DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: March 10, 2022

Dear Administrator:

On May 6, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 11, 2022, the Minnesota Department of Health, completed a revisit and on June 16, 2022 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 11, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 21, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 15, 2022.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: 0LJH12

Dear Administrator:

On May 11, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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DEPARTMENT OF HEALTH

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June 22, 2022

CMS Certification Number (CCN): 245227

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Dear Administrator:

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

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

Effective May 11, 2022 the above facility is certified for:

139 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 139 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: March 10, 2022

Dear Administrator:

On May 6, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 11, 2022, the Minnesota Department of Health, completed a revisit and on June 16, 2022 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 11, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 21, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 15, 2022.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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DEPARTMENT OF HEALTH

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June 22, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: 0LJH12

Dear Administrator:

On May 11, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 11, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 8, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 21, 2022, we informed you that we may impose enforcement remedies.

On March 25, 2022, the Minnesota Departments of Health and Public Safety 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

- 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 June 10, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 10, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 10, 2022.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $11,292, 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 June 10, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bayshore Residence & Rehab Ctr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 10, 2022. 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 10, 2022 (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:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/21/22, through 3/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		5/10/22

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

Electronically Signed | 04/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA	E 041	A generator test was performed on 3/31/2022 A load bank will be scheduled with CAT for 4/26/2022. Monthly, the generator test will be completed per policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 3 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 3/24/22, at 9:45 a.m., it was revealed by a review of available documentation of the emergency generator maintenance and testing that monthly generator tests were not performed from 10/21 through 12/21. On 3/24/22, at 9:45 a.m., it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual load bank test was not performed in the last 12 months. On 3/24/22, at 9:45 a.m., the maintenance director (MD) was interviewed. The MD stated monthly generator tests had not been performed from 10/21 through 12/21. The MD also stated an annual load bank test had not been done in the last 12 months. On 3/24/22, at 9:45 a.m., the executive director (ED) was interviewed. The ED stated the monthly generator tests had not been performed from 10/21 through 12/21. The ED also stated an annual load bank test had not been done in the last 12 months.	E 041	and an annual load test will be performed yearly per facility policy. There were no ill effects experienced from this deficient practice. The Maintenance Director will be in-serviced on the NFPA 110 Generator TELS Masters procedure for performing and recording monthly generator testing. A load bank test will be performed in May of each year and results of this test will be placed in the TELS electronic facility work order platform. The Maintenance Director and/or designee is responsible for compliance. Audits on monthly generator testing will begin monthly x 3 months to ensure compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	
F 000	INITIAL COMMENTS On 3/21/22, through 3/25/22, a standard recertification survey was conducted at your	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 4 facility. A complaint investigation was also conducted. Your facility was found to be (IN or NOT in) compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5227167C (MN72617) H5227168C (MN80880) 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 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	F 550		5/10/22

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F 550	Continued From page 5 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 interview and document review the facility failed to ensure staff were not using personal cell phones in patient care areas during cares for 3 of 5 residents (R14, R49, R21, R25) reviewed. Findings include: R14	F 550	R 14, R 49, R 21 and R 25 met with the Social Services director and reviewed the facility plan of correction for this deficiency. Their response will be recorded in a grievance form and placed in the grievance binder. All current and future residents will be educated that employee cell phone usage will not occur in the resident room at the next resident	

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F 550	Continued From page 6 R14's significant change Minimum Data Set (MDS) dated 12/14/21, indicated R14 was cognitively intact. R14's diagnoses included schizophrenia, anxiety, epilepsy and diabetes mellitus. R14's MDS indicated R14 required assistance with activities of daily living (ADL's) including transfers, toileting, locomotion, dressing and personal hygiene. R49's significant change MDS dated 2/1/22, indicated R49 was cognitively intact. R49's diagnoses included cerebral palsy, quadriplegia, muscle spasms and diabetes mellitus. The assessment identified R49 required extensive assist of two staff with ADL's including transfers, toileting, dressing and personal hygiene. During interview on 3/23/22, at 9:40 a.m. R49 stated on the evening of 3/22/22, he was sitting in the dining room along with R14 and two staff members. R49 heard R14 call out for assistance and observed the two staff looking at their cell phones and not helping R14. R14 called out for assistance four times and the two nurses continued to look at their phones. R49 stated he yelled out to the staff, they looked up from their phones and finally helped R14. R49 stated the staff did not move until after he asked someone to help R14. The staff were looking at their phones and not paying attention to the residents in the dining room. During interview on 3/23/22, at 11:40 a.m. R14 stated there had been times when staff were getting her ready for bed, their cell phones rang, they stopped helping her and they talked on their phones. R14 was unable to give a specifric date. R14 stated it bothered her when her care was interrupted by staff talking on their cell phone and	F 550	council. All employees will be in-serviced on the Employee Use of Telephone policy with emphasis that personal cell phone usage is prohibited in resident care areas or in the presence of residents. The Director of HR and/or designee is responsible for compliance. Audits on employee cell phone use and compliance will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 550	Continued From page 7 felt like staff didn't care about her. R21 R21's quarterly MDS dated1/5/22, indicated R21 was cognitively intact and diagnoses included spina bifida, tracheostomy, and paraplegia. R21's MDS indicated R21 required assistance with ADL's including transfers, toileting and personal hygiene. During interview on 3/23/22, at 1:39 p.m. R21 stated the evening shift staff were observed on their personal cell phones while they were supposed to be working with residents. On an unidentified date, staff were in the middle of helping R21 and their cell phone rang. Staff stopped the care they provided, answered and then started talking on their personal cell phone while in R21's room. R21 stated he was bothered when staff answered their personal cell phone when they were supposed to be helping him and he felt like staff were too busy to help him. R25 R25's quarterly MDS indicated R25 was cognitively intact and had diagnoses including spastic quadriplegia and multiple sclerosis. R25's MDS indicated R25 required assistance with ADL's including transfers, toileting, personal hygiene and bathing. During interview on 3/23/22, at 12:12 p.m. R25 stated the evening of 3/22/22, staff had been in her room to help her get ready for bed. When the staff were assisting her, their cell phone rang, her care was stopped and the staff answered their cell phone. R25 stated this had happened in the past, had happened quite often, and had always	F 550		

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F 550	Continued From page 8 been on the evening (2 p.m.-10 p.m.) shift. R25 stated it bothered her when staff answered their phone when they were assisting her. During interview on 3/23/22, at 12:04 p.m. nursing assistant (NA)-A stated staff were told not to use their personal cell phones while working. NA-A had noticed that staff cell phone use had been pretty excessive and had not been enforced on evening shift. NA-A stated she had seen staff using their personal cell phones while working on the evening shift. During interview on 3/23/22, at 1:45 p.m. NA-D stated there is a policy regarding personal cell phone use and staff were not supposed to use personal cell phones while at work unless they are on a break. During interview on 3/23/22, at1:55 p.m. registered nurse (RN)-B stated staff were not supposed to use their personal cell phones during working hours. During interview on 3/23/22, at 2:16 p.m. RN-C stated she thought there was a policy directing staff not to use their personal cell phones while at work. Staff were encouraged not to use their cell phones in resident rooms or in front of the residents. During interview on 3/23/22, at 2:31 p.m. NA-H stated staff were not supposed to use cell phones during working hours. Staff had signed an agreement indicating they read and understood the policy directing not to use personal cell phones at work.	F 550		

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F 550	Continued From page 9 During interview on 3/23/22, at 2:34 p.m. RN-D stated staff were to keep their personal cell phone put away unless used for urgent/emergency use. During interview on 3/24/22, at 3:16 p.m. the administrator admin stated the facility had a policy in place regarding employee cell phone use. If there were a concern of staff using a personal cell phone the facility would investigate the concern and follow the disciplinary process. During interview on 3/24/22, at 3:35 p.m. the director of nursing (DON) stated staff were not supposed to use personal cell phones during working hours unless they were on a break. It had been brought to her attention that staff had been using cell phones on the floor. The nursing managers had talked to the staff to correct the concern. Had not conducted audits to determine if staff had been using their cell phones since the concern had been brought forward. Review of the Employee Use of Personal Electronic Devices reviewed/revised 11/5/20, indicated the use of personal cell phones while on duty was prohibited for all employees and were not permitted for use in any employee work areas. The policy further identified the use of cell phone was not permitted in resident areas or in the presence of residents.	F 550		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		5/10/22

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F 655	Continued From page 10 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655		

