Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2024

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: January 25, 2024

Dear Administrator:

On February 9, 2024, we informed you that we may impose enforcement remedies.

On March 6, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 25, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 25, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 25, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $11,995, 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 25, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Little Falls Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 25, 2024. 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" and/or an "E"tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 July 25, 2024 (six months after the identification of noncompliance) 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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	INITIAL COMMENTS On 3/1/24, 3/4/24, through 3/6/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53991211C (MN00101163) with deficiences issued at F558 and F677, and H53991380C (MN00101172) with deficiences issued at F686 and F880. As a result of the investigation a deficiency was issued at F550. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		4/8/24

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

Electronically Signed | 03/29/2024

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

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F 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 550	F550- Resident Rights	

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F 550	Continued From page 2 review, the facility failed to ensure call lights were answered in a timely manner that promoted dignity for 2 of 3 residents (R8, R9) reviewed for call lights. Findings include: R8's admission Minimum Data Set (MDS) dated 1/29/24 identified moderately impaired cognition and no behaviors noted. R8 required substantial to maximal assistance with toileting hygiene, partial to moderate assistance with personal hygiene, and supervision or touch with all transfers. R8 used a manual wheelchair for transportation. R8 was always continent of bowel and bladder. R8's diagnoses included non-traumatic dysfunction, Alzheimer's, dementia, and anxiety. R8 was high risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R8 was toileted at 12:00 p.m. and 4:00 p.m. R8's transfers were to be completed with a non-mechanical lift with assistance of one staff. R8's toileting plan required staff to toilet R8 upon rising in the a.m., every three to four hours, at bedtime (HS) (11 a.m... to 12 p.m., 2:00 p.m. to 3:00 p.m., 5:00 p.m. to 6:00 p.m., and as needed (PRN) at night). R8's bowel and bladder risk assessment results dated 1/29/24, identified: R8's cognition was slightly impaired, required extensive assistance with transfers. R8 was frequently incontinent of bladder, had impaired mobility and dependent on staff for transfers. R8 was always continent of bowel. R8 was placed on a scheduled toileting program.	F 550	R8 and R9□s care plans will be reviewed and revised by Nurse Manager. R8 and R9□s toileting schedules will be reviewed and addressed in the care plan. All nursing staff have access to the resident□s care plan. Resident Rights were reviewed social services designee with both residents and the social services designee will meet with them on a weekly basis to ensure that they have not had an incontinent episode that made them feel undignified and that they are being assisted to the bathroom per schedule, and as needed. All residents have the potential to be affected by this deficient practice. All resident□s care plans will be reviewed and revised to ensure their toileting needs and schedules are appropriate and person-centered by Nursing Leadership Team The Resident Bill of Rights, Dignity, and Call light policies will be reviewed by the IDT. All staff will be re-educated on the Resident□s Bill of Rights, Dignity Policy, and the Call Light Policy, including all staff must be responsive to call lights, call lights are to be answered timely to help prevent resident from having an incontinent episode, call light is to not be turned off until resident needs have been met, if a resident's bathroom is being occupied to find an alternative bathroom to assist the resident with toileting, and if a lift is not available to check for an available lift in another area of the care center.	

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F 550	Continued From page 3 R8's call light activity report dated 3/4/24, from 11:54 p.m. through 12:56 p.m. identified: On 3/4/24, the call light was activated at 11:54 a.m. and was responded to 38 minutes 4 seconds after it was activated. On 3/4/24, the call light was activated at 12:39 a.m. and was responded to 16 minutes 39 seconds after it was activated. During an interview/observation on 3/4/24 at 12:15 p.m., R8 pushed herself to her room doorway in a wheelchair and stated she was looking for staff to take her to bathroom. R8 stated she placed her call light on and knew staff were always busy. R8 stated she waited over 20 minutes sometimes and had urine accidents when unable to get to bathroom on time. R8 indicated she could usually wait, but only because she had to and became uncomfortable which happened daily. R8 stated the staff were busy and arrived to help her when they could but sometimes it got to be over 30 minutes. R8 added she was told not to get up by herself, but with the long wait times, sometimes had gotten up but was afraid of falling. R8 stated sometimes it almost felt like they had forgotten about her. During an observation on 3/4/24 at 12:10 p.m., (16 minutes after call light was activated) activities assistant (AA) walked by R8's room and did not answer call light. During an observation on 3/4/24 at 12:32 p.m., (38 minutes after call light was activated) NA-E entered R8's room turned off light and asked what she needed. R8 stated needed to use bathroom. NA-E stated she would have to wait	F 550	DON and/or designee beginning on 3/20/24 will audit call light times to see if call light answered timely. If not, will follow-up to determine reason determine reason call light was on, if related to toileting were they toileted according to care plan/schedule. These audits will be completed 3x/week for 3 weeks, 3x/week for 2 weeks, and weekly for 3 weeks. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 550	Continued From page 4 because the lift she needed was being used by another resident. NA-E exited the room and stood in hallway visiting with another unknown staff. During an observation/interview on 3/4/24 at 12:39 p.m., R8 placed her call light on again and wheeled herself in wheelchair to the doorway of her room, looked around, then pushed her self-back into the room. At 12:41 p.m. activities assistant (AA) entered R8's room and said hello stayed in R8's room until 12:55 p.m. then exited the room. AA stated R8 had requested assistance to go to bathroom but she worked with activities and was unable to assist her. AA also stated staff had been so busy and were helping other residents. During an observation on 3/4/24 at 12:50 p.m., (56 minutes after initial call light was activated) NA-F walked down the hallway past R8's open door and looked at R8, then grabbed sit to stand machine located in the hallway. NA-F pushed stand machine past R8's room to the other end of the hallway. During an observation on 3/4/24 at 12:56 p.m. (1 hour and 2 minutes after this resident initially placed call light on to ask for assistance to bathroom) R8 had pushed herself up to the doorway of her room and NA-D walked up to resident and asked what she needed. R8 stated she need to go to the bathroom. NA-D stated the would be right back with the stand lift, turned off call light, and exited room. At 12:58 p.m. NA-D entered R8's room with stand machine and stated she would assist her to the bathroom. R8 stated "good, I had been waiting a long time." NA-D started to lower R8 onto toilet and R8 began voiding right away in midair. R8 stated, "I really	F 550		

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F 550	Continued From page 5 had to go and had to wait so long." During an interview on 3/4/24 1:00 p.m., NA-D stated R8's brief was soiled with urine, which was normal for her lately, usually urinated four to five times a day, had stress incontinence and placed her call light when she needed to go to the bathroom. R9 admission MDS dated 2/23/24, identified intact cognition and no behaviors noted. R9 had impairment on upper extremity one side and used a cane, walker, and wheelchair for mobility. R9 required partial to moderate assistance with toileting hygiene, personal hygiene, and all transfers. R9 was always continent of urine and had a colostomy (a surgical opening in abdomen, one of colon is diverted through the incision, where a pouch is attached for collecting feces) and a history of urinary tract infection. Diagnoses included hemiplegia (weakness on one side), anxiety, and depression. R9 was at risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R9 was assisted with toileting at 12:00 p.m. and 5:00 p.m. R9's transfers were to be completed with assistance of one staff. R9's toileting plan required staff to toilet her every three to four hours and required staff to ambulate R9 to and from bathroom. R9's bowel and bladder risk assessment dated 2/22/24 identified R9 required limited assistance for transfers due limited mobility and stroke, and always continent of bowel and bladder. R9's toilet program included routine scheduled toileting. During an observation/interview on 3/4/24 at 1:00	F 550		

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F 550	Continued From page 6 p.m., R9 wheeled herself to her room (shared bathroom with R8) and stated stated she needed to go to bathroom but the toilet was being used by her roommate (R8). R9 stated she had her call light on for up to 45 minutes at a time in the past and no one came to help her get to the toilet. R9 stated she needed assistance from staff to go to bathroom. R9 stated she had been incontinent of urine twice and it made her feel ashamed, belittled, and embarrassed.. At 1:20 p.m. R9 was assisted to bathroom by NA-D. During an interview on 3/4/24 at 1:45 p.m., NA-G stated R8 usually told us when she needed the bathroom and was continent of bladder. NA-G stated staff were expected to answer resident call lights within 15 minutes to meet their needs. During an interview on 3/4/24 at 2:00 p.m. NA-E stated staff were expected to answer call lights within 15 minutes to help prevent falls. R8 was unable to get up by herself. NA-E states went into R8's room between 12:30 p.m. and 12:45 p.m. and asked her was she needed, had call light on. NA-E stated R8 needed to go to the bathroom. NA-E stated she informed R8 both lifts were used and when one was available would take her to the toilet. NA-E stated she had taken another resident after that to the toilet and informed NA-D that R8 had to go to the bathroom, then went on break. NA-E stated R8 was forgetful and got confused at times but was able to hold a conversation and was interviewable. During an interview on 3/5/24 at 11:47 a.m. assistant director of nursing (ADON) stated expected staff to answer all lights within 15 minutes to address needs and assure safety. Staff should follow the toileting program for	F 550		

