Lift System Safe Operations and Daily Maintenance Instructions, revised 11/7/17, indicated the following:

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F 689	Continued From page 51 Patient Assessment for the Penner Transfer Lift Systems. - Before using the Penner Transfer Lift System, patients must be assessed by the facility's professional nursing or professional rehabilitation staff to determine which patients are suitable for transfer, which type of Transfer to use, and the number of staff members necessary to transfer each patient. Although one person can perform patient transfers, certain patients or situations may require the help of one or more additional staff members. For example, patients with unpredictable behavior due to dementia may require additional help if their behavior poses risk of injury to themselves or to staff members, patients being transported in the Penner transfer with or without scale outside of the patient ' s room. The above information must be recorded in the patient ' s record and must be communicated to the staff. Penner Transfer Lift Criteria - The Patient Must: a. Have no injuries or medical conditions that might be aggravated by the Penner Transfer Lift procedure. b. Weight less than 400 pounds. c. Be able to follow simple directions. d. Be able to sit upright by the optional chest safety belt. e. Evaluated for safety of extremities that are rigid or any problem he or she has that could cause injury or conflict with the safe operation of the Penner Transfer Lift System.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		4/20/21

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F 690	Continued From page 52 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure routine catheter care was provided in a manner to reduce the risk for infection for 1 of 3 residents (R39) reviewed for urinary tract infections.	F 690	POC F690: 1. R39 has an indwelling catheter. All NAR staff have been provided education regarding proper catheter cares and infection prevention measures to reduce	

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F 690	Continued From page 53 Findings include: R39's significant change Minimum Data Set (MDS) dated 2/22/21, identified R39 had intact cognition and indicated she was occasionally incontinent of bowel and had an indwelling catheter. R39's undated, Face Sheet identified diagnoses of urinary tract infection (UTI) and neuromuscular dysfunction of bladder. R39's care plan dated 1/26/21, identified a risk for UTI related to the use of an indwelling catheter. The care plan directed staff to provide routine catheter care, provide perineal care after each incontinent episode and indicated staff assistance of two for toileting. R39's progress note dated 2/5/21, indicated on 11/26/20, R39 was sent to the hospital for evaluation and was started on an antibiotic for UTI. 12/2/20, antibiotic started for UTI. Sent to hospital again on 12/22/20, and returned on 12/24/20, with a diagnosis of UTI. On 12/31/20, she was sent to the hospital and re-admitted on 1/4/21, with a diagnosis of UTI. On 1/26/21, a catheter was placed. 2/3/21, referral to urology due to chronic antibiotic use. R39's hospital Discharge Summary Notes dated 2/15/21, identified a diagnosis of severe sepsis with septic shock and an infected pressure ulcer, MRSA (Methicillin-resistant staphylococcus aureus) and recurrent complicated UTI. Urine culture results identified Escherichia coli and Enterococcus faecalis (bacteria found in feces that spreads from human to human through poor hygiene).	F 690	the risk for infection by the DON or designee. 2. All residents who have indwelling catheters have the potential to be effected by the deficient practice. 3. The Catheter Care Policy was reviewed by DON with no changes needed. All NAR staff will receive re-education on the proper procedures for catheter care and infection prevention measures to reduce the risk for infection by the DON and/or designee. 4. Random observational audits will be completed to insure catheter care is being performed appropriately. A licensed nurse will perform audits to be completed 3x/week x 2 weeks, then once weekly thereafter. Auditing will begin 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F690 is 4/20/21. Review: KHS Policy: Catheter Care Policy	

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During observation on 3/15/21, at 3:30 p.m. R39 was seated in a recliner chair in her room. R39's wheel chair was next to her and had a disposable pad on it. The disposable pad had a dark brown substance on it which appeared to be feces.

During observation on 3/17/21, nursing assistant (NA)-D and NA - E performed morning cares for R39. NA-D emptied R39's catheter and cleansed the end of the drain with an alcohol swab. After changing her gloves, NA-D wet a washcloth in the bathroom sink, applied soap directly to the cloth and washed R39's perineal area. NA-D wiped once lightly on the left and right side of R39's peri-area. NA-D did not cleanse the labial area and did not cleanse the catheter insertion site or tubing. NA-D then patted the area dry. NA-D and NA-E turned R39 side to side to change her incontinent product but did not cleanse her buttocks.