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F 655	Continued From page 11 Based on interview and document review, the facility failed to develop and provide a baseline care plan to ensure immediate resident needs were identified and addressed for 1 of 3 residents (R446) reviewed who recently admitted to the nursing home. Findings include: R446's Face Sheet dated 3/24/22, indicated admission to the facility on 3/11/22. On 3/22/22, at 8:24 a.m., R446 stated she had not received a baseline care plan since she admitted to the nursing home. R446 stated she would liked to have reviewed her careplan. R446's medical record was reviewed and lacked evidence a baseline careplan had been developed and/or provided to R446 after her admission to the nursing home. On 3/23/22, at 1:56 p.m., licensed practical nurse (LPN)-A stated R446's baseline careplan had not been developed. LPN-A stated the first entries were by actvities and nutrition five days after admission. LPN-A stated an expectation was to find basic medical care needs, psychosocial, transfer status and activities of daily living (ADL) in the baseline care plan. On 3/23/22, at 2:11 p.m., registered nurse (RN)-F stated that the baseline careplan was filled out by each department. RN-F stated the initial careplan would have items such as basic medical cares and ADLs. RN-F reviewed R446's medical record and stated a baseline careplan had not been completed for R446. RN-F stated she had gotten busy and overlooked R446's careplan.	F 655	R 446 has since discharged from the facility. Residents admitted from survey exit until present will have a baseline care plan initiated per policy. Future residents will have the baseline care plan initiated per facility policy. Licensed nurses will be in-serviced on the Care Plan Policy with focus on ensuring that the care plan is developed within 48 hours of the resident stay. The Director of Nursing and/or designee is responsible for compliance. Audits on baseline care plan initiation will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 655	Continued From page 12 On 3/24/22, at 2:00 p.m., the director of nursing (DON) was interviewed. The DON reviewed R446's medical record and stated a baseline careplan had not been completed. The DON stated a baseline careplan should have been completed within 48 hours of admission to ensure staff knew how to care for R446 and could assist her approriately and safely. The facility policy Care Plan-Baseline dated 11/30/21, indicated a baseline plan of care would be developed within 48 hours of the resident's admission so that the resident's immediate needs could be met. The initial careplan needed to include initial goals from admission orders, diet orders, therapy services, and preadmission screening and resident review (PASARR) recommendations, if applicable.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure consistent clinical monitoring and ordered interventions were completed for 1 of 1 resident (R30) who had high blood glucose levels and ordered interventions to	F 684	R 30 MD was contacted for review of current ketone order. New orders were received and noted. R 30 care plan was reviewed and updated. R 30□s MD was notified that the glucose monitoring order	5/10/22

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F 684	Continued From page 13 check ketones of glucose levels greater than 350. Findings include: R30's quarterly Minimum Data Set (MDS) dated 1/17/22, indicated he had intact cognition. Diagnoses included diabetes with diabetic retinopathy and kidney disease, depression, adjustment disorder, peripheral autonomic neuropathy and vision loss. R30 required supervision with mobility on and off the unit and with personal hygiene. R30 was independent with all other activities of daily living (ADLs). R30's Medication Review Report dated 3/22/22, identified orders for staff to continue to offer blood glucose checks, administration of meds, insulin and education every shift and to document refusals in the nurse progress notes. Staff were to notify endocrinology of any blood glucose concerns. An additional order to check R30's ketones if blood glucose was greater than 350 one time or greater than 250 on 2 consecutive checks. If ketones were moderate or high staff were directed to give 1 and 1/2 times the amount of corrective insulin as ordered. Blood glucose was to be rechecked within one to two hours to ensure it was going down. Staff were to perform blood glucose checks as needed for symptoms of hyper or hypo glycemia (high or low blood glucose levels) and as requested by resident. R30's care plan with revision date 9/10/21, indicated R30 had a diagnoses of diabetes type one and was insulin dependent. R30 had a history of non-compliance and poorly controlled diabetes which had resulted in acute kidney injury. In addition, R30 had bouts of fluctuating blood glucose levels which resulted in med	F 684	was not followed. The MDs response will be noted in the resident electronic medical record. Current residents who have glucose parameter orders were reviewed and their care plans were updated as needed. Future residents who have glucose parameter orders will be followed per physician order. Licensed nurses will be in-serviced on Care of the Older Adult with Diabetes Policy and Procedure with focus on section entitled: Glycemic Targets ensuring that the physician is contacted if levels are above or below MD protocol. Director of Nursing and/or designee is responsible for compliance. Audits on glucose parameters and notification of the physician will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 684	Continued From page 14	F 684		

changes and emergency room visits for additional management. Staff were directed to monitor, document and report symptoms of hyper or hypo glycemia, monitor fasting blood glucose as ordered and administer diabetic medications as ordered. The care plan lacked any direction for interventions or follow up following hyper or hypo blood glucose readings.

R30's blood glucose monitoring was reviewed from 2/1/22, through 3/22/22, and revealed the following:

-On 2/4/22, at 4:46 p.m. R30's blood glucose registered 377. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/5/22, at 8:37 a.m. R30's blood glucose registered 475. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/7/22, at 9:18 a.m. R30's blood glucose registered 370. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/7/22, at 8:47 p.m. R30's blood glucose registered 510. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/9/22, at 9:03 p.m. R30's blood glucose registered 531. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/10/22, at 10:32 p.m. R30's blood glucose registered 455. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 2/11/22, at 8:59 p.m. R30's blood glucose registered 370. The record lacked a one to two

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F 684	Continued From page 15 hour follow up blood glucose reading or ketone levels. -On 2/13/22, at 6:34 p.m. R30's blood glucose registered 481. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 2/14/22, at 4:17 p.m. R30's blood glucose registered 355. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 2/14/22, at 9:14 p.m. R30's blood glucose registered 363. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 2/23/22, at 8:27 p.m. R30's blood glucose registered 554. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 2/25/22, at 5:03 a.m. R30's blood glucose registered 520. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 3/3/22, at 12:22 a.m. R30's blood glucose registered 555. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 3/5/22, at 8:23 p.m. R30's blood glucose registered 351. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 3/6/22, at 3:08 a.m. R30's blood glucose registered 356. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 3/13/22, at 8:50 p.m. R30's blood glucose registered 420. The record lacked a one to two hour follow up blood glucose reading or ketone levels. -On 3/14/22, at 8:23 p.m. R30's blood glucose	F 684		

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F 684	Continued From page 16	F 684		

registered 405. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
-On 3/21/22, at 9:43 a.m. R30's blood glucose registered 400. The record lacked a one to two hour follow up blood glucose reading or ketone levels.
R30's medical record lacked evidence of continued monitoring after a recorded blood glucose levels greater than 350 or a check of ketone levels. In addition, there was no evidence the staff notified R30's physician or the endocrinology clinic of his elevated blood glucose levels.

R30's progress notes were reviewed from 2/1/22, through 3/22/22, and lacked documentation of follow up for blood glucose levels 350 or greater.

When interviewed on 3/22/22, at 3:45 p.m. registered nurse (RN)-D stated he was not aware of the order to check R30's ketones if blood glucose level was greater than 350. He did not think anyone was checking R30's ketone levels. If R30 was refusing the test the Medication Administration Record (MAR) would indicate refused and no refusals had been documented on the MAR.

During interview on 3/23/22. at 9:40 a.m. RN-B stated it was typical practice to recheck a resident's blood glucose if it was high, especially if it were over 350. R30 had a Libre machine (a glucose monitoring system worn by the resident that monitors blood glucose every minute) for continuous blood glucose monitoring and the nurses were to scan it when they needed to check a blood glucose level. R30 did refuse glucose checks at times and his refusals would

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F 684	Continued From page 17 be documented in the medical record, however, she was unable to find documentation of R30's refusals. On 3/22/22, at 4:06 p.m. the nurse manager (NM)-C indicated the physician order to check R30's ketones when blood glucose was greater than 350 was an informative entry on the MAR, which was why the nurses had initialed it as completed daily on the MAR. If R30's blood glucose levels were elevated she would expect a progress note for a follow up glucose level or ketone check. If there were no progress notes regarding that meant follow up was not completed. She would expect the staff to follow up on blood glucose levels of 350 or greater if R30 would allow it or to document his refusal of follow up. The facility policy Nursing Care of the Older Adult with Diabetes Mellitus dated 9/30/21, indicated glycemic target range for adults was considered 90-130 milligrams(mg)/deciliter(dl) fasting or before meals glucose. Complications associated with diabetes could be attributed to uncontrolled hyperglycemia and subsequent damage to the vasculature, over treatment of diabetes resulting in hypoglycemia and co-morbidities. Staff should call primary provider as soon as possible for blood glucose levels greater than 250 more than one time in a 24 hour period or greater than 300 more than one time over two consecutive days.	F 684		
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	F 686		5/10/22

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F 686	Continued From page 18 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to promote healing of pressure ulcers for 1 of 7 residents (R83) reviewed for pressure ulcers. Findings include: R83's Admission Record printed 3/24/22, indicated diagnoses that included spastic quadriplegic cerebral palsy (a group of disorders that affect the ability to move and maintain balance and posture), dementia, depression, Alzheimer's disease, cauda equina syndrome (compression on the spinal nerve roots leading to incontinence and paralysis of the legs), muscle weakness, and mild intellectual disabilities. R83's quarterly Minimum Data Set (MDS) dated 2/24/22, indicated R83 was severely cognitively impaired, had no behaviors or rejection of cares. The MDS further indicated R83 required extensive assistance with activities of daily living (ADLs), had an indwelling catheter, was frequently incontinent of bowel, was at risk for developing pressure ulcers and currently had two	F 686	R 83 had a complete skin check performed. There were no documented areas of concern noted. R 83 had a new Braden and pain scale along with updating of the pressure injury care plan and repositioning schedule. All existing residents who have turning and repositioning care plans will be reviewed and updated as needed. Future residents who have turning and repositioning interventions will be followed timely per plan. Nursing staff were in-serviced on the Repositioning Policy focusing on ensuring that it is critical that residents who are dependent on staff are repositioned. The Director of Nursing and/or designee is responsible for compliance. Audits on timely turning and repositioning will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 686	Continued From page 19 stage three pressure ulcers. R83's Care Area Assessment (CAA) with a significant change date of 12/6/21, indicated pressure ulcers were an area of actual problem/need for R83. The CAA indicated R83 had two areas of concern, a stage two pressure ulcer on coccyx and a stage four pressure ulcer to left ischium. The CAA directed this would be addressed on R83's care plan. R83's care plan last reviewed on 1/14/22, indicated R83 had the potential for skin alteration related to history of pressure ulcers, impaired mobility, history of refusals to reposition, spasticity, and incontinence. In addition, R83 had a current stage two pressure ulcer to right ischial tuberosity and unstageable pressure ulcer to left ischial tuberosity. The care plan directed staff to turn, reposition, and boost up in bed every two hours. In addition, the care plan directed staff that R83 should only be up in his wheel chair for two hours at a time. On 3/22/22, R83 was continuously observed from 1:47 p.m. until 3:23 p.m. R83 was seated in his wheelchair in the dining room in front of the television. At 2:13 p.m. nursing assistant (NA)- D approached R83 and asked him how he was doing, another staff who was nearby documenting on a computer volunteered R83 had been up in his chair since lunch time adding he didn't want to lie down after lunch. NA-D did not ask R83 if he wanted to lie down at that time. On 3/23/22, at 3:23 p.m. NA-D stated he received a report from the off going NA and was told R83 had been in his chair since before lunch. Trained medication aide (TMA)-A stated it looked like R83	F 686		

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F 686	Continued From page 20	F 686		

was pushing up in his chair like maybe he was hurting. TMA-A stated the NAs are supposed to mark repositioning on the group sheets but R83's was not marked. NA-D and NA-E asked R83 if he would go back to bed for awhile, R83 was agreeable. Licensed practical nurse (LPN)-A stated R83 should be repositioned and out of his wheelchair every two hours. LPN-A was not sure how long R83 had been in his wheelchair.