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F 550	Continued From page 7 prevention of skin breakdown, infection, and dignity. During an interview on 3/5/24 at 3:26 p.m. floor manager registered nurse (RN)-A stated call light response time was expected to be three to five minutes and 15 minutes at the most. RN-A stated would most definitely affect dignity when you needed to get to bathroom and can not get there. RN-A stated would not be acceptable when a resident had a urine accident in their pants due to inability to get to the bathroom. Facility policy titled Call Light dated 10/23/17, identified residents who turned on their call light would have them answered promptly and their requested needs met. When responding to call lights, employees shall be prompt, effective, and courteous. Employees should never make the resident feel they are too busy to give assistance. Staff who could not fully address the resident's need shall not turn off the call light and only qualified staff may turn it off once they began to address the resident's care needs. Facility policy titled Dignity dated 4/17/23, identified staff were expected to maintain and enhance resident's dignity and assisted in maintaining and enhancing his or her self-worth. Additionally staff will provide care that can help avoid things that could be demeaning to the residents such as compliance with resident's request for bathroom assistance and provide timely response to call lights to prevent adverse events such as accidents or incontinent episodes.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		4/8/24

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LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 558	Continued From page 8 §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 observations, interview, and record review, the facility failed to respond to call lights timely for 2 of 3 residents (R8, R9) reviewed for call light responses and accommodation of needs Findings include: R8's admission Minimum Data Set (MDS) dated 1/29/24 identified moderately impaired cognition and no behaviors noted. R8 required substantial to maximal assistance with toileting hygiene, partial to moderate assistance with personal hygiene, and supervision or touch with all transfers. R8 used a manual wheelchair for transportation. R8 was always continent of bowel and bladder. R8's diagnoses included non-traumatic dysfunction, Alzheimer's, dementia, and anxiety. R8 was high risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R8 was toileted at 12:00 p.m. and 4:00 p.m. R8's transfers were to be completed with a non-mechanical lift with assistance of one staff. R8's toileting plan required staff to toilet R8 upon rising in the a.m., every three to four hours, at bedtime (HS) (11 a.m... to 12 p.m., 2:00 p.m. to 3:00 p.m., 5:00 p.m. to 6:00 p.m., and as needed (PRN) at night). R8's bowel and bladder risk assessment results	F 558	F558- Reasonable Accommodations Needs Nurse Manager will review R8 and R9 toileting schedule and update care plan, as needed. Nursing staff have access to the resident□s care plan. All residents who are on a toileting plan schedule have the potential to be affected by this deficient practice. All resident□s care plans will be reviewed and revised to ensure their toileting needs and schedules are appropriate and person-centered by Nursing Leadership Team. The Urinary Incontinence Program Policy and Call light policy will be reviewed by the IDT. All nursing staff will be re-educated on the Urinary Incontinence Program and the Call Light Policy, including all staff must be responsive to call lights, call lights are to be answered timely to help prevent resident from having an incontinent episode, call light is to not be turned off until resident needs have been met, if a resident's bathroom is being occupied to find an alternative bathroom to assist the resident with toileting, and if a lift is not available to check for an available lift in another area of the care center.	

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F 558	Continued From page 9 dated 1/29/24, identified: R8's cognition was slightly impaired, required extensive assistance with transfers. R8 was frequently incontinent of bladder, had impaired mobility and dependent on staff for transfers. R8 was always continent of bowel. R8 was placed on a scheduled toileting program. R8's call light activity report dated 2/29/24, through 3/6/24 identified: On 2/29/24, the call light was activated at 6:28 p.m. and was responded to 22 minutes 50 seconds after it was activated. On 3/2/24, the call light was activated at 6:23 p.m. and was responded to 20 minutes 22 seconds after it was activated. On 3/3/24, the call light was activated at 8:04 am. and was responded to 17 minutes 55 seconds after it was activated. On 3/3/24, the call light was activated at 6:19 p.m. and was responded to 30 minutes 16 seconds after it was activated. On 3/4/24, the call light was activated at 10:54 a.m. and was responded to 20 minutes 28 seconds after it was activated. On 3/4/24, the call light was activated at 11:54 a.m. and was responded to 38 minutes 4 seconds after it was activated. On 3/4/24, the call light was activated at 12:39 a.m. and was responded to 16 minutes 39 seconds after it was activated.	F 558	DON and/or designee beginning on 3/20/24 will audit call light times to see if call light answered timely. If not, will follow-up to determine the reason call light was on, if related to toileting were they toileted according to care plan/schedule. These audits will be completed 3x/week for 3 weeks, 3x/week for 2 weeks, and weekly for 3 weeks. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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On 3/6/24, the call light was activated at 6:26 a.m. and was responded to 23 minutes 33 seconds after it was activated.

During an interview/observation on 3/4/24 at 12:15 p.m., R8 pushed herself to her room doorway in a wheelchair and stated she was looking for staff to take her to bathroom. R8 stated she placed her call light on and knew staff were always busy. R8 stated she waited over 20 minutes sometimes and had urine accidents when unable to get to bathroom on time. R8 indicated she could usually wait, but only because she had to and became uncomfortable which happened daily. R8 stated the staff were busy and arrived to help her when they could but sometimes it got to be over 30 minutes. R8 added she was told not to get up by herself, but with the long wait times, sometimes had gotten up but was afraid of falling. R8 stated sometimes it almost felt like they had forgotten about her.

During an observation on 3/4/24 at 12:10 p.m., (16 minutes after call light was activated) activities assistant (AA) walked by R8's room and did not answer call light.

During an observation on 3/4/24 at 12:32 p.m., (38 minutes after call light was activated) NA-E entered R8's room turned off light and asked what she needed. R8 stated needed to use bathroom. NA-E stated she would have to wait because the lift she needed was being used by another resident. NA-E exited the room and stood in hallway visiting with another unknown staff.

During an observation/interview on 3/4/24 at 12:39 p.m., R8 placed her call light on again and wheeled herself in wheelchair to the doorway of

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her room, looked around, then pushed her self-back into the room. At 12:41 p.m. activities assistant (AA) entered R8's room and said hello stayed in R8's room until 12:55 p.m. then exited the room. AA stated R8 had requested assistance to go to bathroom but she worked with activities and was unable to assist her. AA also stated staff had been so busy and were helping other residents.

During an observation on 3/4/24 at 12:50 p.m., (56 minutes after initial call light was activated) NA-F walked down the hallway past R8's open door and looked at R8, then grabbed sit to stand machine located in the hallway. NA-F pushed stand machine past R8's room to the other end of the hallway.

During an observation on 3/4/24 at 12:56 p.m. (1 hour and 2 minutes after this resident initially placed call light on to ask for assistance to bathroom) R8 had pushed herself up to the doorway of her room and NA-D walked up to resident and asked what she needed. R8 stated she need to go to the bathroom. NA-D stated the would be right back with the stand lift, turned off call light, and exited room. At 12:58 p.m. NA-D entered R8's room with stand machine and stated she would assist her to the bathroom. R8 stated "good, I had been waiting a long time." NA-D started to lower R8 onto toilet and R8 began voiding right away in midair. R8 stated, "I really had to go and had to wait so long."

During an interview on 3/4/24 1:00 p.m., NA-D stated R8's brief was soiled with urine, which was normal for her lately, usually urinated four to five times a day, had stress incontinence and placed her call light when she needed to go to the

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F 558	Continued From page 12 bathroom. R9 admission MDS dated 2/23/24, identified intact cognition and no behaviors noted. R9 had impairment on upper extremity one side and used a cane, walker, and wheelchair for mobility. R9 required partial to moderate assistance with toileting hygiene, personal hygiene, and all transfers. R9 was always continent of urine and had a colostomy (a surgical opening in abdomen, one of colon is diverted through the incision, where a pouch is attached for collecting feces) and a history of urinary tract infection. Diagnoses included hemiplegia (weakness on one side), anxiety, and depression. R9 was at risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R9 was assisted with toileting at 12:00 p.m. and 5:00 p.m. R9's transfers were to be completed with assistance of one staff. R9's toileting plan required staff to toilet her every three to four hours and required staff to ambulate R9 to and from bathroom. R9's bowel and bladder risk assessment dated 2/22/24 identified R9 required limited assistance for transfers due limited mobility and stroke, and always continent of bowel and bladder. R9's toilet program included routine scheduled toileting. R9's call light activity report dated 2/28/24, through 3/6/24 identified: On 2/28/24, the call light was activated at 5:01 a.m.. and was responded to 27 minutes 29 seconds after it was activated. On 2/29/24, the call light was activated at 5:29	F 558		

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a.m. and was responded to 25 minutes 28 seconds after it was activated.

On 2/29/24, the call light was activated at 6:09 p.m. and was responded to 37 minutes 35 seconds after it was activated.

On 3/1/24, the call light was activated at 2:04 p.m. and was responded to 23 minutes 29 seconds after it was activated.

On 3/2/24, the call light was activated at 7:41 a.m. and responded to 24 minutes after it was activated.

On 3/2/24, the call light was activated at 6:50 p.m. and responded to 33 minutes 23 seconds after it was activated.

On 3/3/24, the call light was activated at 5:06 a.m. and responded to 24 minutes and 58 seconds after it was activated.

On 3/3/24, the call light was activated at 10:30 p.m. and responded to 25 minutes 45 seconds after it was activated.

On 3/4/24, the call light was activated at 6:52 a.m. and responded to 34 minutes 39 seconds after it was activated.

On 3/4/24, the call light was activated at 9:09 a.m. and responded to 25 minutes 59 seconds after it was activated.

On 3/5/24, the call light was activated at 6:52 a.m. and responded to 24 minutes 56 seconds after it was activated.