During interview on 3/17/21, at 12:32 p.m. NA-D stated she knew she should have cleansed around the catheter insertion site and stated "we forget every once in a while." NA-D acknowledged not cleaning R39's buttocks after removing the incontinent brief and stated if R39 wanted something more done she could ask.

During interview on 3/22/21, at 4:45 p.m. the director of nursing (DON) stated they were always trying to keep track of UTI's. The DON stated they had seen more UTI's in the facility and she blamed COVID as people were not out of their rooms socializing and having snacks and drinks in common areas. She stated when in their rooms the residents were not as good about drinking. The DON stated handwashing was something that was audited all the time but did not have

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F 690	Continued From page 55 documentation of the audits. The DON further stated they were trying to increase staffing so toileting could happen more often that it currently was. The DON stated when residents went to the hospital they seemed to always come back with a UTI. The DON further acknowledged that a urine culture was completed before antibiotics were ordered for a UTI. A facility policy titled Catheter Care dated 1/7/19, identified a purpose of infection prevention. The policy directed staff to use a basin with warm soap and water and to wash the genital area around the catheter and up the tubing when performing perineal care.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to change oxygen tubing according to manufacturer recommendations and provide a system to ensure it was completed for 1 of 1 residents (R51) reviewed for respiratory care. This has the potential to affect all 4 residents receiving respiratory therapy. Findings include:	F 695	1. R51's oxygen tubing is being changed every Friday night. Charge Nurse will enter treatment orders for licensed nurse to change oxygen tubing every Friday night. Charge Nurse will also update R51 care plan to reflect use of oxygen and tubing change requirements. 2. All residents who utilize oxygen have the potential to be effected by the deficient	4/20/21

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F 695	Continued From page 56 R51's quarterly Minimum Data Set (MDS) dated 3/8/21, indicated R51 was cognitively intact, had diagnoses including asthma and received oxygen therapy. R51's Physicians Order Sheet dated 3/18/21, included orders for oxygen 1-4 liters as needed for respiratory distress, acute dyspnea (shortness of breath) and hypoxia (inadequate supply of oxygen to the tissues) to bring oxygen saturations above 88%. R51's medical record lacked direction of when staff should change the tubing and lacked evidence of oxygen tubing changes R51's care plan reviewed 3/18/21, did not address R51's respiratory status or use of oxygen therapy. R51 was observed seated in his room wearing oxygen on 3/15/21, at 2:49 p.m.; 3/16/21, at 1:51 p.m.; and 3/17/21, at 7:14 a.m. The oxygen tubing was not labeled with the date and time it was last changed. During interview on 3/18/21, at 9:27 a.m. the director of nursing (DON) stated the night shift staff were assigned to change and label oxygen tubing on Friday nights. The DON further stated R51's oxygen tubing was unlabeled and she expected staff to change and label the tubing every Friday night according to the LPN Night Duties list and facility policy. - At 11:59 a.m. R51 stated his oxygen tubing had only been changed once to his knowledge.	F 695	practice. 3. The Northwest Respiratory Manual for replacement of oxygen tubing was reviewed by the DON with no changes needed. DON will educate all licensed nurses regarding changing oxygen tubing weekly for all residents. DON will also educate the licensed nurses on labeling the tubing with the date and time, entering a nurse order in the eTAR to change oxygen tubing weekly for all residents with oxygen. Care plans will be updated by the Charge Nurses to specify respiratory status and use of oxygen and weekly tubing changes. 4. Random observational audits will be completed to ensure that tubing has been changed, signed off in eTAR and labeled with date and time. Audits will be completed 3x/week x 2 weeks, then once weekly thereafter (based on MDS schedule, could be fewer per week). Auditing will begin 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F695 is 4/20/21. Review: NWR Manual on Oxygen Tubing	