On 3/22/22, at 3:39 p.m. R83 was brought back to his room, and lifted into bed using a mechanical lift. LPN-A removed R83's brief, he had a small amount of soft brown stool, R83's dressings were intact, his buttocks were red but blanchable. LPN-A changed the dressing on R83's sacrum and left ischial tuberosity. LPN-A stated both areas looked improved.

On 3/23/22, at 11:20 a.m. NA-F stated the NAs do a hand-off report at change of shift. She stated on 3/22/22, she told the on-coming NAs that R83 had been up since before lunch. NA-F thought she had gotten R83 into his wheelchair at around 11:20 a.m. (R83 was in his wheelchair on 3/22/22, for approximately four hours).

On 3/23/22, at 2:03 p.m. registered nurse (RN)-E stated R83 was a reasonable and agreeable person and she would have expected staff to change his position every two hours, especially since he had pressure ulcers, that had been showing great improvement over the past six months. RN-E stated if R83 didn't want to go back to bed she would have expected the NAs to explain why it was important for him to lie down for awhile and then he would likely have said yes. RN-E verified R83 needed to be re-approached and the length of time he was up in his

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F 686	Continued From page 21 wheelchair was too long. On 3/24/22, at 3:19 p.m. the director of nursing (DON) verified she would expect the NAs to talk about last repositioning at the change of shift and she would expect timely repositioning (every two hours) of residents at risk for pressure ulcers as well as those with healing pressure ulcers. The facility policy titled Repositioning dated 2/7/22, indicated the purpose of repositioning for residents was to promote comfort for all bed/chair bound residents, prevent skin breakdown, promote circulation, and provide pressure relief for residents. The policy indicated repositioning was critical for residents who were immobile or dependent on staff for repositioning.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		5/10/22

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F 688	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and develop interventions to maintain and/or improve range of motion (ROM) for 1 of 1 resident (R29) who had identified impaired ROM and contractures. Findings include: R29's quarterly Minimum Data Set (MDS) indicated R29 had diagnoses of encephalopathy, anoxic brain damage, anxiety, non-psychotic mental disorder and stiffness in hand. R29 was totally dependent with all areas of activities of daily living (ADLs). R29 had identified ROM impairments on both sides of upper and lower extremities. R29's ADL comprehensive Care Area Assessment (CAA) dated 10/15/21, indicated R29 was at risk for complications of mobility such as contractures. R29's Fall CAA dated 10/15/21, indicated R29 was at risk for falls related to contributing factors that included loss of arm or leg movement. R29's Order Summary Report with active orders as of 3/24/22, indicated an order for bilateral soft cone hand splints secondary to contractures. R29's care plan with revision date 10/15/21, indicated R29 had no purposeful movement due to anoxic brain damage and was totally dependent upon staff for all ADL's. Staff were directed to assist R29 with all of her ADL needs, including repositioning and transfers. The care plan lacked identification of R29's limited range of	F 688	R 29 MD was contacted for PT evaluation and treatment orders for contracture plan. R 29 will have a new ROM assessment completed and the care plan was reviewed and updated per therapy recommendation. All other residents with splints, cones AFO braces were reviewed and their care plans and ROM assessments were updated as needed. Future residents with contractures or the potential for contractures will be screened and the appropriate interventions initiated. Nursing and therapy staff were in-serviced on the Resident Mobility and Range of Motion Policy with emphasis on item #8 that documentation of the resident progress toward the goal will include attempts to address any changes or declines in the resident□s condition or needs. The Director of Nursing and/or designee is responsible for compliance. Audits on ROM assessment completion and use of appropriate equipment interventions will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 688	Continued From page 23 motion, contractures to hands or need for interventions such as use of ordered bilateral soft soft cone hand splints or ROM exercises to maintain movement and prevent further contractures. On 3/22/22, at 3:10 p.m. R29 was observed in bed lying on her back. Her right hand was tightly clenched in a fist and had a slight swollen appearance. Her left hand thumb was open, however her fingers were in a clenched position. There were no positioning devices in place for her hands and no positioning devices were observed in the room. On 3/23/22, at 7:29 a.m. R29 was observed lying on her back in bed. R29 was fully dressed. There were no positioning devices in place for her hands and no positioning devices were observed in the room. During interview on 3/23/22, at 9:12 a.m. nursing assistant (NA)-M stated they had tried to place splints in R29's hands in the past but they made her uncomfortable so they quit using them. The aides did not do ROM exercises with R29; however, they were able to get her to open her fingers enough to wash the palms of her hands during cares. On 3/24/22, at 11:05 a.m. registered nurse (RN)-B stated R29's cones had been discontinued a long time ago. She knew the aides were able to open R29's fingers enough to provide hand hygiene. The facility offered therapy referrals but none had been made for R29. The facility did not have aides do ROM exercises. Exercises for residents were done by therapy.	F 688		

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F 688	Continued From page 24 During interview on 3/24/22, at 2:35 p.m. RN-C stated R29's hand splints were ordered in 2019 and just had never been discontinued from her chart. Resident range of motion was assessed during the quarterly MDS screening and if a decline was noted, it would generate a therapy referral. The aides did not do ROM exercises unless it was set up by therapy and R29 was not receiving any exercises. Therapy consults were generated when a resident had a fall, change of condition or the resident requested it or if a decline was noted during the quarterly MDS screening. When interviewed on 3/23/22, at 2:19 p.m. the therapy director stated R29 had not been seen by the therapy department for the last two years. A policy for rehabilitation, ROM and therapy was requested, however none were received.	F 688		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		5/10/22

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F 756	Continued From page 25 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist monthly medication reviews were completed monthly for 2 of 3 residents (R19, R20), and the consultant pharmacist recommendations were addressed for for 1 of 3 residents (R45) reviewed for unnecessary medications. Finding include: R19's Admission Record printed 3/24/22, indicated R19's diagnoses included dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit.	F 756	R 19 monthly pharmacist medication review was completed on 3/23/2022 and R 20 monthly pharmacist medication review was completed on 3/23/2022. All other residents were reviewed and their monthly medication review was addressed. R 45s pharmacy recommendation for unnecessary medications was addressed by the physician on 3/23/2022. All other residents were reviewed and no further recommendations for unnecessary medications were present. All other resident pharmacy medication reviews from survey exit until current have	

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F 756	Continued From page 26 R19's annual Minimum Data Set (MDS) dated 12/27/21, indicated R19 was severely cognitively impaired, had no behaviors, and had taken antipsychotic medications each of the seven days of the assessment period and had taken antidepressant medications each of the five days of the assessment period. R19's Care Area Assessment (CAA) dated 12/27/21, noted R19 had confusion, disorientation, and forgetfulness, and decreased ability to make himself understood. The CAA noted consultant pharmacist (CP) review of medication regimen would be helpful. The CAA further indicated R19 took antidepressant and antipsychotic medications. R19's care plan revised 1/18/21, directed staff to educate resident and family on risk, benefits, and side effects of antidepressant, antipsychotic, and antianxiety medications and to monitor for paradoxical side effects related to antianxiety medications. R19's care plan further directed staff to consult with pharmacy and physician on when to consider a dosage reduction. R19's Order Summary Report printed 3/24/22, identified orders for hydroxyzine HCl (antihistamine used to treat anxiety) 25 milligrams (mg) two times daily related to anxiety; quetiapine (antipsychotic) 50 mg twice daily related to dementia and 50 mg at bedtime for depression and anxiety. The facility was unable to provide monthly medication reviews for R19 for October, September, August, July, June, and May of 2021.	F 756	been reviewed by the attending physician. Future medication reviews will be addressed timely but no later than 60 days from recommendation date. Nursing leadership was in-serviced on the Pharmacy Drug Medication Review policy with emphasis on item # 7 that if pharmacy recommendations are not addressed within 60 days, the recommendation will be sent to the Medical Director for review and recommendation. The Director of Nursing and/or designee is responsible for compliance. Audits on pharmacy consultant recommendation response will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 756	Continued From page 27 R20's Admission Record printed 3/24/22, indicated R20's diagnoses included depression, post traumatic stress disorder, fibromyalgia (widespread muscle pain and tenderness), and anxiety. R20's quarterly MDS dated 1/4/22, identified R20 as cognitively intact, had no behaviors or rejection of care, and had taken antianxiety and antidepressants each of the seven days of the assessment period. R20's MDS also indicated she had depression. R20's CAA dated 10/5/21, noted R20 was taking opioids, antidepressants, psychoactive, sedative hypnotics, and antianxiety medications, and had a mood decline. The CAA indicated R20 had depression, anxiety disorder, and pain diagnoses. R20's care plan revised 10/6/21, directed staff to monitor for side effects of pain medications, mood and behavior, complaints of pain, and non-pharmacological interventions to relieve pain. In addition staff were directed to educate resident and family on risk, benefits, and side effects of antianxiety and antidepressant medication, to monitor, document and report side effects and paradoxical side effects of antianxiety medication. The care plan did not address quarterly review of medications and potential gradual dose reductions. R20's Order Summary Report printed 3/24/22, identified orders for buspirone HCl (anxiolytic used to treat depression)15 mg three times a day related to post-traumatic stress disorder; gabapentin (nerve pain medication) 300 mg two times daily related to fibromyalgia; Lexapro (selective serotonin reuptake inhibitor [SSRI]) 10	F 756		

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F 756	Continued From page 28	F 756		

mg one time daily related to major depression; meclizine HCl (antihistamine used to treat dizziness) 25 mg three times daily related to dizziness; Percocet (narcotic used to treat severe pain) 5-325 mg one tablet daily for pain and two tablets at bedtime for pain.