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F 558	Continued From page 14 On 3/6/24, the call light was activated at 5:27 a.m. and responded to 23 minutes 30 seconds after it was activated. During an observation/interview on 3/4/24 at 1:00 p.m., R9 wheeled herself to her room (shared bathroom with R8) and stated needed to go to bathroom but the toilet was being used by her roommate (R8). R9 stated she had her call light on for up to 45 minutes at a time in the past and no one came to help her get to the toilet. R9 stated she needed assistance from staff to go to bathroom. R9 stated she had been incontinent of urine twice and it made her feel ashamed, belittled, and embarrassed.. At 1:20 p.m. R9 was assisted to bathroom by NA-D. During an interview on 3/4/24 at 1:05 p.m., NA-D stated staff were expected to answer call light within in 7 to 15 minutes. NA-D stated it was not acceptable for a resident to have call light on to use the bathroom for one hour. NA-D indicated there was not enough staff to answer all the lights in a timely manner and was important to meet the resident's needs as soon as possible. During an interview on 3/4/24 at 1:45 p.m., NA-G stated R8 usually told us when she needed to use the bathroom and was continent of bladder. NA-G stated staff were expected to answer resident call lights within 15 minutes to meet their needs. During an interview on 3/4/24 at 2:00 p.m., NA-E stated staff were expected to answer call lights within 15 minutes to help prevent falls. R8 was unable to get up by herself. NA-E states R8's had call light on, entered her room between 12:30 p.m. and 12:45 p.m. and asked her what she needed. NA-E stated R8 needed to go to the	F 558		

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bathroom. NA-E stated she informed R8 both lifts were being used and when one was available they would take her to the toilet. NA-E stated she had taken another resident after that to the toilet, she informed NA-D that R8 had to go to the bathroom, then went on break. NA-E stated R8 was forgetful and got confused at times but was able to hold a conversation and was interviewable.

During an interview on 3/5/24 at 11:47 a.m., assistant director of nursing (ADON) stated expected staff to answer all lights within 15 minutes to address needs and assure safety. Staff should follow the toileting program for prevention of skin breakdown, infection, and dignity.

During an interview on 3/5/24 at 3:26 p.m. floor manager registered nurse (RN)-A stated call light response time was expected to be three to five minutes and 15 minutes at the most. RN-A stated would not be acceptable when a resident had a urine accident in their pants due to inability to get to the bathroom.

Facility policy titled Call Light dated 10/23/17, identified residents who turned on their call light would have them answered promptly and their requested needs met. Staff were expected to assure the residents' quality of life through the care center's effectiveness in answering call lights. The alerted call lights were visually displayed on the consoles and marquees on every unit and all care center personnel must be responsive to call lights at all times. When responding to call lights, employees shall be prompt, effective, and courteous. Employees should never make the resident feel they are too

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F 558	Continued From page 16 busy to give assistance. Staff who could not fully address the resident's need shall not turn off the call light and only qualified staff may turn it off once they began to address the resident's care needs.	F 558		
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 timely incontinence care for 1 of 3 residents (R3) who was dependent on staff to provide assistance with a check and change program for incontinence. Findings include: R3's quarterly Minimum Data Set (MDS) dated 1/9/24, identified moderately impaired cognition, disorganized thinking, and no behaviors. R3 was independent with activities of daily living (ADLs), ambulation with a walker, and all transfers. R3 was continent of bowel and bladder. R3's care area assessment (CAA) dated 3/5/24, identified R3 had a recent left hip fracture resulted from a fall. R3 diagnoses included dementia, muscle weakness, abnormalities of gait and mobility, bilateral hearing loss, benign prostatic hyperplasia (BPH) (enlarged prostate causes blockage of urine, frequent urination, and/or incontinence) with lower urinary tract systems and urinary urgency. Since R3 fractured	F 677	F677- ADL Care Provided for Dependent Residents R2 and R3 toileting schedule with be reviewed and assessed by the Nurse Manager and care plan will be updated, as needed. All residents who need assistance with toileting have the potential to be affected by this deficient practice. All residents who need assistance with toileting will have their toileting schedules reviewed to ensure appropriate and care plan will be updated, as needed, by the Nurse Manager. The Urinary Incontinence Program Policy and Person-Centered Care Planning Policy were reviewed by the Nursing Leadership Team. The DON and/or designee will educate all nursing staff on the Urinary Incontinence Program Policy and Person-Centered Care Planning Policy, including toileting residents per their plan of care. The facility is going to implement a toileting	4/8/24

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F 677	Continued From page 17 hip he has required assistance with dressing, toileting, hygiene, and bed mobility. R3 was incontinent of bowel 0 to 1 times a day and bladder 1 to 2 times a day. R3 wore a pull up and required assistance to transfer to the toilet with a Hoyer lift. R3's toileting plan included every two to three hours during his healing from the hip fracture to help prevent falls. Urinal at bedside has helped to decrease incontinence. Nursing assistance (NA) care sheet undated identified staff were to toilet and reposition R3 every two to three hours and urinal at bedside at night. R3's care plan dated 2/28/24, identified R3 had a deficit in bladder incontinence urgency related to BPH and was at risk for bowel decline in bowel incontinence related to cognitive deficit. Staff were directed to offer toilet every two to three hours and as needed (PRN) with Hoyer lift, assist of two and urinal placed at bedside at night. R3's bowel and bladder risk assessment dated 2/29/24, identified frequently incontinent of bowel and bladder. Inability to toilet self-due to physical limitations and required routine scheduled toileting. During an observation on 3/1/24 at 1:59 p.m., nursing assistant (NA)-A and NA-C entered R3's room and pushed the mechanical lift. R3 sat in wheelchair with foot protectors and gripper socks on feet fully dressed. NA-A and NA-C hooked up the sling loops to mechanical lift and lifted R3 off wheel chair and lowered him onto the bed. R3 laid flat on his back. NA-C asked R3 if he needed to be changed and he said no do not think so. NA-C pulled down his pants and lifted the front of	F 677	guide that will help identify when the resident was last toileted. Nurse Manager will review these forms for compliance of toileting schedules and follow-up as needed. The DON and/or designee will complete a toileting audit to ensure that the resident is receiving assistance or reminders to the bathroom per the resident□s toileting schedule. The audit will be completed 3x/week for 3 weeks, 3x/week for 2 weeks, and weekly for 3 weeks. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 677	Continued From page 18 his brief up and stated, "oh yes you do you are very wet", pulled the sides of the brief loose, and lowered the front of the brief down. R3 had a large amount of stool in the front perineal (peri) area, between his legs and brief saturated with urine. NA-A assisted R3 to his left side while NA-C used 10 peri wipes and cleaned off stool from R3's lower back, buttocks, and rectal area with gloves on. R3's stool was pasty and stuck onto his lower back. NA-A removed soiled gloves and placed a clean brief under R3. NA-A applied a clean pair of gloves and assisted R3 onto his back. NA-A cleaned stool from the font peri area and up along the sides of the groin with visible stool on peri wipes. R3 was turned onto his right side and NA-A cleaned stool from right backside and between R3's legs. An additional 10 peri wipes were saturated with large amounts of stool. The brief was removed and another clean one placed underneath R3. NA-A and NA-C removed soiled gloves, sanitized hands and attached the sides of the brief, covered R3 up with a blanket, and placed call light. During an interview on 3/1/24 at 2:36 p.m., NA-C stated R2 had worked the entire day shift and R2 had been checked and changed last at 7:30 a.m. when gotten up for the day, and should have been every two to three hours. NA-C stated we were short staffed and it had been way too long, almost seven hours, so he should have been changed hours ago. NA-C stated R2's stool was stuck onto his lower back and hard to remove. NA-C also stated R2 recently had hip surgery, was independent prior to that, and now required so much more assistance with everything. During an interview on 3/5/24 at 11:05 a.m., NA-A stated had worked the entire day shift along with	F 677		

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F 677	Continued From page 19 two other NA's. NA-A stated one of the NA's was removed from floor and sent to the other side of the building. NA-A stated it was hard when they were left with only two NA's, 11 residents required assistance of two staff. NA-A verified R2 had not been changed since 7:30 a.m. and should have been checked and changed around 10:30 a.m. and again at 1:30 p.m. NA-A confirmed they got behind. During an interview on 3/5/24 at 4:03 p.m., registered nurse (RN)-B stated R2 recently had hip surgery and was no longer independent. RN-B stated staff would be expected to offer toilet and/or check or change R2 every two to three hours to protect skin and off load pressure from sitting/lying. Requested ADL policy and was not received.	F 677		
F 686 SS=D	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. 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:	F 686		4/8/24