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F 695	Continued From page 57 The facilities Routine Licensed Practical Nurse (LPN) Night Duties list directed staff to change, label and date all oxygen tubing; however, did not identify how the nurse was to verify the oxygen tubing change was completed as directed. The facility completed CMS-672 signed 3/23/21, identified the facility had 4 residents receiving respiratory treatments. The facilities Respiratory manual, dated 3/07, indicated Northwest Respiratory Services recommended replacement of the oxygen cannula tubing every week to reduce the risk of infections.	F 695		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		4/20/21

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F 726	Continued From page 58 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure trained medication assistants (TMA) were adequately trained to identify, assess, and monitor pressure and non-pressure skin wounds for 2 of 4 residents (R10, R39) identified to have worsening skin conditions. This had the potential to affect all 15 residents receiving pressure ulcer care or preventative skin care. Further, the facility failed to ensure nursing assistants (NA)'s were adequately trained to apply elastic dressing (ACE) wrap, used to control swelling in residents with edema (swelling) for 1 of 1 resident (R38) observed to have ace wraps applied to his lower extremity. Findings include: The CMS-672 (form completed by the provider summarizing resident needs and services) identified 5 residents with pressure sores and 10 residents who were receiving preventative skin care. R39's physician communication form dated 1/25/21, indicated R39 had three new areas. One to her right buttock which appeared to be a	F 726	1. R10 discharged from facility on 3/27/21. R39 is still a resident in the facility. As of 3/22/21, all wound dressings or treatments are performed by a LPN or RN. 2. All residents who require wound dressings or treatments have the potential to be effected by deficient practice. 3. All residents with orders for a dressing or treatment will have the dressing/treatments completed by an LPN or RN. Littlefork Medical Center changed their existing TMA policy to no longer allow TMAs or NARs to perform dressings or treatments. All dressings and treatments will be changed by licensed staff. All nursing staff, TMA's and NARs were educated in the practice change by the DON. 4. Random observational audits will be completed to ensure appropriate licensed staff are completing all treatments and dressings. DON or designee will complete the audits 3x/week x 2 weeks, then once weekly. Auditing began on 4/12/21. Staff will be re-educated on an ongoing basis as needed based on the results of the	

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F 726	Continued From page 59 "shearing injury", staged as unstageable pressure ulcer. The area measured 8.8 centimeters (cm) long x 6.2 cm wide and was covered with eschar. The entire right buttock from from top of gluteus maximums to right gluteal fold was purple even after several minutes of offloading and was rock hard . The area had almost tripled in size since the writer saw it 6 days prior. The second open area on her left buttock measured at 1.2 cm x 1.2 cm x 0.1 cm and appeared to be from "friction". The third open area was on the right gluteal fold and measured 0.8 cm x 0.8 cm x 0.1 cm. R39's hospital Discharge Summary dated 2/15/21, identified R39 had an indwelling Foley catheter since January 2021, due to ongoing skin breakdown and sacral pressure ulcers. She was sent to the emergency department for increased temperature and increased confusion. R39 was found to have an infected appearing right buttock pressure ulcer as well as urinary tract infection. The recommended a wound consult and indicated, "may need some debridement verses local wound cares." R39's significant change Minimum Data Set (MDS) dated 2/22/21, indicated she had intact cognition and did not display rejection of care behaviors. The MDS indicated R39 required total assistance from staff for bed mobility, transfers and toileting, was occasionally incontinent of bowel and had an indwelling catheter. The MDS further identified a stage I pressure ulcer (Intact skin with non- blanchable redness of a localized area, usually over a bony prominence) and an unstageable pressure ulcer (Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or	F 726	audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F686 is 4/20/21 Review: Corp. Comp: TMA Policy	

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black) in the wound bed) present on admission.

R39's January 2021, Treatment Administration Record (TAR), identified the following wound care orders:

- Wound care, right buttock one time per day every three days, document daily monitoring of pressure ulcer to include an evaluation of the pressure ulcer if no dressing present or an evaluation of the dressing if present. Cleanse area, apply Alevyn (foam dressing) to open area on right buttock. The TAR indicated the wound care was completed by a TMA 1 of 2 opportunities.