The facility was unable to provide monthly medication reviews for R20 for August, July, June, or May of 2021.

R45's Admission Record printed 3/24/22, indicated diagnoses that included schizoaffective disorder, anxiety disorder, insomnia, suicidal ideations, developmental disorders of scholastic skills, and major depression.

R45's quarterly MDS dated 1/30/22, indicated R45 was cognitively intact and was taking antidepressants, antianxiety, and antipsychotic medications each of the seven days of the assessment period. The MDS also indicated R20 had mild depression symptoms and did not have behaviors or reject cares.

R45's Care Area Assessment (CAA) dated 11/5/21, noted R45 was taking antipsychotics, antidepressant, sedative hypnotic, antianxiety medications. R45's CAA indicated she had depression, anxiety, cognitive impairment, and schizophrenia.

R45's care plan revised 1/14/22, directed staff to monitor for side effects of psychoactive medications, perform an abnormal involuntary movement scale (AIMS) quarterly and as needed. Monitor, record, report any risk to harm self.

R45's Order Summary Report printed 3/24/22,

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F 756	Continued From page 29 identified orders for clonazepam (sedative used to treat anxiety) 0.5 mg three times a day for anxiety/poor sleep/ chronic pain; fluoxitine HCl (SSRI) 40 mg one time daily for depression; Risperdal (antipsychotic) three mg at bedtime related to paranoid schizophrenia; quetiapine (antipsychotic) 100 mg daily at bedtime for paranoid schizophrenia; Trazodone (antidepressant and sedative) 50 mg at bedtime for sleep. A Consultant Pharmacist Communication to the Physician note dated 9/9/21,and 10/20/21, requested the physician to consider monitoring for dizziness and drowsiness related to clonazepam, quetiapine, and risperidone to reduce the future risk of falls. There was no documented response to the requests. On 3/24/22, at 3:17 p.m. and 4:12 p.m. the director of nursing (DON) stated it was her expectation that monthly medication reviews (MMRs) would be conducted monthly. The DON stated she could not explain why the MMRs were not completed. The DON stated if the communication between the pharmacist and the physician was not signed then the physician did not respond and there was not any follow up to the recommendations. The DON verified orthostatic blood pressures should have been intiated after R45's fall related to her medication regimine. On 3/24/22, at 4:28 p.m the consultant pharmacist (CP) stated it was her expectation that recommendations would be addressed within 60 days, if it was not addressed after 60 days she would take it to the medical director. The CP stated she has only been employed at the facility	F 756		

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F 756	Continued From page 30 for the past month so was unable to speak to the missed MMRs and recommendations not being followed up. The facility policy titled Psychotropic Medications dated 4/16/21, directed the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications. This would include regular review for continued need, appropriate dosage, side effects, risk and/or benefits.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dishwasher	F 812	The dishwasher booster was repaired on 3/23/2022. From repair date until current,	5/10/22

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F 812	Continued From page 31 temperatures were maintained or implement other strategies to effectively sanitize dishware and utensils to reduce the risk of foodborne illness. This had potential to affect 88 of 89 residents residing in the nursing home along with staff and visitors who consume meals from the main production kitchen. Findings include: During the initial kitchen tour on 3/22/22, at 1:07 p.m., dietary aide (DA)-A was washing the lunch dishes. DA-A had just loaded a bin with hard plastic trays and metallic sheet cooking pans and placed in high temperature Holbart dishwasher. The dial gauge on wash read 155 degrees Fahrenheit (F) and the dial gauge on rinse read 168 degrees F. A gray sticker above the gauges placed "160F MIN" (wash) and "180F MIN" rinse. DA-A placed a second load of dishes into the dishwasher and rinse gauge of 162 degrees F. DA-A stated the booster was not working. The booster was what brought water to the appropriate temperature for wash and rinse. DA-A stated they used the dishwasher as the primary way of cleaning the dishes and did not clean dishes manually. DA-A stated the correct rinse temperatures were 180-185 degrees F. Review of facility Dish Machine Temperature Log dated 3/22, indicated on 3/18/22, the dinner dishwasher temperatures had not been reported on the log. The log indicated each day in the month along with all meals where the temperatures were recorded. The log indicated low readings on 3/14/22, 3/16/22, 3/17/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, and 3/22/22. The top of log indicated "required wash temp-160 degrees or above" and "required rinse temp-180	F 812	the dish temperature log temperatures were recorded per policy. No residents were affected by this deficient practice. Future dishwasher and/or other equipment failures, alternative methods for serving meals will be initiated per policy. Dietary staff were in-serviced on the Dish Machine Temperature Log Policy and procedure with emphasis on monitoring the dish temperatures throughout the dishwashing process and to report malfunctions to the Dietary Director. The Director will implement the necessary immediately to ensure proper dish sanitation is performed. Director of Dietary Services and/or designee is responsible for compliance. Audits on dishwashing temperatures will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 812	Continued From page 32	F 812		

degrees or above". The log also indicated to notify the dietary manager if temperatures were not within the required range. The temperature log did not identify that the dietary manager was notified of low temperature readings.

Review of the Temp Rite Dishwasher Temperature Test Strip log for the last 12 months indicated the last Temp Right Dishwasher Temperature Test Strip was used to check wash and rinse temperatures on 3/8/22.

On 3/22/22, at 1:22 p.m., the food services supervisor (FSS) stated he was aware the booster was not working and explained, to his knowledge, the booster had been broken for "over a week" now. The FSS was unaware of any changes being made to the dishwashing process since the booster had broken stating "everything stayed the same" in regards to the process for cleaning and sanitizing the dishes used by the residents. She stated the facility had been in touch with Ecolab about the booster being broken.

The food services director (FSD) stated on 3/22/22, at 3:36 p.m., he was aware the booster was not working. The FSD stated the Hobart dishwasher was a high temp machine and relied on hot water to sanitize. The FSD reviewed the temperature log and stated there were several temperature readings below the appropriate temperatures. FSD stated the low temperature readings had not been brought to anybodies attention and they should have been. The FSD stated they had contacted Ecolab yesterday and Ecolab asked if somebody local could respond sooner. A "general parts" vendor was contacted and unable to come today for repairs. Disposable

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F 812	Continued From page 33 items were started after interview completed and hand washing started for items that are not disposable. FSD stated all but one resident, a total of 88 residents, were served on dishware and items from the main production kitchen. A facility policy for dish cleaning was requested but not provided.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/10/22

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F 880	Continued From page 34 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 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	F 880	R 292, R 49, R3 and R 34 were assessed	

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F 880	Continued From page 35 review the facility failed to ensure staff were wearing face masks and eye protection according to guidance from the Centers for Disease Control and Prevention while caring for residents (R34, R292, R49, and R3) which had the potential to expose 15 residents on the memory care unit and 33 residents on the Park Breeze unit to COVID-19. Findings include: R292's Face Sheet printed 3/24/22, identified a diagnosis of dementia without behavioral disturbance. R292's Brief Interview for Mental Status (BIMS) assessment dated 3/24/22, identified severe cognitive impairment. R34's quarterly Minimum Data Set (MDS) dated 1/21/22, identified severe cognitive impairment. Diagnoses included: Alzheimer's disease and cognitive communication deficit. During observation on 3/23/22, at 11:36 a.m. nursing assistant (NA)-G was assisting and redirecting R292 to the dining room. NA-G was within 18 inches of R292 and was wearing his mask below his nose and above his upper lip, his goggles were on his forehead while he was assisting R292. NA-G assisted R292 for about ten minutes. During observation on 3/23/22, at 12:10 p.m. NA-G was observed sitting in the dining room and assisting R34 to eat his lunch and was sitting within 24 inches of R34. NA-G was wearing his mask below his nose and above his upper lip and his goggles were on his forehead. When NA-G	F 880	for COVID 19 symptoms and their physician was notified that improper mask wearing by staff was observed. The MD response will be recorded in the resident electronic medical record. All other residents residing on Park Breeze were assessed and there were no ill effects recorded for this deficient practice. Future residents will be cared for by staff who have donned their PPE appropriately. Facility staff was in-serviced on the PPE Face Mask Policy with emphasis on the proper procedure for wearing the mask (over the nose and covering the mouth) and eye protection is to be worn per the county positivity rate. The Infection Preventionist and Director of Nursing is responsible for compliance. A directed plan of correction will be completed and the root cause identified for this deficient practice. Family education will be sent via Cliniconex and staff will have competency testing for use in donning/doffing of proper PPE. Audits on use of proper PPE during aerosol treatments, donning and doffing of PPE and proper mask wearing and eye protection for all shifts 4x week for one week, then twice weekly for one week and until 100% compliance is met. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 880	Continued From page 36	F 880		

saw that he was being observed, he placed his goggles correctly over his eyes and adjusted his mask to cover his nose.