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F 686	Continued From page 20 Based on observation, interview and document review, the facility failed to follow physician orders and provide appropriate wound care to promote healing and prevent potential worsening of a moisture-associated skin damage (MASD) for 1 of 1 resident (R2) with current MASD. Findings include: R2's annual Minimum Data Set dated 1/12/22, identified intact cognition with verbal behavioral symptoms such as screaming, threatening that significantly interfered with resident cares and disrupted care and living environment 1 to 3 times out of 7 days a week. R2 refused cares 1 to 3 days out of 7. R2 had impairment upper and lower body extremities on both sides and required substantial to maximal assistance with eating, toileting, upper and lower body dressing, roll right and left, chair/bed transfers, and does not walk. R2 was dependent on staff for oral hygiene, showers/bathes, personal hygiene, sit to lying, lying to sitting, sit to stand, and toilet transfers. R2 was frequently incontinent of bladder and always incontinent of bowel. R2 had a current MASD and placed on a turning and repositioning schedule. R2's (CAA) dated 3/4/24, identified diagnoses peripheral vascular disease (PVD) (narrowed arteries reduce blood flow to the arms or legs), cerebral vascular accident (CVA) (Stroke) with right hemiparesis (weakness on one side of the body), emphysema/chronic obstructive pulmonary disease (COPD), dorsopathy (group of diseases of the musculoskeletal system and connective tissue associated with degenerative diseases of the spine). R2 had several risk factors for impaired skin integrity. R2 currently has MASD on his lower right buttock and on a scheduled turn	F 686	F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer R2's wound orders have been verified by Nurse Manager and the correct wound supplies are at the facility and stored in the resident's room. RN A & B Were educated on 3/25/2024 by outside wound care provider how to perform R2's wound care, including following R2 treatment order, how to cleanse the wound, and how to pack the wound. R2's Skin Care Plan and schedule will be reviewed Nurse Manager and will be up to date in the care plan. Progress checks for R2's coccyx wound have been scheduled daily for the resident in the EHR wound section. R2 continues to be followed by in-house wound nurse weekly and rounding outside provider wound nurse once a month and the NP. All residents with MASD wounds have the potential to be affected by this deficient practice. New Skin Condition Policy, Implementation of Medication Prescriptions and Treatment and Therapy Orders, and House Standing Orders were reviewed by Nursing Leadership Team. The nurse managers will review all current residents with MASD that they have the necessary wound supplies per treatment orders. Nursing will review wound orders and wound supplies weekly and re-order as needed. DON or designee will educate all licensed nursing staff on the New Skin Condition Policy, Implementation of Medication Prescriptions and Treatment and Therapy	

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F 686	Continued From page 21 and repositioning schedule. R2 refused cares at times and displayed some cognitive deficits. R2 was incontinent of bowel and bladder. R2's Braden assessment score (a tool to assess pressure ulcer risk) dated 1/9/24, was 11 and indicated high risk for skin breakdown. R2's physician order dated 1/10/24, cleanse buttocks with wound daily and apply Med-honey (a brand name honey, Leptospermum, based gel with antibacterial and bacterial resistant properties to help prevent infections, support the removal of necrotic tissue, and encourage the body's natural wound healing process) with adhesive foam dressing and change daily and as needed (PRN). R2's progress notes dated 2/13/24, identified wound is not healing, not blanchable (skin returned back to natural color) area of wound continues to deteriorate. R2 continued to refuse to lay on side and to reposition from side to side. Area frequently had BM (bowel movement) on it and bandage had been changed several times a day. Planned on talking to nurse practitioner (NP) regarding this wound. R2's NP visit dated 2/16/24, identified seen today as requested by R2 and facility administrator for ongoing coccyx wound. Nursing reported recently Medi-honey treatment had been started two to three days ago. Wound margins appeared to be improving per registered nurse today. R2's left buttock just above rectum showed a fifty-cent piece sized macerated area. Same size noted last NP visit on 1/10/24, approximately 3 centimeters (cm) diameter. Appeared to be pressure induced ulcer with less surrounding skin	F 686	Orders, and House Standing Orders regarding, not using peri-wipes on the wound for wound care, following standing house orders and/or resident's treatment orders from the provider, and utilizing a cotton-tipped applicator to pack tunneling in wounds versus a gloved finger. Education to licensed nurses will include when obtaining a new wound treatment order, nurses will notify the provider if they do not have the supplies in stock at the facility.t. Staff will order the new supplies at the time they receive the order and ask the Provider for clarification on the wound treatment order, specifically, what they should do to treat the wound until the wound supplies have been delivered. Wound Supply Auditing will be completed to monitor that the correct wound supplies are in stock and being utilized according to resident treatment order. Wound auditing will also be conducted to ensure staff are properly treating wounds. Audits will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for 3 weeks beginning on 4/1/24 by the DON or designee. . Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 686	Continued From page 22 maceration. R2 had chronic moisture associated dermatitis to buttocks which has improved today. Slough remained on wound bed however improvement noted with Medi-honey treatment. R2's order summary report dated 2/29/24, left buttock MASD length 2.75 cm x width 3.5 cm x depth 3.0 cm x 3.0 cm tunneling (a track that occurs from the edge to deep within the subcutaneous tissue and occurs only in one direction) located at the 4 o'clock 3.0 cm, no undermining (dead space in the wound a shelf or lip under edges of wound). Moderate serosanguinous (appears thin, watery, cloudy, and yellow to tan in color and first sign the body is fighting an infection) exudate (wound drainage). Tissue type/color: red 10%, pink/red: healthy granulation (new connective tissue and microscopic blood vessels that form on the surface of a wound during healing process): yellow 90%, adherent fibrinous slough (a by-product of the inflammatory phase of wound healing and can contribute to delayed wound healing, increased risk for infection, and prevent an accurate wound assessment), and loosely adherent clumpy slough. Treatment intervention: Cleanse wound per facility protocol. Lightly pack Sorbact (a hydrophobic microbe binding wound dressing to manage exudate and donates moisture and hydrates the wound bed) 3 inches (in) x 3 in gauze into tunneling area and then up to skin level. Cover with bordered adhesive foam dressing silicone 3 in x 3 in dressing (a high-performance foam adhesive dressing highly absorbent, breathable wound dressing which prevents wound exudate strike-through and acts as a barrier to outside contamination that enhances a moist wound environment which has been shown to enhance wound healing). Change	F 686		

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F 686	Continued From page 23 daily. During an observation and interview on 3/1/24 at 2:45 p.m., nursing assistant (NA)-C and licensed practical nurse (LPN)-B entered R2's room, transferred R2 with a mechanical lift from wheelchair to bed, and completed check and change. NA-C pulled down front of brief saturated with urine and cleansed front area with a peri wipe. NA-C and LPN-B turned R2 over onto his side left side and wound dressing located on the right inner buttocks had come loose. LPN-B removed saturated dressing with gloves on and a very strong foul odor was noted. LPN-B removed gloves, sanitized hands and exited room. At 2:50 p.m. LPN-B re-entered room, applied gloves, and sprayed wound cleaner (Sea Cleans) into a kerlix super sponge, dabbed the wound located on the right inner buttock gently, and surrounding skin. LPN-B grabbed a roll of kerlix dressing and cut off a small piece of it, applied normal saline, and attempted to pack the frayed edged piece of Kerlix into the tunneling of the wound with her gloved finger. LPN-B cut another small piece from the roll of Kerlix and placed it on tope of the packing. LPN-B then applied Allevyn Gentle Boarder dressing on top. LPN-B stated measurements were completed by staff nurse daily. LPN-B identified assessment of the wound during dressing change and stated wound had recently gotten worse this past week. R2's had a good amount of slough on top, moderate amount of serosanguinous drainage on the dressing. LPN-B stated R2's tunneling was about three o'clock and was packed with my finger. LPN-B stated a new order was written for a special type of gauze, had been ordered unsure of where from, not here yet, and not sure when it was to be delivered. LPN-B stated R2's surrounding skin	F 686		

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F 686	Continued From page 24 was red but blanchable. LPN-B verified no other skin problems were noted on R2 today. LPN-B and NA-C transferred R2 back into wheelchair via mechanical lift. LPN-B and NA-C both grabbed the back of his pants, placed their arms through R2's and lifted him up into the chair. During an observation on 3/4/24 at 4:07 p.m., nursing assistant (NA)-B entered R2's room with gown, gloves, and mask on. NA-B removed a wedge from underneath R2's right side of his back, pulled sides of brief down. NA-B wiped R2's front peri area with a peri wipe (Tena Proskin Classic Wipes Freshly scented used on the delicate perineal area. Gentle cleansing formula contains aloe, vitamin E and chamomile pre-moistened for convenient use. No rinsing required). NA-B turned R2 onto his right side, wipe a very small amount of stool and stated the dressing on his buttock wound was 90% saturated with drainage, brief was dry underneath him. NA-B radioed nurse R2's dressing needed to be changed. At 4:16 p.m. licensed practical nurse (LPN)-A entered R2's room with gloves on, removed the saturated dressing from R2's coccyx area. A very strong odor was noted once the dressing was removed, and LPN-A wiped off R2's wound with the same type of peri wipe NA-B had just used to clean his front peri area (Tena Proskin Classic Wipes). LPN-A confirmed R2 did not have packing in the wound. LPN-A packed the wound on left buttock with hydrophobic microbe binding dressing with hydrogel with her gloved finger. LPN-A covered the wound with Allevyn classic adhesive 7.5 cm x 7.5 cm 3 in x 3 in, removed gloves and sanitized hands. LPN-A exited R2's room. At 4:25 p.m. NA-B covered up R2 and removed gown, gloves, mask,	F 686		

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F 686	Continued From page 25 and exited room. NA-B stated to surveyor not sure that peri wipe should have been used on the wound but it looks worse than one week ago. NA-B showed surveyor package of peri wipes used on R2 and ingredients listed were: Water/Eau, glycerin, Phenoxyethanol Sodium Benzoate, Sodium Cocoyl, Apple amino acids, Potassium Sorbate, Fragrance, aloe Barbadensis leaf Extract (house plant), chamomilla recutitia (Matricaria/plant) Flower extract, citric acid, tocopherol acetate. Alcohol free. During an interview on 3/5/24 at 4:03 p.m., RN-B stated RN-A and physicians monitored R2's wound on his buttocks. RN-B stated was the first time in two weeks she had seen R2's wound on his buttock and looked worse due to tunneling, covered in slough, and appeared open more. RN-B stated she was aware R2 refused to offload and most likely affected the healing process of his wound. RN-B stated current orders indicated wound cleaner to be used which would have been more effective than normal saline and then pack with blue packing. RN-B stated unaware of where to find a copy of the facility protocols. RN-B stated "a big heck no with using a peri wipe to cleanse [R2's] wound, that was not ok". RN-B stated the peri wipes were not designed to be used on or inside wounds and R2's wound needed to be cleaned out, it was in the butt area with poop in it, wound cleaner should have been used. RN-B stated R2 had not refused dressing changes to his wound located on his buttock that she was aware of. During an interview on 3/6/24 at 8:15 a.m., case manager registered nurse (RN)-A stated facility protocol wound cleaning would have been most likely in the standing orders. RN-A stated the	F 686		