- Wound Care, right buttock, right gluteal fold and left buttock one time per day on Friday evening. Cleanse wound with wound cleanser and pat dry well. Apply no sting barrier prep to skin surrounding wound. Apply Mepilex (foam dressing) sacrum dressing to entire right buttock. Apply Alevyn dressing to left buttock and right gluteal fold. The TAR indicated the wound care was completed by a TMA.

- PRN (as needed) dressing changes, monitor dressings to right buttock, left buttock and right gluteal fold three times per day during the day. Resident had the following dressing changes ordered. Right buttocks order to cleanse area well and apply no sting barrier wipes to surrounding skin (not on wound), apply Mepilex Sacrum. Left Buttock, cleanse wound and apply no-sting barrier wipe and apply Mepilex sacrum dressing. The TAR indicated the dressing change was completed by a trained medication aide (TMA) 2 of 6 opportunities.

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R39's February 2021, TAR identified the following wound care orders:

- PRN dressing changes, monitor dressings to right buttock, left buttock and right gluteal fold three times per day during the day. Resident had the following dressing changes ordered. Right buttocks order to cleanse area well and apply no sting barrier wipes to surrounding skin (not on wound), apply Mepilex Sacrum. Left Buttock, cleanse wound and apply no-sting barrier wipe and apply Mepilex sacrum dressing.
The TAR indicated the wound care was provided by a TMA 6 of 36 opportunities and not recorded 12 of 36 opportunities.

- Wound care one time per day. Left fourth and fifth toes, paint with betadine, cover with gauze and secure with burn netting. The TAR indicated wound care was completed by a TMA 6 of 13 opportunities and not recorded 4 of 13 opportunities.

- Monitor wounds two times daily for 14 days. For pressure ulcer unspecified buttock stage III. Document daily monitoring of pressure ulcer to include an evaluation of the pressure ulcer if no dressing present and an evaluation of the dressing if present and for the presence of complications such as increase in size or signs/symptoms of infection (increased redness, warmth, swelling, drainage) and the status of the area surrounding the pressure ulcer. Special instructions: left toes, right buttock, right heel, left heel. The TAR indicated the wound care was completed by a TMA 1 of 20 opportunities and not recorded 18 of 20 opportunities.

R39's March 2021, identified the following wound

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care order:

- PRN dressing changes, monitor dressings to right buttock, left buttock and right gluteal fold three times per day during the day. Resident had the following dressing changes ordered. Right buttocks order to cleanse area well and apply no sting barrier wipes to surrounding skin (not on wound), apply Mepilex Sacrum. Left Buttock, cleanse wound and apply no-sting barrier wipe and apply Mepilex sacrum dressing.
The TAR indicated the treatment was administered by a TMA 17 of 54 opportunities and not recorded 14 of 54 opportunities.

- Wound care one time per day. Left fourth and fifth toes, paint with betadine, cover with gauze and secure with burn netting. The TAR indicated wound care was completed by a TMA 13 of 18 opportunities.

- Wound care to right and left buttock. Cleanse well, apply no sting barrier wipe to surrounding skin and apply Mepilex sacrum dressing. The TAR indicated not recorded for 2 of 2 opportunities.

- Wound care to right buttock. Cleanse well, apply no sting barrier wipe to surrounding skin and apply Mepilex sacral dressing. The TAR indicated wound care was completed by a TMA 6 of 19 opportunities and not recorded 8 of 19 opportunities.

- Wound care to right and left heels three times per day. Apply Alevyn to right and left heels, remove old dressings and change if soiled or not intact following showers. The TAR indicated the dressings was completed by a TMA 16 of 54

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opportunities and not recorded 19 of 54 opportunities.

- Monitor wounds two times daily for 14 days. For pressure ulcer unspecified buttock stage III. Document daily monitoring of pressure ulcer to include an evaluation of the pressure ulcer if no dressing present and an evaluation of the dressing if present and for the presence of complications such as increase in size or signs/symptoms of infection (increased redness, warmth, swelling, drainage) and the status of the area surrounding the pressure ulcer. Special instructions: left toes, right buttock, right heel, left heel. The TAR indicated the wound care was completed by a TMA 2 of 8 opportunities and not recorded 5 of 8 opportunities.