During observation on 3/23/22, at 12:16 p.m. NA-G was still assisting R34 with eating his lunch and NA-G's mask was below his nose and over his upper lip, NA-G's goggles were on his forehead and was still right next to R34.

During an interview on 2/23/22 at 1:27 p.m. NA-G stated he received training on COVID-19 and received training on wearing personal protective equipment (PPE), which included wearing of facemasks and eye protection. He stated they were train on putting mask and goggles on and fitting them to their face. He stated the mask was to be always worn and needed to cover the nose and mouth, and the goggles needed to be worn when providing care to residents. There were not issues with the way the mask or goggles were fitting. NA-G said sometimes he wears his goggle on his head because he does not want them to fog up and knows he should wear them. NA-G did not answer why he was wearing his mask below his nose and above the lip.

During an interview on 3/23/22, at 1:37 p.m. trained medication assistant (TMA)-B stated the facemasks were to be always worn and supposed to cover the nose and the mouth and staff need to wear eye protection when providing resident cares. TMA-B stated if she saw staff not wearing facemasks or eye protection correctly, she would remind them.

During an interview on 3/24/22, at 1:45 p.m. registered nurse (RN)-F stated when working on the floor staff should always have PPE in place.

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F 880	Continued From page 37 This included facemask over nose and mouth and eye protection over the eyes when providing care to residents. R49's Face Sheet printed 3/24/22, identified R49 had diagnoses including history of respiratory disease, diabetes mellitus type 1 and cerebral palsy. R49's care plan dated 5/22/19, identified R49 had difficulty breathing related to previous respiratory failure with hypoxia and shortness of breath. Staff were directed to provide inhalers as ordered, and monitor and report signs and symptoms of respiratory distress and pleuritic pain. R3's Face Sheet printed 3/24/22, identified R3 had diagnoses including chronic respiratory failure with hypoxia and inhalation pneumonitis. During observation on 3/24/22, at 8:23 a.m. housekeeping aide (HA)-A was wearing a face mask over her mouth but under the nose (not covering the nostrils) while cleaning R49's room and R3's room. HA-A was within 6 feet of both resident while talking to and cleaning their rooms for approximately 3-5 minutes. During interview on 3/24/22, at 9:04 a.m. HA-A stated she tried to keep the face mask over her nose but it kept sliding down. HA-A also stated staff were to wear face masks over the mouth and nose while working. During an interview on 3/24/22, at 4:04 p.m. the infection preventionist (IP) stated it was required for staff to wear a face mask that would cover their nose and mouth at all times and staff would	F 880		

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F 880	Continued From page 38 be expected to wear eye protection when providing care to residents. The facility's policy for Person Protective Equipment-Using Face Masks dated 8/18/21, identified the face mask covers the nose and mouth while performing treatment or services for the patient. Face masks are mandatory until further notice. The facility's policy for Personal Protective Equipment-Using Protective Eyewear dated 8/25/21, identified eye protection was mandatory for all facility employees and must be worn in all resident care areas.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;	F 886		5/10/22

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F 886	Continued From page 39 (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or	F 886		

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F 886	Continued From page 40 processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to track all staff who were or were not tested during outbreak and routine screening per Center for Medicare and Medicaid Services (CMS) guidelines. This had the possibility for effect all 89 residents residing in the facility. Findings include, CMS's Quality, Safety and Oversite Group (QSO) memo 20-38 for nursing homes dated 3/10/22, identified facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following: 1. For symptomatic staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. 2. Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other staff are tested, the dates that staff who tested negative are retested, and the results of all tests. 3. For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test. Review of facility testing documentation for staff indicated: 1/1/22, through 1/31/22: five staff tested positive for COVID-19, and 56 staff tests did not have results identified on them. There was not any	F 886	COVID-19 Testing performed on staff from 1/1/2022 through present, the results will be entered into the facility staff line listing. The Medical Director, facility residents and families will receive a message indicating this deficient practice. Future COVID outbreaks, staff will be tested per facility policy. The Infection Preventionist, Director of Nursing and Administrator will be in-serviced on the COVID-19 testing policy with emphasis on testing staff and residents utilizing the testing table located within the policy. The Infection Preventionist is responsible for compliance. Audits on staff testing and completion of the staff line listing will begin 2x week for 2 weeks, weekly x 4 then monthly to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 5/10/2022	

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F 886	Continued From page 41 documentation which indicated all staff were tested. 2/1/22, through 2/21/22: four staff tested positive for COVID-19, and 54 staff tests did not have results identified on them. There was not any documentation which indicated all staff were tested. Testing results for staff from 2/22/22, through 3/20/22, were requested but not received. There were 3 positive residents within the past 4 weeks. The dates of the positive tests were 2/21/22, 2/28/22, and 3/3/22. During an interview on 3/24/22, at 4:04 p.m. the infection preventionist registered nurse (RN)-G stated the county transmission rate was 3.65% and required twice a week testing for unvaccinated staff. RN-G stated the facility's most recent round of outbreak testing ended last week. During outbreak testing all staff were required to be tested twice a week. The administrator oversaw tracking of testing for staff. During an interview on 3/24/22, at 1:23 p.m. the administrator stated the process for employee testing required employees to report for their shift and test twice a week during out break and unvaccinated employees are to test twice a week when not in outbreak. The administrator stated staff would perform self-tests and then have them read by another employee who would sign off it was completed and the result. The administrator stated there should have been someone at the entrance during shift change to read and sign off on the tests. There were not any employees to his knowledge who were specifically staffing the door, one of the staff who was working on the floor should do it. He stated they do not have a	F 886		

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	245227	A. BUILDING _____ B. WING _____	C 03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	**1601 ST LOUIS AVENUE DULUTH, MN 55802**

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F 886	Continued From page 42 procedure in place to ensure all staff were tested. He stated staff who have not tested could have gone on the floor and worked with residents. He stated, "It's too cumbersome to track in a tracking sheet or spread sheet". The facility's undated COVID-19 Outbreak, and Routine Testing Procedure identified: for staff - document date, time, s/s, when testing was conducted, when results were obtained and the action the facility took based on the results. Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other staff were tested, the dates that staff who tested negative were retested, and the results of all tests. All staff that tested negative were expected to be retested until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. For staff routine testing, document the facility's community positivity rate, the corresponding testing frequency indicated (e.g., every other week), and the date each positivity rate was collected. Also, document the date(s) that testing was performed for all staff, and the results of each test.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 8, 2022

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: 0LJH11

Dear Administrator:

The above facility was surveyed on March 21, 2022 through March 25, 2022 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	C 03/25/2022

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BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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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 3/21/22, through 3/25/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. In addition a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). The following complaints were found to be UNSUBSTANTIATED with no deficiencies: H5227167C (MN72617) H5227168C (MN80880) 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 surveyors 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 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 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	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees	2 302		5/10/22

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2 302	Continued From page 3 trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 3 of 8 staff (LPN-B, NA-K, NA-L) received annual training that included all required components of Alzheimer's/dementia care. In addition, the facility failed to provide information on how they communicated Alzheimer's training to the consumer. This had the potential to affect all residents currently residing in the facility with a diagnosis of Alzheimer's or dementia. Findings include: Minnesota state statue 144.6503 for Alzheimer's disease or related disorder training, directed areas of required training for direct care staff and their supervisors included: -an explanation of Alzheimer's disease and related disorders -assistance with activities of daily living -problem solving with challenging behaviors -communications skills During an interview on 3/24/22, at 3:45 p.m. Social Worker (SW)-A stated she would look for information on how the facility communicated Alzheimer's training to the consumer. On 3/24/22, at 4:48 p.m the administrator stated he was unsure how they communicated information on Alzheimer's training to the	2 302	Corrected	

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2 302	Continued From page 4 consumer. On 3/25/22, at 8:09 a.m. the director of nursing (DON) stated they were unable to provide information on communication to the consumer on Alzheimer's training. At that time, the DON verified she was unable to provide any training date for nursing assistant (NA)-K; NA-L's last training date was on 1/26/16, and licensed practical nurse (LPN)-B last received training for Alzheimer's on 12/9/17. The DON verified all three employees were current employees. The facility assessment dated 1/22/22, indicated on hire and annually all staff would be educated on caring for persons with Alzheimer's or other dementia disorders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure training for Alzheimer's was communicated to the consumer. In addition, the DON or designee could ensure the training for Alzheimer's was completed for all staff. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program	2 890		5/10/22

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2 890	Continued From page 5 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. 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 a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and develop interventions to maintain and/or improve range of motion (ROM) for 1 of 1 resident (R29) who had identified impaired ROM and contractures. Findings include: R29's quarterly Minimum Data Set (MDS) indicated R29 had diagnoses of encephalopathy, anoxic brain damage, anxiety, non-psychotic mental disorder and stiffness in hand. R29 was totally dependent with all areas of activities of daily living (ADLs). R29 had identified ROM impairments on both sides of upper and lower extremities. R29's ADL comprehensive Care Area Assessment (CAA) dated 10/15/21, indicated R29 was at risk for complications of mobility such as contractures.	2 890	Corrected	