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F 686	Continued From page 26 wound wash used at this facility was located in a spray bottle. RN-A verified a peri wipe was not appropriate to cleanse a wound on R2's buttocks. RN-A stated a peri wipe would have most likely spread the germs around instead of cleaning it. RN-A stated a new order was written on 2/29/24, and the supplies were not received until Monday 3/4/24. RN-A stated staff were expected to continue the previous wound treatment orders until they received the proper supplies. RN-A indicated R2's wound should have been packed with a small cotton swab and not with a finger. RN-A stated the physician orders were not followed and staff were expected to verify them if unsure or unable to locate supplies. RN-A stated staff were expected to follow the physician orders, would have promoted healing and help prevent infection. During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated staff would be expected to verify physician order and follow them. ADON verified R2's right buttock wound had tunneling and had not three weeks ago. ADON indicated R2 was being followed by a wound nurse once a month and the NP. ADON stated when staff received the new order on 2/29/24, and supplies were not available they would be expected to reach out to triage and provided an update supplies were not available in house, ask for clarification on how they should have proceeded to prevent worsening of the wound and potential infection. ADON verified R2's wound order change had occurred through a third party and the wound dressings /supplies would have been delivered by mail. ADON also stated depending how deep R2's tunneling was a small cotton swab would have most likely been the best way to pack it.	F 686		

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F 686	Continued From page 27 Facility House Standing Orders dated 5/18/23, identified cleanse all wounds with wound cleaner. Wound nurse will be notified to conduct a root cause analysis (RCA) to determine wound type and emend dressings. Facility policy titled Implementation of Medication Prescriptions and Treatment and Therapy Orders dated 12/7/22, identified prescriptions for medications and orders for treatments must be implemented as quickly as possible and as prescribed by a qualified person. The DON was responsible to assure the prescriptions and orders have been implemented appropriately through client monitoring, supervision of staff, and review of client records. Additionally the DON or designee was to assure that staff was trained on the tasks required by the new order or prescription and staff been determined competent to follow the written instructions for the client.	F 686		
F 880 SS=D	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:	F 880		4/8/24

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F 880	Continued From page 28 §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; (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	F 880		

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F 880	Continued From page 29 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 observation, interview and document review, the facility failed to implement recommended influenza A infection control procedures for the use of personal protective equipment (PPE), for masks, during direct cares with residents to prevent the spread of infection for 2 of 3 residents (R2, R7) observed. This deficient practice had the potential to affect all residents currently residing in the facility. Findings include: R2's influenza nasopharynx/nasal test results dated 3/1/24 at 5:54 p.m. revealed positive for influenza A. During an observation on 3/4/24 at 10:56 a.m., R2 laid in bed with curtain pulled to room. Sign posted before room entrance revealed "STOP! Contact precautions, Gloves, Gown, Equipment, Transport" (nothing on sign about a mask). Registered nurse (RN)-C entered R2's room with a mask, isolation gown, gloves on and pushed a vitals machine. At 11:00 a.m. RN-C exited R7's room, wiped off vitals machine and cuff, removed gloves, mask, isolation gown, and sanitized	F 880	F880- Infection Control R2 and R7 were started on droplet precautions as soon as it was identified the residents had the wrong precautions initiated. This change was made on 3/5/24. All residents who are on isolation precautions have the potential to be affected by this deficient practice. The Transmission Based Precautions policy and Strict Isolation Precautions was reviewed by Nursing Leadership Team with no changes. All residents who are on isolation precautions will be reviewed to ensure appropriate signage is displayed based on the reason they are on isolation. DON and/or designee will educate all staff on the Transmission Based Precautions policy and Strict Isolation Precautions policy, including appropriate PPE, and infection prevention and control. A guide indicating specific infections and the appropriate precautions to put in place has been created and will be stored with PPE supplies upon the need. This will	

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F 880	Continued From page 30 hands. R2 was heard coughing frequently, with his couch sound loose and wet. During an observation on 3/4/24 at 3:25 p.m. and 4:30 p.m,. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can located outside R2's room. During an observation on 3/4/24 at 4:16 p.m., licensed practical nurse (LPN)-A entered R2's room with only gloves on, and no mask or gown. LPN-A removed R2's dressing from the coccyx saturated at least 90% with wound drainage, cleaned the skin, radioed RN-C and requested more supplies. R2 talked to staff continuously and had a frequent loose cough during observation. R2 was unable to physically cover his mouth. RN-C dropped off supplies at door and LPN-A applied dressing, visited with R2 then removed gloves, sanitized hands, and exited the room. During an observation on 3/5/24 at 11:54 p.m. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can on floor located outside room. R7's influenza nasopharynx/nasal test results dated 3/2/24 at 2:14 p.m., revealed positive for influenza A. During an observation on 3/4/24 at 3:35 p.m., R7 resident sat in recliner with door open with an occasional loose cough. Contact precaution sign was posted on outside of door (no mention of	F 880	ensure that the facility is utilizing the correct precautions and that precautions can be implemented promptly and appropriately. All nursing staff will be educated on this facility process change by the DON and/or designee. Educare was assigned to all staff for Infection Prevention and Control. Audits will be completed on all residents who are on isolation to ensure correct precautions are implemented 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for 3 weeks beginning on 4/1/24 by the DON or designee. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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	245399	A. BUILDING _____ B. WING _____	C 03/06/2024

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F 880	Continued From page 31 mask on it). An additional sign posted outside R7's room indicated "KEEP DOOR CLOSED". The isolation storage container outside the door had masks and one disposable gown in it and a garbage can located on floor. During an observation on 3/5/24 at 11:55 a.m., R7 sat in recliner with door open with a frequent loose cough. There was a contact precaution sign reminder outside his door (no mention of mask on it). Masks were located on top of isolation cart along with gowns in bottom drawer. Three sizes of gloves in boxes hung out side of door. During an interview on 3/5/24 at 11:05 a.m., nursing assistant (NA)-A stated R2 tested positive for influenza A on Friday 3/1/24, and should have been placed on droplet precautions right away. NA-A stated the sign posted outside of R2's room was for contact precautions only. NA-A stated the sign was unclear, asked case manager (RN)-A, and clarification had not been provided yet. NA-A stated influenza A was spread through the air, staff should have been required to wear a mask to avoid breathing in the flu bug and would have helped prevent the spread of influenza A. NA-A indicated the other two residents tested positive for influenza A should had droplet precaution signs posted on their door. NA-A stated was unaware if any other residents had contracted Influenza A other than those three. During an interview on 3/5/24 at 3:26 p.m., RN-A stated once the resident was confirmed to have influenza A and droplet precaution signs should have been immediately placed outside the resident's door by the floor nurse. RN-A stated a mask would be required to be worn in the room to help prevent the spread of the infection.	F 880		

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F 880	Continued From page 32 During an interview on 3/5/24 at 4:03 p.m., RN-B verified three residents on the 100 wing tested positive for influenza A. RN-B stated those three residents should have been placed on Influenza A precautions with a droplet sign posted outside their door. RN-B stated staff were required to wear a mask prior to entering each room to help prevent the spread of infection to themselves and others. During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated the infection control nurse was currently on vacation. ADON stated once the resident was confirmed positive for influenza A, staff would be expected to immediately place the droplet precaution sign outside the resident's door and resident on droplet precautions to help prevent the spread of infection. Facility policy titled Standard Precautions dated 5/8/17, identified standard precautions are used to prevent spread of infections. A mask, eye protection or face shield maybe worn to protect mucus membranes of the eyes, nose, and mouth at any time during procedures and patient care activities that are likely to generate splashes, or sprays of blood, body fluids, sections, or excretions. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than five microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. Influenza A would be considered an exampled of an infection that required droplet precautions. In addition to standard precautions a mask must be	F 880		

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F 880	Continued From page 33 worn when working within three feet of resident. Use color coded signs and/or other measures to alert staff of the implementation of isolation or droplet precautions, while protecting the privacy of the resident. Yellow was the color code for droplet precautions.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2024

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: D91Z11

Dear Administrator:

The above facility was surveyed on March 1, 2024 through March 6, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/124, and 3/4/24, through 3/6/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53991211C (MN00101163) with licensing order issued at 920, and H53991380C (MN00101172) with licensing orders issued at 0900 and 1358. As a result of the investigation a licensing order was issued at 1805. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		4/8/24

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2 900	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders and provide appropriate wound care to promote healing and prevent potential worsening of a moisture-associated skin damage (MASD) for 1 of 1 resident (R2) with current MASD. Findings include: R2's annual Minimum Data Set dated 1/12/22, identified intact cognition with verbal behavioral symptoms such as screaming, threatening that significantly interfered with resident cares and disrupted care and living environment 1 to 3 times out of 7 days a week. R2 refused cares 1 to 3 days out of 7. R2 had impairment upper and lower body extremities on both sides and required substantial to maximal assistance with eating, toileting, upper and lower body dressing, roll right and left, chair/bed transfers, and does not walk. R2 was dependent on staff for oral hygiene, showers/bathes, personal hygiene, sit to lying, lying to sitting, sit to stand, and toilet transfers. R2 was frequently incontinent of bladder and always incontinent of bowel. R2 had a current MASD and placed on a turning and repositioning schedule. R2's (CAA) dated 3/4/24, identified diagnoses peripheral vascular disease (PVD) (narrowed arteries reduce blood flow to the arms or legs), cerebral vascular accident (CVA) (Stroke) with right hemiparesis (weakness on one side of the body), emphysema/chronic obstructive pulmonary disease (COPD), dorsopathy (group of diseases of the musculoskeletal system and connective tissue associated with degenerative diseases of the spine). R2 had several risk factors for	2 900	Corrected	