- Wound care once daily to right gluteal fold, change as needed and daily if dressing soiled and after showers. Cleanse area and apply no sting barrier wipe to surrounding skin and apply Alevyn to the area.
The TAR indicated the wound care was completed by a TMA 4 of 10 opportunists and not recorded 5 of 10 opportunities.

During interview on 3/17/21, at 8:04 a.m. TMA - B stated the TMA's were able to completed dressing changes. TMA-B stated she did dressing changes for R39 and identified four other residents who's dressing she regularly completed. TMA-B stated if she was not comfortable with a dressing changes she would get a nurse.

During interview on 3/18/21, at 1:11 p.m. registered nurse (RN)-C was asked about TMA's completing wound care on declining or

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complicated wounds. RN-C stated, "that's a good question" and indicated she would find out. In regard to competency training and return demonstration RN-C stated none had been done that she was aware of.

On 3/22/21, at 1:35 p.m. the medical director (MD) stated he was not aware TMA's were completing wound care for residents with complicated or declining wounds. The MD stated TMA's should not complete wound care for pressure ulcers greater than a stage II.

On 3/22/21, at 4:42 p.m. the director of nursing (DON) stated when she started at the facility she said TMA's should not be doing wound care but they TMA's and licensed practical nurses said yes they were. The DON stated RN-C did hands on training and the TMA's took a wound class. The DON stated RN-C would be the person responsible for doing a return demonstration with the TMA's. The DON further stated the facility just changed their practice and TMA's would no longer be completing wound care.

R38's admission MDS dated 2/18/21, identified R38 had intact cognition. R38 required extensive assistance with bed mobility, transfer, dressing and grooming and was total dependent for toileting and wheelchair mobility. Diagnoses included fracture of left humerus, congestive heart failure and diabetes. R38 had two venous

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and/or arterial ulcers identified and required application of nonsurgical dressings other than to R38's feet

R38's Physician Nursing Home Visit progress notes dated 2/25/21, indicated R38 had a venous stasis ulcer on her right lower extremity, and pressure injuries on her right and left toes.

R38's February 2021, TAR identified the following wound care orders:

- Wound care to the left arm one time per day. Cleanse pin point site. Pat dry. Apply an ABD pad and wrap lightly with Kerlix. Can change as needed if saturated. The TAR indicated the wound care was provided by a TMA 4 of 12 opportunities and not recorded 2 of 12 opportunities.

- Wound care to bilateral (both sides) great toes. Apply copious amounts of betadine to the wounds. Apply Mepilex AG (an antimicrobial foam dressing) and cover with a 4 by 4 gauze. Wrap both feet with Kerlix (a type of rolled bandage). The TAR indicated the wound care was provided by a TMA 9 of 19 opportunities and not recorded 7 of 19 opportunities.

- Wound care one time per day during the day. Drainage management to right calf, apply an ABD pad to weepy areas of the calf and secure it with Kerlix or rolled gauze. The TAR indicated the wound care was provided by a TMA 3 of 7 opportunities and not recorded 3 of 7 opportunities.

- Wound care to the venous stasis ulcer on the right leg on time per day during the day. Cleanse

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F 726	Continued From page 67 On 3/19/21, at 1:40 p.m. TMA-A was observed to enter the general tub room with R38's chart to complete an ordered dressing change to R38's feet bilaterally. Registered nurse (RN)-C instructed TMA-A on the wound orders and how to complete the dressing change. RN-C stated R38's dressing was usually done in the evenings and TMA-A, who always worked the day shift, was not aware of how to do the dressing. However, TMA-A had initialed administration of dressing changes for R38 12 of 28 opportunities in February 2021 and 4 of 21 opportunities for dressing changes in March 2021. TMA-A washed her hands, used alcohol based hand rub and gloved. RN-C had already gathered all the dressing supplies and placed them near R38's chair in the tub room. R38's dressings had already been removed prior to her receiving her bath. TMA-A proceeded to cleanse the wounds with betadine, apply Mepilex dressing and Kerlix as ordered. TMA-A required several directions from RN-C and referenced R38's chart to complete the dressing changes. RN-C stated it would have been easier if TMA-A had removed the old dressing's herself to see what was in place from the previous dressing change and normally TMA-A would refer to the resident's treatment record to review the dressing order and so was not familiar where to find the most updated orders in the residents chart. TMA-A indicated she would be looking for symptoms of infection during dressing changes and if noted would inform the RN and request she come to look at it. TMA-A indicated RN-C showed her how to do a resident's dressing change but the orders for dressings were always changing.	F 726		