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2 890	Continued From page 6 R29's Fall CAA dated 10/15/21, indicated R29 was at risk for falls related to contributing factors that included loss of arm or leg movement. R29's Order Summary Report with active orders as of 3/24/22, indicated an order for bilateral soft cone hand splints secondary to contractures. R29's care plan with revision date 10/15/21, indicated R29 had no purposeful movement due to anoxic brain damage and was totally dependent upon staff for all ADL's. Staff were directed to assist R29 with all of her ADL needs, including repositioning and transfers. The care plan lacked identification of R29's limited range of motion, contractures to hands or need for interventions such as use of ordered bilateral soft soft cone hand splints or ROM exercises to maintain movement and prevent further contractures. On 3/22/22, at 3:10 p.m. R29 was observed in bed lying on her back. Her right hand was tightly clenched in a fist and had a slight swollen appearance. Her left hand thumb was open, however her fingers were in a clenched position. There were no positioning devices in place for her hands and no positioning devices were observed in the room. On 3/23/22, at 7:29 a.m. R29 was observed lying on her back in bed. R29 was fully dressed. There were no positioning devices in place for her hands and no positioning devices were observed in the room. During interview on 3/23/22, at 9:12 a.m. nursing assistant (NA)-M stated they had tried to place splints in R29's hands in the past but they made her uncomfortable so they quit using them. The	2 890		

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2 890	Continued From page 7 aides did not do ROM exercises with R29; however, they were able to get her to open her fingers enough to wash the palms of her hands during cares. On 3/24/22, at 11:05 a.m. registered nurse (RN)-B stated R29's cones had been discontinued a long time ago. She knew the aides were able to open R29's fingers enough to provide hand hygiene. The facility offered therapy referrals but none had been made for R29. The facility did not have aides do ROM exercises. Exercises for residents were done by therapy. During interview on 3/24/22, at 2:35 p.m. RN-C stated R29's hand splints were ordered in 2019 and just had never been discontinued from her chart. Resident range of motion was assessed during the quarterly MDS screening and if a decline was noted, it would generate a therapy referral. The aides did not do ROM exercises unless it was set up by therapy and R29 was not receiving any exercises. Therapy consults were generated when a resident had a fall, change of condition or the resident requested it or if a decline was noted during the quarterly MDS screening. When interviewed on 3/23/22, at 2:19 p.m. the therapy director stated R29 had not been seen by the therapy department for the last two years. A policy for rehabilitation, ROM and therapy was requested, however none were received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to assess and develop interventions to maintain and/or improve range of motion.	2 890		

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2 890	Continued From page 8 The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to promote healing of pressure ulcers for 1 of 7 residents (R83) reviewed for pressure ulcers. Findings include: R83's Admission Record printed 3/24/22, indicated diagnoses that included spastic quadriplegic cerebral palsy (a group of disorders that affect the ability to move and maintain balance and posture), dementia, depression, Alzheimer's disease, cauda equina syndrome	2 905	Corrected	5/10/22

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2 905	Continued From page 9 (compression on the spinal nerve roots leading to incontinence and paralysis of the legs), muscle weakness, and mild intellectual disabilities. R83's quarterly Minimum Data Set (MDS) dated 2/24/22, indicated R83 was severely cognitively impaired, had no behaviors or rejection of cares. The MDS further indicated R83 required extensive assistance with activities of daily living (ADLs), had an indwelling catheter, was frequently incontinent of bowel, was at risk for developing pressure ulcers and currently had two stage three pressure ulcers. R83's Care Area Assessment (CAA) with a significant change date of 12/6/21, indicated pressure ulcers were an area of actual problem/need for R83. The CAA indicated R83 had two areas of concern, a stage two pressure ulcer on coccyx and a stage four pressure ulcer to left ischium. The CAA directed this would be addressed on R83's care plan. R83's care plan last reviewed on 1/14/22, indicated R83 had the potential for skin alteration related to history of pressure ulcers, impaired mobility, history of refusals to reposition, spasticity, and incontinence. In addition, R83 had a current stage two pressure ulcer to right ischial tuberosity and unstageable pressure ulcer to left ischial tuberosity. The care plan directed staff to turn, reposition, and boost up in bed every two hours. In addition, the care plan directed staff that R83 should only be up in his wheel chair for two hours at a time. On 3/22/22, R83 was continuously observed from 1:47 p.m. until 3:23 p.m. R83 was seated in his wheelchair in the dining room in front of the television. At 2:13 p.m. nursing assistant (NA)- D	2 905		

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2 905	Continued From page 10	2 905		

approached R83 and asked him how he was doing, another staff who was nearby documenting on a computer volunteered R83 had been up in his chair since lunch time adding he didn't want to lie down after lunch. NA-D did not ask R83 if he wanted to lie down at that time.

On 3/23/22, at 3:23 p.m. NA-D stated he received a report from the off going NA and was told R83 had been in his chair since before lunch. Trained medication aide (TMA)-A stated it looked like R83 was pushing up in his chair like maybe he was hurting. TMA-A stated the NAs are supposed to mark repositioning on the group sheets but R83's was not marked. NA-D and NA-E asked R83 if he would go back to bed for awhile, R83 was agreeable. Licensed practical nurse (LPN)-A stated R83 should be repositioned and out of his wheelchair every two hours. LPN-A was not sure how long R83 had been in his wheelchair.

On 3/22/22, at 3:39 p.m. R83 was brought back to his room, and lifted into bed using a mechanical lift. LPN-A removed R83's brief, he had a small amount of soft brown stool, R83's dressings were intact, his buttocks were red but blanchable. LPN-A changed the dressing on R83's sacrum and left ischial tuberosity. LPN-A stated both areas looked improved.

On 3/23/22, at 11:20 a.m. NA-F stated the NAs do a hand-off report at change of shift. She stated on 3/22/22, she told the on-coming NAs that R83 had been up since before lunch. NA-F thought she had gotten R83 into his wheelchair at around 11:20 a.m. (R83 was in his wheelchair on 3/22/22, for approximately four hours).

On 3/23/22, at 2:03 p.m. registered nurse (RN)-E stated R83 was a reasonable and agreeable

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2 905	Continued From page 11 person and she would have expected staff to change his position every two hours, especially since he had pressure ulcers, that had been showing great improvement over the past six months. RN-E stated if R83 didn't want to go back to bed she would have expected the NAs to explain why it was important for him to lie down for awhile and then he would likely have said yes. RN-E verified R83 needed to be re-approached and the length of time he was up in his wheelchair was too long. On 3/24/22, at 3:19 p.m. the director of nursing (DON) verified she would expect the NAs to talk about last repositioning at the change of shift and she would expect timely repositioning (every two hours) of residents at risk for pressure ulcers as well as those with healing pressure ulcers. The facility policy titled Repositioning dated 2/7/22, indicated the purpose of repositioning for residents was to promote comfort for all bed/chair bound residents, prevent skin breakdown, promote circulation, and provide pressure relief for residents. The policy indicated repositioning was critical for residents who were immobile or dependent on staff for repositioning. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents were postioned timely per the care plan. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	2 905		

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2 905	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dishwasher temperatures were maintained or implement other strategies to effectively sanitize dishware and utensils to reduce the risk of foodborne illness. This had potential to affect 88 of 89 residents residing in the nursing home along with staff and visitors who consume meals from the main production kitchen. Findings include: During the initial kitchen tour on 3/22/22, at 1:07 p.m., dietary aide (DA)-A was washing the lunch dishes. DA-A had just loaded a bin with hard plastic trays and metallic sheet cooking pans and placed in high temperature Holbart dishwasher. The dial gauge on wash read 155 degrees Fahrenheit (F) and the dial gauge on rinse read 168 degrees F. A gray sticker above the gauges placed "160F MIN" (wash) and "180F MIN" rinse. DA-A placed a second load of dishes into the dishwasher and rinse gauge of 162 degrees F. DA-A stated the booster was not working. The	21015	Corrected	5/10/22

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21015	Continued From page 13	21015		

booster was what brought water to the appropriate temperature for wash and rinse. DA-A stated they used the dishwasher as the primary way of cleaning the dishes and did not clean dishes manually. DA-A stated the correct rinse temperatures were 180-185 degrees F.

Review of facility Dish Machine Temperature Log dated 3/22, indicated on 3/18/22, the dinner dishwasher temperatures had not been reported on the log. The log indicated each day in the month along with all meals where the temperatures were recorded. The log indicated low readings on 3/14/22, 3/16/22, 3/17/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, and 3/22/22. The top of log indicated "required wash temp-160 degrees or above" and "required rinse temp-180 degrees or above". The log also indicated to notify the dietary manager if temperatures were not within the required range. The temperature log did not identify that the dietary manager was notified of low temperature readings.

Review of the Temp Rite Dishwasher Temperature Test Strip log for the last 12 months indicated the last Temp Right Dishwasher Temperature Test Strip was used to check wash and rinse temperatures on 3/8/22.