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2 900	Continued From page 4 impaired skin integrity. R2 currently has MASD on his lower right buttock and on a scheduled turn and repositioning schedule. R2 refused cares at times and displayed some cognitive deficits. R2 was incontinent of bowel and bladder. R2's Braden assessment score (a tool to assess pressure ulcer risk) dated 1/9/24, was 11 and indicated high risk for skin breakdown. R2's physician order dated 1/10/24, cleanse buttocks with wound daily and apply Med-honey (a brand name honey, Leptospermum, based gel with antibacterial and bacterial resistant properties to help prevent infections, support the removal of necrotic tissue, and encourage the body's natural wound healing process) with adhesive foam dressing and change daily and as needed (PRN). R2's progress notes dated 2/13/24, identified wound is not healing, not blanchable (skin returned back to natural color) area of wound continues to deteriorate. R2 continued to refuse to lay on side and to reposition from side to side. Area frequently had BM (bowel movement) on it and bandage had been changed several times a day. Planned on talking to nurse practitioner (NP) regarding this wound. R2's NP visit dated 2/16/24, identified seen today as requested by R2 and facility administrator for ongoing coccyx wound. Nursing reported recently Medi-honey treatment had been started two to three days ago. Wound margins appeared to be improving per registered nurse today. R2's left buttock just above rectum showed a fifty-cent piece sized macerated area. Same size noted last NP visit on 1/10/24, approximately 3 centimeters (cm) diameter. Appeared to be	2 900		

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2 900	Continued From page 5 pressure induced ulcer with less surrounding skin maceration. R2 had chronic moisture associated dermatitis to buttocks which has improved today. Slough remained on wound bed however improvement noted with Medi-honey treatment. R2's order summary report dated 2/29/24, left buttock MASD length 2.75 cm x width 3.5 cm x depth 3.0 cm x 3.0 cm tunneling (a track that occurs from the edge to deep within the subcutaneous tissue and occurs only in one direction) located at the 4 o'clock 3.0 cm, no undermining (dead space in the wound a shelf or lip under edges of wound). Moderate serosanguinous (appears thin, watery, cloudy, and yellow to tan in color and first sign the body is fighting an infection) exudate (wound drainage). Tissue type/color: red 10%, pink/red: healthy granulation (new connective tissue and microscopic blood vessels that form on the surface of a wound during healing process): yellow 90%, adherent fibrinous slough (a by-product of the inflammatory phase of wound healing and can contribute to delayed wound healing, increased risk for infection, and prevent an accurate wound assessment), and loosely adherent clumpy slough. Treatment intervention: Cleanse wound per facility protocol. Lightly pack Sorbact (a hydrophobic microbe binding wound dressing to manage exudate and donates moisture and hydrates the wound bed) 3 inches (in) x 3 in gauze into tunneling area and then up to skin level. Cover with bordered adhesive foam dressing silicone 3 in x 3 in dressing (a high-performance foam adhesive dressing highly absorbent, breathable wound dressing which prevents wound exudate strike-through and acts as a barrier to outside contamination that enhances a moist wound environment which has been shown to enhance wound healing). Change	2 900		

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2 900	Continued From page 6 daily. During an observation and interview on 3/1/24 at 2:45 p.m., nursing assistant (NA)-C and licensed practical nurse (LPN)-B entered R2's room, transferred R2 with a mechanical lift from wheelchair to bed, and completed check and change. NA-C pulled down front of brief saturated with urine and cleansed front area with a peri wipe. NA-C and LPN-B turned R2 over onto his side left side and wound dressing located on the right inner buttocks had come loose. LPN-B removed saturated dressing with gloves on and a very strong foul odor was noted. LPN-B removed gloves, sanitized hands and exited room. At 2:50 p.m. LPN-B re-entered room, applied gloves, and sprayed wound cleaner (Sea Cleans) into a kerlix super sponge, dabbed the wound located on the right inner buttock gently, and surrounding skin. LPN-B grabbed a roll of kerlix dressing and cut off a small piece of it, applied normal saline, and attempted to pack the frayed edged piece of Kerlix into the tunneling of the wound with her gloved finger. LPN-B cut another small piece from the roll of Kerlix and placed it on tope of the packing. LPN-B then applied Allevyn Gentle Boarder dressing on top. LPN-B stated measurements were completed by staff nurse daily. LPN-B identified assessment of the wound during dressing change and stated wound had recently gotten worse this past week. R2's had a good amount of slough on top, moderate amount of serosanguinous drainage on the dressing. LPN-B stated R2's tunneling was about three o'clock and was packed with my finger. LPN-B stated a new order was written for a special type of gauze, had been ordered unsure of where from, not here yet, and not sure when it was to be delivered. LPN-B stated R2's surrounding skin was red but blanchable. LPN-B verified no other	2 900		

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2 900	Continued From page 7 skin problems were noted on R2 today. LPN-B and NA-C transferred R2 back into wheelchair via mechanical lift. LPN-B and NA-C both grabbed the back of his pants, placed their arms through R2's and lifted him up into the chair. During an observation on 3/4/24 at 4:07 p.m., nursing assistant (NA)-B entered R2's room with gown, gloves, and mask on. NA-B removed a wedge from underneath R2's right side of his back, pulled sides of brief down. NA-B wiped R2's front peri area with a peri wipe (Tena Proskin Classic Wipes Freshly scented used on the delicate perineal area. Gentle cleansing formula contains aloe, vitamin E and chamomile pre-moistened for convenient use. No rinsing required). NA-B turned R2 onto his right side, wipe a very small amount of stool and stated the dressing on his buttock wound was 90% saturated with drainage, brief was dry underneath him. NA-B radioed nurse R2's dressing needed to be changed. At 4:16 p.m. licensed practical nurse (LPN)-A entered R2's room with gloves on, removed the saturated dressing from R2's coccyx area. A very strong odor was noted once the dressing was removed, and LPN-A wiped off R2's wound with the same type of peri wipe NA-B had just used to clean his front peri area (Tena Proskin Classic Wipes). LPN-A confirmed R2 did not have packing in the wound. LPN-A packed the wound on left buttock with hydrophobic microbe binding dressing with hydrogel with her gloved finger. LPN-A covered the wound with Allevyn classic adhesive 7.5 cm x 7.5 cm 3 in x 3 in, removed gloves and sanitized hands. LPN-A exited R2's room. At 4:25 p.m. NA-B covered up R2 and removed gown, gloves, mask, and exited room. NA-B stated to surveyor not sure that peri wipe should have been used on the	2 900		

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2 900	Continued From page 8 wound but it looks worse than one week ago. NA-B showed surveyor package of peri wipes used on R2 and ingredients listed were: Water/Eau, glycerin, Phenoxyethanol Sodium Benzoate, Sodium Cocoyl, Apple amino acids, Potassium Sorbate, Fragrance, aloe Barbadensis leaf Extract (house plant), chamomilla recutitia (Matricaria/plant) Flower extract, citric acid, tocopherol acetate. Alcohol free. During an interview on 3/5/24 at 4:03 p.m., RN-B stated RN-A and physicians monitored R2's wound on his buttocks. RN-B stated was the first time in two weeks she had seen R2's wound on his buttock and looked worse due to tunneling, covered in slough, and appeared open more. RN-B stated she was aware R2 refused to offload and most likely affected the healing process of his wound. RN-B stated current orders indicated wound cleaner to be used which would have been more effective than normal saline and then pack with blue packing. RN-B stated unaware of where to find a copy of the facility protocols. RN-B stated "a big heck no with using a peri wipe to cleanse [R2's] wound, that was not ok". RN-B stated the peri wipes were not designed to be used on or inside wounds and R2's wound needed to be cleaned out, it was in the butt area with poop in it, wound cleaner should have been used. RN-B stated R2 had not refused dressing changes to his wound located on his buttock that she was aware of. During an interview on 3/6/24 at 8:15 a.m., case manager registered nurse (RN)-A stated facility protocol wound cleaning would have been most likely in the standing orders. RN-A stated the wound wash used at this facility was located in a spray bottle. RN-A verified a peri wipe was not appropriate to cleanse a wound on R2's buttocks.	2 900		

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2 900	Continued From page 9 RN-A stated a peri wipe would have most likely spread the germs around instead of cleaning it. RN-A stated a new order was written on 2/29/24, and the supplies were not received until Monday 3/4/24. RN-A stated staff were expected to continue the previous wound treatment orders until they received the proper supplies. RN-A indicated R2's wound should have been packed with a small cotton swab and not with a finger. RN-A stated the physician orders were not followed and staff were expected to verify them if unsure or unable to locate supplies. RN-A stated staff were expected to follow the physician orders, would have promoted healing and help prevent infection. During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated staff would be expected to verify physician order and follow them. ADON verified R2's right buttock wound had tunneling and had not three weeks ago. ADON indicated R2 was being followed by a wound nurse once a month and the NP. ADON stated when staff received the new order on 2/29/24, and supplies were not available they would be expected to reach out to triage and provided an update supplies were not available in house, ask for clarification on how they should have proceeded to prevent worsening of the wound and potential infection. ADON verified R2's wound order change had occurred through a third party and the wound dressings /supplies would have been delivered by mail. ADON also stated depending how deep R2's tunneling was a small cotton swab would have most likely been the best way to pack it. Facility House Standing Orders dated 5/18/23, identified cleanse all wounds with wound cleaner. Wound nurse will be notified to conduct a root	2 900		