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On 3/22/21, at 10:09 a.m. RN-C stated she was going to be busy doing dressing changes. She was notified when she came on shift the TMA's were no longer able to do any dressing changes, and this was effective immediately . RN-C indicated she was not sure if the TMA's had been informed of the new policy yet, as she had just been notified of it herself.

During interview on 3/22/21, at 4:44 p.m. the director of nursing (DON) stated when she first started, there was a document in the scheduling book that identified the TMA's were able to provide wound care and dressing changes. When she started she stated no TMA's were doing wound cares and the TMA's and LPN's identified they were. RN-C does hands on when she brings them on and they actually took a wound class. The DON indicated they had changed it now, since survey started, and the TMA's were no longer able to provide wound care or dressing changes.

R10's admission Minimum Data Set (MDS) dated 12/17/20, identified R10 had no cognitive impairment and required extensive assistance for bed mobility, dressing, grooming, transfers and toileting. Further, R10 was at risk to develop pressure ulcers, however his skin was dry and intact with no pressure ulcers or skin concerns present. The MDS included diagnoses of cerebrovascular accident (blood flow to the brain is stopped and cells die) (CVA) and hemiplegia (paralysis on one side of the body).

R10's admission progress note dated 12/10/20, indicated R10 had some trace edema in his lower extremities and no significant skin issues were noted.

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R10's Physician Orders sheet indicated an order on 1/20/21 to apply ACE wrap to his right lower extremity from the toes to the knee. Apply the wrap in the morning and remove at bedtime.

On 3/17/21, at 7:24 a.m. NA-B was observed assisting R10 with his morning cares. NA-B obtained a roll of ACE wrap and proceeded to wrap R10's right foot and lower leg. NA-B started the wrap at the base of R10's toes on his right foot and proceeded to wrap his right foot and lower leg with the ACE wrap. NA-B stated the nurse notified the nursing assistants when a resident needed to have an ACE wrap applied.

During interview on 3/17/21 at 1:50 p.m. NA-B stated the nursing assistants applied R10's ACE wrap to his right leg until the nurses could get in to do his dressing. NA-B stated she had never received training to apply an ACE wrap.

During interview on 3/18/21, at 12:48 p.m. registered nurse (RN)-C stated the nursing assistants were not suppose to apply resident ACE wraps unless they had received training. RN-C identified application of an ACE wrap was a nurse's responsibility.

During interview on 3/18/21, at 1:09 p.m. the director of nursing (DON) stated she was aware the nursing assistants were applying resident ACE wraps. The DON identified she had inquired if the NA's were trained in the application of ACE wraps and was told that sometimes the NA's were trained. The DON stated she could not recall training any of the nursing assistants in the application of ACE wraps. If a nursing assistant was not trained in something they should know

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F 726	Continued From page 70 better and not do it. Documentation of wound care education/training and competencies provided to NA's/TMA's was requested but none received.	F 726		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		4/20/21

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F 880	Continued From page 71 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to	F 880	DIRECTED PLAN OF CARE: Equipment/Environment: 1. R253 and R10 are both discharged from facility.	