On 3/22/22, at 1:22 p.m., the food services supervisor (FSS) stated he was aware the booster was not working and explained, to his knowledge, the booster had been broken for "over a week" now. The FSS was unaware of any changes being made to the dishwashing process since the booster had broken stating "everything stayed the same" in regards to the process for cleaning and sanitizing the dishes used by the residents. She stated the facility had been in touch with Ecolab about the booster

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21015	Continued From page 14 being broken. The food services director (FSD) stated on 3/22/22, at 3:36 p.m., he was aware the booster was not working. The FSD stated the Hobart dishwasher was a high temp machine and relied on hot water to sanitize. The FSD reviewed the temperature log and stated there were several temperature readings below the appropriate temperatures. FSD stated the low temperature readings had not been brought to anybodies attention and they should have been. The FSD stated they had contacted Ecolab yesterday and Ecolab asked if somebody local could respond sooner. A "general parts" vendor was contacted and unable to come today for repairs. Disposable items were started after interview completed and hand washing started for items that are not disposable. FSD stated all but one resident, a total of 88 residents, were served on dishware and items from the main production kitchen. A facility policy for dish cleaning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures were maintained or implement other strategies to effectively sanitize dishware and utensils to reduce the risk of foodborne illness. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21015		

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21015	Continued From page 15 (21) days.	21015		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff were wearing face masks and eye protection according to guidance from the Centers for Disease Control and Prevention while caring for residents (R34, R292, R49, and R3) which had the potential to expose 15 residents on the memory care unit and 33 residents on the Park Breeze unit to COVID-19. Findings include: R292's Face Sheet printed 3/24/22, identified a diagnosis of dementia without behavioral disturbance. R292's Brief Interview for Mental Status (BIMS) assessment dated 3/24/22, identified severe cognitive impairment. R34's quarterly Minimum Data Set (MDS) dated 1/21/22, identified severe cognitive impairment. Diagnoses included: Alzheimer's disease and cognitive communication deficit.	21385	Corrected	5/10/22

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21385	Continued From page 16 During observation on 3/23/22, at 11:36 a.m. nursing assistant (NA)-G was assisting and redirecting R292 to the dining room. NA-G was within 18 inches of R292 and was wearing his mask below his nose and above his upper lip, his goggles were on his forehead while he was assisting R292. NA-G assisted R292 for about ten minutes. During observation on 3/23/22, at 12:10 p.m. NA-G was observed sitting in the dining room and assisting R34 to eat his lunch and was sitting within 24 inches of R34. NA-G was wearing his mask below his nose and above his upper lip and his goggles were on his forehead. When NA-G saw that he was being observed, he placed his goggles correctly over his eyes and adjusted his mask to cover his nose. During observation on 3/23/22, at 12:16 p.m. NA-G was still assisting R34 with eating his lunch and NA-G's mask was below his nose and over his upper lip, NA-G's goggles were on his forehead and was still right next to R34. During an interview on 2/23/22 at 1:27 p.m. NA-G stated he received training on COVID-19 and received training on wearing personal protective equipment (PPE), which included wearing of facemasks and eye protection. He stated they were train on putting mask and goggles on and fitting them to their face. He stated the mask was to be always worn and needed to cover the nose and mouth, and the goggles needed to be worn when providing care to residents. There were not issues with the way the mask or goggles were fitting. NA-G said sometimes he wears his goggle on his head because he does not want them to fog up and knows he should wear them.	21385		

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21385	Continued From page 17 NA-G did not answer why he was wearing his mask below his nose and above the lip. During an interview on 3/23/22, at 1:37 p.m. trained medication assistant (TMA)-B stated the facemasks were to be always worn and supposed to cover the nose and the mouth and staff need to wear eye protection when providing resident cares. TMA-B stated if she saw staff not wearing facemasks or eye protection correctly, she would remind them. During an interview on 3/24/22, at 1:45 p.m. registered nurse (RN)-F stated when working on the floor staff should always have PPE in place. This included facemask over nose and mouth and eye protection over the eyes when providing care to residents. R49's Face Sheet printed 3/24/22, identified R49 had diagnoses including history of respiratory disease, diabetes mellitus type 1 and cerebral palsy. R49's care plan dated 5/22/19, identified R49 had difficulty breathing related to previous respiratory failure with hypoxia and shortness of breath. Staff were directed to provide inhalers as ordered, and monitor and report signs and symptoms of respiratory distress and pleuritic pain. R3's Face Sheet printed 3/24/22, identified R3 had diagnoses including chronic respiratory failure with hypoxia and inhalation pneumonitis. During observation on 3/24/22, at 8:23 a.m. housekeeping aide (HA)-A was wearing a face mask over her mouth but under the nose (not covering the nostrils) while cleaning R49's room	21385		

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21385	Continued From page 18 and R3's room. HA-A was within 6 feet of both resident while talking to and cleaning their rooms for approximately 3-5 minutes. During interview on 3/24/22, at 9:04 a.m. HA-A stated she tried to keep the face mask over her nose but it kept sliding down. HA-A also stated staff were to wear face masks over the mouth and nose while working. During an interview on 3/24/22, at 4:04 p.m. the infection preventionist (IP) stated it was required for staff to wear a face mask that would cover their nose and mouth at all times and staff would be expected to wear eye protection when providing care to residents. The facility's policy for Person Protective Equipment-Using Face Masks dated 8/18/21, identified the face mask covers the nose and mouth while performing treatment or services for the patient. Face masks are mandatory until further notice. The facility's policy for Personal Protective Equipment-Using Protective Eyewear dated 8/25/21, identified eye protection was mandatory for all facility employees and must be worn in all resident care areas SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff were wearing face mask and eye protection according to guidance from the Centers for Disease Control and Prevention while caring for residents. The Director of Nursing or designee could	21385		

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21385	Continued From page 19 educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB)	21426	Corrected	5/10/22

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21426	Continued From page 20 screening was completed on 3 of 5 employees and 5 of 5 employees received Mantoux tuberculin skin test (TST) prior to hire and results documented in millimeters (MM) of induration (hardening). Findings include: Maintenance staff (MS)-A was hired on 12/27/21. Initial screening form completed on 12/15/21, indicated no signs or symptoms of TB and no history of TB. No documentation was given indicating step one or step 2 TST was administered or documented. Registered nurse (RN)- H was hired on 12/27/21. Initial screening completed on 12/28/21, indicated no sign or symptoms of TB and no history of TB. No documentation was given indicating step one or step 2 TST was administered or documented. Nurse assistant (NA)-J was hired on 1/17/22. No documentation of initial screening or two step TST results were provided. Nurse assistant (NA)-I was hired on 1/30/22. No documentation of initial screening or two step TST results were provided. Health Unit Clerk (HUC)-A was hired on 2/9/22. No documentation of initial screening or two step TST results were provided. Housekeeper (HK)-B was hired on 3/1/22. No documentation of initial screening or two step TST results were provided. RN-G stated during interview on 3/25/22, at 8:33 a.m., that the two staff screening forms presented were all that could be found. RN-G stated the	21426		

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21426	Continued From page 21 infection preventionist (IP) did not have a way of tracking to verify if the screening or TST's were done and when, or if, staff were up-to-date on new hire TST's. Executive director (ED) stated during interview on 3/25/22, at 8:52 a.m., the reason only two screening forms were presented was because the others were not done. The facility policy Tuberculosis, Employee screening dated 10/4/21, indicated all employees would be screened for latent tuberculosis infection (LTBI) and active tuberculosis (TB) disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment. The facility policy Tuberculosis-Administration and Interpretation of the Tuberculin Skin Test (TST) dated 10/4/21, indicated that after initial TST was administered and read, unless otherwise indicated, to give a second PPD one to two weeks after the initial TST for individuals with less than 10 mm of induration documented on first. Suggested method of correction: The director of nursing or designee could review and update systems for employee tuberculosis screenings. The director of nursing or designee could educate all appropriate staff. The director of nursing or designee could monitor to ensure ongoing compliance with tuberculosis policy and procedures. Time period for correction: 21 days	21426		

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21535	Continued From page 22	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: (R45) reviewed for unnecessary medications. Finding include: R19's Admission Record printed 3/24/22, indicated R19's diagnoses included dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder, major depressive disorder, and cognitive communication deficit.	21535	Corrected	5/10/22

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21535	Continued From page 23	21535		

R19's annual Minimum Data Set (MDS) dated 12/27/21, indicated R19 was severely cognitively impaired, had no behaviors, and had taken antipsychotic medications each of the seven days of the assessment period and had taken antidepressant medications each of the five days of the assessment period.

R19's Care Area Assessment (CAA) dated 12/27/21, noted R19 had confusion, disorientation, and forgetfulness, and decreased ability to make himself understood. The CAA noted consultant pharmacist (CP) review of medication regimen would be helpful. The CAA further indicated R19 took antidepressant and antipsychotic medications.

R19's care plan revised 1/18/21, directed staff to educate resident and family on risk, benefits, and side effects of antidepressant, antipsychotic, and antianxiety medications and to monitor for paradoxical side effects related to antianxiety medications. R19's care plan further directed staff to consult with pharmacy and physician on when to consider a dosage reduction.

R19's Order Summary Report printed 3/24/22, identified orders for hydroxyzine HCl (antihistamine used to treat anxiety) 25 milligrams (mg) two times daily related to anxiety; quetiapine (antipsychotic) 50 mg twice daily related to dementia and 50 mg at bedtime for depression and anxiety.

The facility was unable to provide monthly medication reviews for R19 for October, September, August, July, June, and May of 2021.