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2 900	Continued From page 10 cause analysis (RCA) to determine wound type and emend dressings. Facility policy titled Implementation of Medication Prescriptions and Treatment and Therapy Orders dated 12/7/22, identified prescriptions for medications and orders for treatments must be implemented as quickly as possible and as prescribed by a qualified person. The DON was responsible to assure the prescriptions and orders have been implemented appropriately through client monitoring, supervision of staff, and review of client records. Additionally the DON or designee was to assure that staff was trained on the tasks required by the new order or prescription and staff been determined competent to follow the written instructions for the client. SUGGESTED METHOD OF CORRECTION: The DON or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 920	Continued From page 11	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care for 1 of 3 residents (R3) who was dependent on staff to provide assistance with a check and change program for incontinence. Findings include: R3's quarterly Minimum Data Set (MDS) dated 1/9/24, identified moderately impaired cognition, disorganized thinking, and no behaviors. R3 was independent with activities of daily living (ADLs), ambulation with a walker, and all transfers. R3 was continent of bowel and bladder. R3's care area assessment (CAA) dated 3/5/24, identified R3 had a recent left hip fracture resulted from a fall. R3 diagnoses included dementia, muscle weakness, abnormalities of gait and mobility, bilateral hearing loss, benign prostatic hyperplasia (BPH) (enlarged prostate causes blockage of urine, frequent urination, and/or incontinence) with lower urinary tract systems and urinary urgency. Since R3 fractured hip he has required assistance with dressing, toileting, hygiene, and bed mobility. R3 was	2 920	Corrected	4/8/24

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2 920	Continued From page 12 incontinent of bowel 0 to 1 times a day and bladder 1 to 2 times a day. R3 wore a pull up and required assistance to transfer to the toilet with a Hoyer lift. R3's toileting plan included every two to three hours during his healing from the hip fracture to help prevent falls. Urinal at bedside has helped to decrease incontinence. Nursing assistance (NA) care sheet undated identified staff were to toilet and reposition R3 every two to three hours and urinal at bedside at night. R3's care plan dated 2/28/24, identified R3 had a deficit in bladder incontinence urgency related to BPH and was at risk for bowel decline in bowel incontinence related to cognitive deficit. Staff were directed to offer toilet every two to three hours and as needed (PRN) with Hoyer lift, assist of two and urinal placed at bedside at night. R3's bowel and bladder risk assessment dated 2/29/24, identified frequently incontinent of bowel and bladder. Inability to toilet self-due to physical limitations and required routine scheduled toileting. During an observation on 3/1/24 at 1:59 p.m., nursing assistant (NA)-A and NA-C entered R3's room and pushed the mechanical lift. R3 sat in wheelchair with foot protectors and gripper socks on feet fully dressed. NA-A and NA-C hooked up the sling loops to mechanical lift and lifted R3 off wheel chair and lowered him onto the bed. R3 laid flat on his back. NA-C asked R3 if he needed to be changed and he said no do not think so. NA-C pulled down his pants and lifted the front of his brief up and stated, "oh yes you do you are very wet", pulled the sides of the brief loose, and lowered the front of the brief down. R3 had a	2 920		

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2 920	Continued From page 13 large amount of stool in the front perineal (peri) area, between his legs and brief saturated with urine. NA-A assisted R3 to his left side while NA-C used 10 peri wipes and cleaned off stool from R3's lower back, buttocks, and rectal area with gloves on. R3's stool was pasty and stuck onto his lower back. NA-A removed soiled gloves and placed a clean brief under R3. NA-A applied a clean pair of gloves and assisted R3 onto his back. NA-A cleaned stool from the font peri area and up along the sides of the groin with visible stool on peri wipes. R3 was turned onto his right side and NA-A cleaned stool from right backside and between R3's legs. An additional 10 peri wipes were saturated with large amounts of stool. The brief was removed and another clean one placed underneath R3. NA-A and NA-C removed soiled gloves, sanitized hands and attached the sides of the brief, covered R3 up with a blanket, and placed call light. During an interview on 3/1/24 at 2:36 p.m., NA-C stated R2 had worked the entire day shift and R2 had been checked and changed last at 7:30 a.m. when gotten up for the day, and should have been every two to three hours. NA-C stated we were short staffed and it had been way too long, almost seven hours, so he should have been changed hours ago. NA-C stated R2's stool was stuck onto his lower back and hard to remove. NA-C also stated R2 recently had hip surgery, was independent prior to that, and now required so much more assistance with everything. During an interview on 3/5/24 at 11:05 a.m., NA-A stated had worked the entire day shift along with two other NA's. NA-A stated one of the NA's was removed from floor and sent to the other side of the building. NA-A stated it was hard when they were left with only two NA's, 11 residents required	2 920		

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2 920	Continued From page 14 assistance of two staff. NA-A verified R2 had not been changed since 7:30 a.m. and should have been checked and changed around 10:30 a.m. and again at 1:30 p.m. NA-A confirmed they got behind. During an interview on 3/5/24 at 4:03 p.m., registered nurse (RN)-B stated R2 recently had hip surgery and was no longer independent. RN-B stated staff would be expected to offer toilet and/or check or change R2 every two to three hours to protect skin and off load pressure from sitting/lying. Requested ADL policy and was not received. SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with activities of daily living. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor and auidt to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		4/8/24

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21385	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement recommended influenza A infection control procedures for the use of personal protective equipment (PPE), for masks, during direct cares with residents to prevent the spread of infection for 2 of 3 residents (R2, R7) observed. This deficient practice had the potential to affect all residents currently residing in the facility. Findings include: R2's influenza nasopharynx/nasal test results dated 3/1/24 at 5:54 p.m. revealed positive for influenza A. During an observation on 3/4/24 at 10:56 a.m., R2 laid in bed with curtain pulled to room. Sign posted before room entrance revealed "STOP! Contact precautions, Gloves, Gown, Equipment, Transport" (nothing on sign about a mask). Registered nurse (RN)-C entered R2's room with a mask, isolation gown, gloves on and pushed a vitals machine. At 11:00 a.m. RN-C exited R7's room, wiped off vitals machine and cuff, removed gloves, mask, isolation gown, and sanitized hands. R2 was heard coughing frequently, with his couch sound loose and wet. During an observation on 3/4/24 at 3:25 p.m. and 4:30 p.m,. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can located outside R2's room.	21385	Corrected	

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21385	Continued From page 16 During an observation on 3/4/24 at 4:16 p.m., licensed practical nurse (LPN)-A entered R2's room with only gloves on, and no mask or gown. LPN-A removed R2's dressing from the coccyx saturated at least 90% with wound drainage, cleaned the skin, radioed RN-C and requested more supplies. R2 talked to staff continuously and had a frequent loose cough during observation. R2 was unable to physically cover his mouth. RN-C dropped off supplies at door and LPN-A applied dressing, visited with R2 then removed gloves, sanitized hands, and exited the room. During an observation on 3/5/24 at 11:54 p.m. R2 laid in bed with occasional loose cough with door open and contact precautions sign posted (no mention of mask on it) with an isolation storage cart with gowns, masks and gloves, and garbage can on floor located outside room. R7's influenza nasopharynx/nasal test results dated 3/2/24 at 2:14 p.m., revealed positive for influenza A. During an observation on 3/4/24 at 3:35 p.m., R7 resident sat in recliner with door open with an occasional loose cough. Contact precaution sign was posted on outside of door (no mention of mask on it). An additional sign posted outside R7's room indicated "KEEP DOOR CLOSED". The isolation storage container outside the door had masks and one disposable gown in it and a garbage can located on floor. During an observation on 3/5/24 at 11:55 a.m., R7 sat in recliner with door open with a frequent loose cough. There was a contact precaution sign reminder outside his door (no mention of mask on it). Masks were located on top of isolation cart along with gowns in bottom drawer. Three sizes	21385		

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21385	Continued From page 17 of gloves in boxes hung out side of door. During an interview on 3/5/24 at 11:05 a.m., nursing assistant (NA)-A stated R2 tested positive for influenza A on Friday 3/1/24, and should have been placed on droplet precautions right away. NA-A stated the sign posted outside of R2's room was for contact precautions only. NA-A stated the sign was unclear, asked case manager (RN)-A, and clarification had not been provided yet. NA-A stated influenza A was spread through the air, staff should have been required to wear a mask to avoid breathing in the flu bug and would have helped prevent the spread of influenza A. NA-A indicated the other two residents tested positive for influenza A should had droplet precaution signs posted on their door. NA-A stated was unaware if any other residents had contracted Influenza A other than those three. During an interview on 3/5/24 at 3:26 p.m., RN-A stated once the resident was confirmed to have influenza A and droplet precaution signs should have been immediately placed outside the resident's door by the floor nurse. RN-A stated a mask would be required to be worn in the room to help prevent the spread of the infection. During an interview on 3/5/24 at 4:03 p.m., RN-B verified three residents on the 100 wing tested positive for influenza A. RN-B stated those three residents should have been placed on Influenza A precautions with a droplet sign posted outside their door. RN-B stated staff were required to wear a mask prior to entering each room to help prevent the spread of infection to themselves and others. During an interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated the	21385		