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F 880	Continued From page 72 affect all 48 residents residing in the facility. In addition, the facility failed to ensure a standing lift was disinfected prior to use for 1 of 1 residents (R10) after 1 of 1 residents (R253) was observed to utilize the standing lift while on quarantine precautions for COVID-19 Findings include: A line list for infection surveillance was requested from December 2020, through March 2021. A line list was provided from 12/1/20, through 3/22/21, listing resident name, room number, infection date, diagnosis, medication, provider, outcome and dated of infection signs and symptoms were resolved. The December 2020, list identified the facility had 11 urinary tract infections (UTI), 3 respiratory infections, and 6 skin infections. The analysis for December 2020, did not address the 11 UTI's, or the 6 skin infections for patterns or trends and did not identify any interventions implemented. The January 2021, list identified the facility had 4 UTI's, 1 respiratory infection, and 2 skin infections. The analysis for January 2021, did not address the 4 UTI's or 2 skin infections for patterns or trends and did not identify any interventions implemented. The February 2021, list identified the facility had 7 UTI's, 2 respiratory infections, one skin infection and 2 gastrointestinal (GI) infections. The analysis for February 2021, did not address the GI and skin infection; however the 7 UTI's, and the 2 respiratory infections were not analyzed for patterns or trends and did not identify any interventions implemented.	F 880	2. All residents who utilize mechanical lifts have the potential to be effected by this deficient practice. 3. On 4/9/2021, the facility□s Quality Assurance and Performance Improvement Committee met to conduct a root cause analysis to identify the problems that resulted in this deficiency and developed interventions or corrective action plan to prevent reoccurrence. 4. Training will be completed by DON or designee for all staff responsible for resident care equipment and environment on the facility policies/procedures for proper disinfection, including following manufacturer direction for use. Each staff member will demonstrate competency at the conclusion of training. 5. The DON or designee will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, and then 3x week for two weeks and, then once weekly. Auditing began on April 12th. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 6. Completion date for F880 is April 20,, 2021. TRACKING AND TRENDING INFECTION CONTROL PROGRAM	

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	245542	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

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F 880	Continued From page 73 The March 2021, ongoing list identified the facility had 7 current UTI's for the month. During a telephone interview on 3/22/21, at 3:36 p.m. registered nurse (RN)-A, the infection preventionist (IP), stated the infection surveillance was tracked through ABXtracker (a computer program to aide in monitoring infections and antibiotic usage). She would watch for trends or patterns and enter tracking/trending notes. RN-A stated at the end of each month she placed infections from the month on a map to look for trends. RN-A stated they had not noticed any recent trends with infections and stated the number of infections had not changed over the recent months. RN-A stated the infections should be analyzed more, as the numbers have not changed in a while as the pattern for UTI's went back to June 2020. During an interview on 3/22/21, at 4:28 p.m. the director of nursing (DON) stated she would get her information about infections from the IP and would expect to be told if any trends or concerns arose. The DON stated recently every time a resident went to the ER for anything they would come back with the diagnosis of a UTI and stated they had not followed up on the issue. The DON stated she did not remember if a pattern of UTI's had been brought up in Quality Assurance/Program Improvement (QAPI) meeting. The facility Infection Surveillance Policy dated 5/8/17, indicated the facility will conduct ongoing surveillance for infections and to identify both individual cases and trends in the transmission of infections, to permit interventions to try to stop or	F 880	1. All residents are affected by this practice. All infections will be tracked and trended per our facility policy on infection surveillance going forward by IPCO or designee. 2. All residents have the potential to be effected by this deficient practice. 3. On 4/9/2021, the facility□s Quality Assurance and Performance Improvement Committee met to conduct a root cause analysis to identify the problems that resulted in this deficiency and developed interventions or corrective action plan to prevent reoccurrence. 4. IPCO and DON reviewed and revised policies for infection surveillance as needed. We will continue to utilize infection control program of ABX tracker to monitor all of our residents and staff for communicable, respiratory infection, according to CDC guidelines. The lead/charge nurse for each shift will document all resident and employee infections on the facility□s shared infection log. Compliance and review of infection control log will be completed by the Infection Preventionist or DON daily. The data will be analyzed for possible trends/outbreaks. The IPCO or DON will investigate any potential outbreaks and follow up as appropriate. IPCO and DON will review infection prevention and tracking and trending. Any unexpected increased in infection will be reported to the Medical Director, and/or Public Health, and state survey agency in order to obtain guidance/assistance for infection control concerns. 5. IPCO, DON, RNs and Administration	