R20's Admission Record printed 3/24/22, indicated R20's diagnoses included depression,

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21535	Continued From page 24 post traumatic stress disorder, fibromyalgia (widespread muscle pain and tenderness), and anxiety. R20's quarterly MDS dated 1/4/22, identified R20 as cognitively intact, had no behaviors or rejection of care, and had taken antianxiety and antidepressants each of the seven days of the assessment period. R20's MDS also indicated she had depression. R20's CAA dated 10/5/21, noted R20 was taking opioids, antidepressants, psychoactive, sedative hypnotics, and antianxiety medications, and had a mood decline. The CAA indicated R20 had depression, anxiety disorder, and pain diagnoses. R20's care plan revised 10/6/21, directed staff to monitor for side effects of pain medications, mood and behavior, complaints of pain, and non-pharmacological interventions to relieve pain. In addition staff were directed to educate resident and family on risk, benefits, and side effects of antianxiety and antidepressant medication, to monitor, document and report side effects and paradoxical side effects of antianxiety medication. The care plan did not address quarterly review of medications and potential gradual dose reductions. R20's Order Summary Report printed 3/24/22, identified orders for buspirone HCl (anxiolytic used to treat depression)15 mg three times a day related to post-traumatic stress disorder; gabapentin (nerve pain medication) 300 mg two times daily related to fibromyalgia; Lexapro (selective serotonin reuptake inhibitor [SSRI]) 10 mg one time daily related to major depression; meclizine HCl (antihistamine used to treat dizziness) 25 mg three times daily related to	21535		

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21535	Continued From page 25 dizziness; Percocet (narcotic used to treat severe pain) 5-325 mg one tablet daily for pain and two tablets at bedtime for pain. The facility was unable to provide monthly medication reviews for R20 for August, July, June, or May of 2021. R45's Admission Record printed 3/24/22, indicated diagnoses that included schizoaffective disorder, anxiety disorder, insomnia, suicidal ideations, developmental disorders of scholastic skills, and major depression. R45's quarterly MDS dated 1/30/22, indicated R45 was cognitively intact and was taking antidepressants, antianxiety, and antipsychotic medications each of the seven days of the assessment period. The MDS also indicated R20 had mild depression symptoms and did not have behaviors or reject cares. R45's Care Area Assessment (CAA) dated 11/5/21, noted R45 was taking antipsychotics, antidepressant, sedative hypnotic, antianxiety medications. R45's CAA indicated she had depression, anxiety, cognitive impairment, and schizophrenia. R45's care plan revised 1/14/22, directed staff to monitor for side effects of psychoactive medications, perform an abnormal involuntary movement scale (AIMS) quarterly and as needed. Monitor, record, report any risk to harm self. R45's Order Summary Report printed 3/24/22, identified orders for clonazepam (sedative used to treat anxiety) 0.5 mg three times a day for anxiety/poor sleep/ chronic pain; fluoxitine HCl (SSRI) 40 mg one time daily for depression;	21535		

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21535	Continued From page 26 Risperdal (antipsychotic) three mg at bedtime related to paranoid schizophrenia; quetiapine (antipsychotic) 100 mg daily at bedtime for paranoid schizophrenia; Trazodone (antidepressant and sedative) 50 mg at bedtime for sleep. A Consultant Pharmacist Communication to the Physician note dated 9/9/21,and 10/20/21, requested the physician to consider monitoring for dizziness and drowsiness related to clonazepam, quetiapine, and risperidone to reduce the future risk of falls. There was no documented response to the requests. On 3/24/22, at 3:17 p.m. and 4:12 p.m. the director of nursing (DON) stated it was her expectation that monthly medication reviews (MMRs) would be conducted monthly. The DON stated she could not explain why the MMRs were not completed. The DON stated if the communication between the pharmacist and the physician was not signed then the physician did not respond and there was not any follow up to the recommendations. The DON verified orthostatic blood pressures should have been intiated after R45's fall related to her medication regimine. On 3/24/22, at 4:28 p.m the consultant pharmacist (CP) stated it was her expectation that recommendations would be addressed within 60 days, if it was not addressed after 60 days she would take it to the medical director. The CP stated she has only been employed at the facility for the past month so was unable to speak to the missed MMRs and recommendations not being followed up. The facility policy titled Psychotropic Medications	21535		

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21535	Continued From page 27 dated 4/16/21, directed the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications. This would include regular review for continued need, appropriate dosage, side effects, risk and/or benefits. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist monthly medication reviews were completed monthly and the recommendations addressed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
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 interview and document review the facility failed to ensure staff were not using personal cell phones in patient care areas during	21805	Corrected	5/10/22

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21805	Continued From page 28 cares for 3 of 5 residents (R14, R49, R21, R25) reviewed. Findings include: R14 R14's significant change Minimum Data Set (MDS) dated 12/14/21, indicated R14 was cognitively intact. R14's diagnoses included schizophrenia, anxiety, epilepsy and diabetes mellitus. R14's MDS indicated R14 required assistance with activities of daily living (ADL's) including transfers, toileting, locomotion, dressing and personal hygiene. R49's significant change MDS dated 2/1/22, indicated R49 was cognitively intact. R49's diagnoses included cerebral palsy, quadriplegia, muscle spasms and diabetes mellitus. The assessment identified R49 required extensive assist of two staff with ADL's including transfers, toileting, dressing and personal hygiene. During interview on 3/23/22, at 9:40 a.m. R49 stated on the evening of 3/22/22, he was sitting in the dining room along with R14 and two staff members. R49 heard R14 call out for assistance and observed the two staff looking at their cell phones and not helping R14. R14 called out for assistance four times and the two nurses continued to look at their phones. R49 stated he yelled out to the staff, they looked up from their phones and finally helped R14. R49 stated the staff did not move until after he asked someone to help R14. The staff were looking at their phones and not paying attention to the residents in the dining room. During interview on 3/23/22, at 11:40 a.m. R14 stated there had been times when staff were	21805		

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21805	Continued From page 29	21805		

getting her ready for bed, their cell phones rang, they stopped helping her and they talked on their phones. R14 was unable to give a specifric date. R14 stated it bothered her when her care was interrupted by staff talking on their cell phone and felt like staff didn't care about her.

R21
R21's quarterly MDS dated1/5/22, indicated R21 was cognitively intact and diagnoses included spina bifida, tracheostomy, and paraplegia. R21's MDS indicated R21 required assistance with ADL's including transfers, toileting and personal hygiene.

During interview on 3/23/22, at 1:39 p.m. R21 stated the evening shift staff were observed on their personal cell phones while they were supposed to be working with residents. On an unidentified date, staff were in the middle of helping R21 and their cell phone rang. Staff stopped the care they provided, answered and then started talking on their personal cell phone while in R21's room. R21 stated he was bothered when staff answered their personal cell phone when they were supposed to be helping him and he felt like staff were too busy to help him.

R25
R25's quarterly MDS indicated R25 was cognitively intact and had diagnoses including spastic quadriplegia and multiple sclerosis. R25's MDS indicated R25 required assistance with ADL's including transfers, toileting, personal hygiene and bathing.

During interview on 3/23/22, at 12:12 p.m. R25 stated the evening of 3/22/22, staff had been in her room to help her get ready for bed. When the

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21805	Continued From page 30 staff were assisting her, their cell phone rang, her care was stopped and the staff answered their cell phone. R25 stated this had happened in the past, had happened quite often, and had always been on the evening (2 p.m.-10 p.m.) shift. R25 stated it bothered her when staff answered their phone when they were assisting her. During interview on 3/23/22, at 12:04 p.m. nursing assistant (NA)-A stated staff were told not to use their personal cell phones while working. NA-A had noticed that staff cell phone use had been pretty excessive and had not been enforced on evening shift. NA-A stated she had seen staff using their personal cell phones while working on the evening shift. During interview on 3/23/22, at 1:45 p.m. NA-D stated there is a policy regarding personal cell phone use and staff were not supposed to use personal cell phones while at work unless they are on a break. During interview on 3/23/22, at1:55 p.m. registered nurse (RN)-B stated staff were not supposed to use their personal cell phones during working hours. During interview on 3/23/22, at 2:16 p.m. RN-C stated she thought there was a policy directing staff not to use their personal cell phones while at work. Staff were encouraged not to use their cell phones in resident rooms or in front of the residents. During interview on 3/23/22, at 2:31 p.m. NA-H stated staff were not supposed to use cell phones during working hours. Staff had signed an agreement indicating they read and understood	21805		

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21805	Continued From page 31 the policy directing not to use personal cell phones at work. During interview on 3/23/22, at 2:34 p.m. RN-D stated staff were to keep their personal cell phone put away unless used for urgent/emergency use. During interview on 3/24/22, at 3:16 p.m. the administrator admin stated the facility had a policy in place regarding employee cell phone use. If there were a concern of staff using a personal cell phone the facility would investigate the concern and follow the disciplinary process. During interview on 3/24/22, at 3:35 p.m. the director of nursing (DON) stated staff were not supposed to use personal cell phones during working hours unless they were on a break. It had been brought to her attention that staff had been using cell phones on the floor. The nursing managers had talked to the staff to correct the concern. Had not conducted audits to determine if staff had been using their cell phones since the concern had been brought forward. Review of the Employee Use of Personal Electronic Devices reviewed/revised 11/5/20, indicated the use of personal cell phones while on duty was prohibited for all employees and were not permitted for use in any employee work areas. The policy further identified the use of cell phone was not permitted in resident areas or in the presence of residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff were not using personal cell phones in patient care areas during cares.	21805		

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21805	Continued From page 32 The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure attempts to form a family council were conducted. This had the potential to affect all 89 residents who resided in the facility. Findings include: On 3/22/22, at 3:03 p.m. the activities director (AD) stated the family council had not met since 10/17/19, and the facility had not made attempts	21942	Corrected	5/10/22

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21942	Continued From page 33 to schedule a family council meeting since 3/20/20. Facility attempts to form a family council meeting since 3/20/20 were requested and were not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure attempts were made annually to establish a family council. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		