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21385	Continued From page 18 infection control nurse was currently on vacation. ADON stated once the resident was confirmed positive for influenza A, staff would be expected to immediately place the droplet precaution sign outside the resident's door and resident on droplet precautions to help prevent the spread of infection. Facility policy titled Standard Precautions dated 5/8/17, identified standard precautions are used to prevent spread of infections. A mask, eye protection or face shield maybe worn to protect mucus membranes of the eyes, nose, and mouth at any time during procedures and patient care activities that are likely to generate splashes, or sprays of blood, body fluids, sections, or excretions. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than five microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. Influenza A would be considered an exampled of an infection that required droplet precautions. In addition to standard precautions a mask must be worn when working within three feet of resident. Use color coded signs and/or other measures to alert staff of the implementation of isolation or droplet precautions, while protecting the privacy of the resident. Yellow was the color code for droplet precautions. Suggested Method of Correction: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to assure the type of precautions and appropriate PPE to be used is identified and proper signage placed outside the	21385		

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21385	Continued From page 19 resident's room identifying the correct CDC category of transmission based precautions (e.g. contact, droplet, or airborne). The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21385		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner that promoted dignity for 2 of 3 residents (R8, R9) reviewed for call lights. Findings include: R8's admission Minimum Data Set (MDS) dated 1/29/24 identified moderately impaired cognition and no behaviors noted. R8 required substantial to maximal assistance with toileting hygiene, partial to moderate assistance with personal hygiene, and supervision or touch with all transfers. R8 used a manual wheelchair for transportation. R8 was always continent of bowel and bladder. R8's diagnoses included non-traumatic dysfunction, Alzheimer's,	21805	Corrected	4/8/24

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	00382	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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) COMPLETE DATE
21805	Continued From page 20 dementia, and anxiety. R8 was high risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R8 was toileted at 12:00 p.m. and 4:00 p.m. R8's transfers were to be completed with a non-mechanical lift with assistance of one staff. R8's toileting plan required staff to toilet R8 upon rising in the a.m., every three to four hours, at bedtime (HS) (11 a.m... to 12 p.m., 2:00 p.m. to 3:00 p.m., 5:00 p.m. to 6:00 p.m., and as needed (PRN) at night). R8's bowel and bladder risk assessment results dated 1/29/24, identified: R8's cognition was slightly impaired, required extensive assistance with transfers. R8 was frequently incontinent of bladder, had impaired mobility and dependent on staff for transfers. R8 was always continent of bowel. R8 was placed on a scheduled toileting program. R8's call light activity report dated 3/4/24, from 11:54 p.m. through 12:56 p.m. identified: On 3/4/24, the call light was activated at 11:54 a.m. and was responded to 38 minutes 4 seconds after it was activated. On 3/4/24, the call light was activated at 12:39 a.m. and was responded to 16 minutes 39 seconds after it was activated. During an interview/observation on 3/4/24 at 12:15 p.m., R8 pushed herself to her room doorway in a wheelchair and stated she was looking for staff to take her to bathroom. R8 stated she placed her call light on and knew staff were always busy. R8 stated she waited over 20 minutes sometimes and had urine accidents	21805		

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21805	Continued From page 21 when unable to get to bathroom on time. R8 indicated she could usually wait, but only because she had to and became uncomfortable which happened daily. R8 stated the staff were busy and arrived to help her when they could but sometimes it got to be over 30 minutes. R8 added she was told not to get up by herself, but with the long wait times, sometimes had gotten up but was afraid of falling. R8 stated sometimes it almost felt like they had forgotten about her. During an observation on 3/4/24 at 12:10 p.m., (16 minutes after call light was activated) activities assistant (AA) walked by R8's room and did not answer call light. During an observation on 3/4/24 at 12:32 p.m., (38 minutes after call light was activated) NA-E entered R8's room turned off light and asked what she needed. R8 stated needed to use bathroom. NA-E stated she would have to wait because the lift she needed was being used by another resident. NA-E exited the room and stood in hallway visiting with another unknown staff. During an observation/interview on 3/4/24 at 12:39 p.m., R8 placed her call light on again and wheeled herself in wheelchair to the doorway of her room, looked around, then pushed her self-back into the room. At 12:41 p.m. activities assistant (AA) entered R8's room and said hello stayed in R8's room until 12:55 p.m. then exited the room. AA stated R8 had requested assistance to go to bathroom but she worked with activities and was unable to assist her. AA also stated staff had been so busy and were helping other residents. During an observation on 3/4/24 at 12:50 p.m., (56 minutes after initial call light was activated)	21805		

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21805	Continued From page 22 NA-F walked down the hallway past R8's open door and looked at R8, then grabbed sit to stand machine located in the hallway. NA-F pushed stand machine past R8's room to the other end of the hallway. During an observation on 3/4/24 at 12:56 p.m. (1 hour and 2 minutes after this resident initially placed call light on to ask for assistance to bathroom) R8 had pushed herself up to the doorway of her room and NA-D walked up to resident and asked what she needed. R8 stated she need to go to the bathroom. NA-D stated the would be right back with the stand lift, turned off call light, and exited room. At 12:58 p.m. NA-D entered R8's room with stand machine and stated she would assist her to the bathroom. R8 stated "good, I had been waiting a long time." NA-D started to lower R8 onto toilet and R8 began voiding right away in midair. R8 stated, "I really had to go and had to wait so long." During an interview on 3/4/24 1:00 p.m., NA-D stated R8's brief was soiled with urine, which was normal for her lately, usually urinated four to five times a day, had stress incontinence and placed her call light when she needed to go to the bathroom. R9 admission MDS dated 2/23/24, identified intact cognition and no behaviors noted. R9 had impairment on upper extremity one side and used a cane, walker, and wheelchair for mobility. R9 required partial to moderate assistance with toileting hygiene, personal hygiene, and all transfers. R9 was always continent of urine and had a colostomy (a surgical opening in abdomen, one of colon is diverted through the incision, where a pouch is attached for collecting feces) and a history of urinary tract infection. Diagnoses	21805		

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21805	Continued From page 23 included hemiplegia (weakness on one side), anxiety, and depression. R9 was at risk for pressure ulcers. Nursing assistant (NA) care sheet dated 3/4/24, identified R9 was assisted with toileting at 12:00 p.m. and 5:00 p.m. R9's transfers were to be completed with assistance of one staff. R9's toileting plan required staff to toilet her every three to four hours and required staff to ambulate R9 to and from bathroom. R9's bowel and bladder risk assessment dated 2/22/24 identified R9 required limited assistance for transfers due limited mobility and stroke, and always continent of bowel and bladder. R9's toilet program included routine scheduled toileting. During an observation/interview on 3/4/24 at 1:00 p.m., R9 wheeled herself to her room (shared bathroom with R8) and stated stated she needed to go to bathroom but the toilet was being used by her roommate (R8). R9 stated she had her call light on for up to 45 minutes at a time in the past and no one came to help her get to the toilet. R9 stated she needed assistance from staff to go to bathroom. R9 stated she had been incontinent of urine twice and it made her feel ashamed, belittled, and embarrassed.. At 1:20 p.m. R9 was assisted to bathroom by NA-D. During an interview on 3/4/24 at 1:45 p.m., NA-G stated R8 usually told us when she needed the bathroom and was continent of bladder. NA-G stated staff were expected to answer resident call lights within 15 minutes to meet their needs. During an interview on 3/4/24 at 2:00 p.m. NA-E stated staff were expected to answer call lights within 15 minutes to help prevent falls. R8 was	21805		

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21805	Continued From page 24 unable to get up by herself. NA-E states went into R8's room between 12:30 p.m. and 12:45 p.m. and asked her was she needed, had call light on. NA-E stated R8 needed to go to the bathroom. NA-E stated she informed R8 both lifts were used and when one was available would take her to the toilet. NA-E stated she had taken another resident after that to the toilet and informed NA-D that R8 had to go to the bathroom, then went on break. NA-E stated R8 was forgetful and got confused at times but was able to hold a conversation and was interviewable. During an interview on 3/5/24 at 11:47 a.m. assistant director of nursing (ADON) stated expected staff to answer all lights within 15 minutes to address needs and assure safety. Staff should follow the toileting program for prevention of skin breakdown, infection, and dignity. During an interview on 3/5/24 at 3:26 p.m. floor manager registered nurse (RN)-A stated call light response time was expected to be three to five minutes and 15 minutes at the most. RN-A stated would most definitely affect dignity when you needed to get to bathroom and can not get there. RN-A stated would not be acceptable when a resident had a urine accident in their pants due to inability to get to the bathroom. Facility policy titled Call Light dated 10/23/17, identified residents who turned on their call light would have them answered promptly and their requested needs met. When responding to call lights, employees shall be prompt, effective, and courteous. Employees should never make the resident feel they are too busy to give assistance. Staff who could not fully address the resident's need shall not turn off the call light and only	21805		

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21805	Continued From page 25 qualified staff may turn it off once they began to address the resident's care needs. Facility policy titled Dignity dated 4/17/23, identified staff were expected to maintain and enhance resident's dignity and assisted in maintaining and enhancing his or her self-worth. Additionally staff will provide care that can help avoid things that could be demeaning to the residents such as compliance with resident's request for bathroom assistance and provide timely response to call lights to prevent adverse events such as accidents or incontinent episodes. SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for assuring dignified care. The facility could provide ongoing education and training and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		