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F 880	Continued From page 74 slow the transmission of such infections. R253's 48 hour base line care plan dated 3/11/21, indicated R253 required an assist of two with a sit to stand lift to transfer. R253's care plan dated 3/11/21, indicated R253 was at risk of developing COVID-19 related to the community infection rate. The care plan listed interventions, which included directing staff to encourage frequent handwashing, redirect R253 to her room when wandering and set up a personal protective equipment (PPE) station. On 3/15/21, at 7:25 p.m. a PPE station was observed hanging on R253's room door and an unidentified staff member was observed to donn an isolation gown and gloves from the ppe station to enter the room. The unidentified staff member was wearing a face mask and goggles. On 3/16/21, at 1:47 p.m. nursing assistant (NA)-C stated R253 and her room mate were recent admissions and were under new admission quarantine precautions for COVID-19. On 3/17/21, at 8:00 a.m. NA-C was observed to obtain a stand lift from another resident's room, she obtained a disinfectant wipe from the vital signs cart and gave the lift a cursory wipe to the equipment. NA-C entered R253's room with the stand lift after disposing the wipe in the garbage. -At 8:15 a.m. NA-C was observed to exit R253's room with the stand lift and leave it in the hallway outside of R253's room. NA-C was not observed to obtain a disinfect wipe to disinfect the equipment and the stand lift. The PPE station and R253's room lacked disinfectant wipes. The stand lift was continuously observed from 8:15 a.m. to	F 880	will receive training on infection control practices, active surveillance, tracking and trending for a comprehensive infection program. The facility utilized Educare module Infection Prevention and Control: SNF. Documentation of completed training will be provided April 19th, 2021. 7. IPCO and DON will monitor logs and progress notes daily or more often if needed. . Any unexpected increased in infection will be reported to the Medical Director, and/or Public Health, and state survey agency in order to obtain guidance/assistance for infection control concerns. . The monitoring results will be to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 8. Completion date for F880 is April 20,, 2021.	

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F 880	Continued From page 75	F 880		

8:28 a.m. and remained in the hall outside of R253's doorway.
-At 8:28 a.m. an unidentified staff member took the stand lift into R10's room and assisted R10 to transfer from his wheelchair to the toilet using the undisinfected stand lift to assist with the transfer.

During interview on 3/17/21, at 8:37 a.m. NA-C stated she did not disinfect the stand lift after using it to assist to transfer R253 from her wheelchair to the toilet and back to her wheelchair. NA-C indicated staff were directed to disinfect the lifts with a disinfectant wipe before and after use. NA-C stated the wipes were located at the end of the hall in the vital signs cart and the staff had to go and obtain one each time it was needed.

During interview on 3/18/21, at 1:09 p.m. The director of nursing (DON) stated the nursing assistants were instructed to disinfect the equipment before and after resident use.

The facility's Coronavirus Prevention, Screening, and Identification policy revised 3/12/21, indicated all new residents would be quarantined to their room and monitored for symptoms of respiratory infection for 14 days. The policy directed staff to use full PPE, including face mask, eye protection, gown and gloves. However, the policy lacked direction for use and care of equipment used in quarantined rooms.

The facility's Cleaning/Disinfecting Resident Care Equipment reviewed 6/5/17, identified non-critical items that come in contact with intact skin include mechanical lifts and could be disinfected where they were used. Durable medical equipmentshould be cleaned and disinfected

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F 880	Continued From page 76 before reuse by another resident. The policy directed staff to disinfect mechanical lifts after each use. Staff were directed to disinfect all areas that would come into contact with the resident during use such as handles, arms, knee pads, and foot rests, using one wipe to clean and a second wipe to disinfect.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/17/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Littlefork Medical Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and NFPA 99 2012 and the 2012 edition of NFPA 99, Health Care Facilities Code. Littlefork Medical Center C & NC was constructed at 3 different times. The original building was built in1964 as a hospital and was type II (000). In 1978 a 1-story without a basement,Type III (200) construction was constructed to the east of the hospital. In 1992 1-story additions were constructed to the north and east wings and are Type III (200) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and separated from the old hospital building with a 2-hour fire barrier. The old hospital section does not have a fire sprinkler system. This part of the building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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K 000	Continued From page 1 MET.	K 000		