



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: March 4, 2025

Dear Administrator:

On March 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

The Shores Of Worthington

March 14, 2025

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 22, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: March 4, 2025

Dear Administrator:

On March 14, 2025, we informed you that we may impose enforcement remedies.

On April 8, 2025, the Minnesota Department(s) of Health and Public Safety completed a revisit 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.

The deficiency(ies) not corrected is/are as follows:

- F636 - Comprehensive Assessments & Timing
- F656 - Develop/implement Comprehensive Care Plan
- F684 - Quality of Care
- F758 - Free from Unnec Psychotropic Meds/prn use
- F812 - Food Procurement, store/prepare/serve-Sanitary
- F842 - Resident Records - Identifiable Information
- F865 - QapiPrgm/plan, Disclosure/good faith attmpt
- F880 - Infection Prevention & Control
- F882 - Infection Preventionist Qualifications/role
- F844 - Qapi Training
- K271 - Discharge From Exits

In addition, at the time of this revisit, we identified the following deficiency(ies):

- F837 - Governing Body

REMEDIES

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

- Mandatory Denial of Payment for new Medicare 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 4, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, 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 4, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Shores Of Worthington will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2025. 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.
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- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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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 4, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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The Shores Of Worthington

April 22, 2025

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Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 03/31/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2025
NAME OF PROVIDER OR SUPPLIER THE SHORES OF WORTHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187		
(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 2/24/25 through 3/04/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, 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 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk	E 006			4/3/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2025

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

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

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NAME OF PROVIDER OR SUPPLIER THE SHORES OF WORTHINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187			
(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 006	Continued From page 1 assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:			E 006			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2025
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E 006	Continued From page 2 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain an emergency preparedness plan (EP) was reviewed and updated at least annually. This deficient practice had the potential to affect all 57 residents who currently resided in the facility. Findings include: Review of the 2/21/22, EP disaster plan lacked evidence of review and update at least annually. The EP disaster plan further lacked review or revision as the plan was not individualized and identified in its documents as portions being from another nursing facility (Slayton Rehabilitation and Healthcare Center) that had closed its doors a few years ago. Interview on 3/4/25 at 10:45 a.m., with the administrator identified he was unaware of the EP not being individualized or reviewed.	E 006	Immediate Corrective Action: Outdated documents in the emergency preparedness book were removed. Review paperwork was placed in the front of the book to more accurately convey dates of review. Corrective Action as it applies to others: Administrator was educated on the need to maintain an up to date and individualized emergency preparedness plan. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that Emergency Preparedness book is individualized. Corrections will be monitored by: Administrator		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)	E 018			4/3/25

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E 018	Continued From page 3 §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018			

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E 018	Continued From page 4 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by:			E 018			

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E 018	Continued From page 5 Based on interview and document review, the facility failed to include and identify in their emergency preparedness plan (EP), a way to track staff or volunteers during an emergency. This had the potential to affect all 57 residents served by the facility, as well as staff, visitors and volunteers. Findings include: The facility's October 2024, EP was reviewed. The plan included a system/form to track clients during a facility evacuation. However, the plan lacked direction, policies, or procedures, to track locations of on-duty staff or volunteers during an emergency. Interview on 3/4/25 at 10:40 a.m., with the administrator confirmed he did not have a procedure for tracking on-duty staff or volunteers during and emergency.	E 018	Immediate Corrective Action: Forms were added to the Emergency Preparedness book to indicate how the facility will track on-duty staff or volunteers in the event of an emergency. Corrective Action as it applies to others: Administrator was educated on the need to ensure that the facility maintains a plan for tracking on-duty staff or volunteers in the event of an emergency. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure the Emergency Preparedness book maintains a plan for tracking on-duty staff or volunteers in the event of an emergency. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Corrections will be monitored by: Administrator		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).	E 024			4/3/25

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E 024	Continued From page 6 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness plan (EP) addressed the use of volunteers in an emergency. This had the			E 024	Immediate Corrective Action: Forms were added to the Emergency Preparedness book to indicate how the facility will utilize volunteers in the event of		

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E 024	Continued From page 7 potential to affect all 57 residents who resided in the facility. Findings include: Review of the October 2024, facility EP the facility lacked a policy or procedure for the use of volunteers in an emergency.. Interview on 3/4/25 at 10:45 a.m., with administrator agreed that the facility lacked a policy or procedure for the use of volunteers in an emergency.	E 024	an emergency. Corrective Action as it applies to others: Administrator was educated on the need to ensure that the facility maintains a plan for utilizing volunteers in the event of an emergency. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure the Emergency Preparedness book maintains a plan for utilizing volunteers in the event of an emergency. Corrections will be monitored by: Administrator		
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 034			4/3/25

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E 034	Continued From page 8 and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness communication plan included a means of providing information about the facility's occupancy needs and it's ability to provide assistance to the authority having jurisdiction, the incident command center, or designee. Findings include: Review of the October 2024, emergency preparedness plan (EP) identified that the communication plan did not include a means of	E 034	Immediate Corrective Action: Forms were added to the Emergency Preparedness book Communication Plan to indicate how the facility will communicate with the authority having jurisdiction in regards to facility occupancy and the ability to provide assistance in an emergency. Corrective Action as it applies to others: Administrator was educated on the need to ensure that the facility Communication Plan includes information regarding how		

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E 034	Continued From page 9 providing information about the facilities occupancy needs and it's ability to provide assistance to the authority having jurisdiction. Interview on 3/4/25 at 10:45 a.m., with the administrator agreed that the EP did not identify how the facility would communicate with the authority having jurisdiction or the designee for the facility occupancy needs and ability to provide assistance during an emergency.	E 034	the facility will communicate occupancy and ability to provide assistance to officials with jurisdiction in the event of an emergency elsewhere. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure the Emergency Preparedness book Communicate Plan includes a plan for communicating occupancy and needs to authorities with jurisdiction. Corrections will be monitored by: Administrator		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039			4/3/25

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E 039	Continued From page 10 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039			

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E 039	Continued From page 11 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039			

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E 039	Continued From page 12 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that	E 039			

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E 039	Continued From page 13 requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community	E 039			

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E 039	Continued From page 14 based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next	E 039			

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E 039	Continued From page 15 required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039			

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E 039	Continued From page 16 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039			

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

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E 039	Continued From page 17 community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct	E 039			

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E 039	Continued From page 18 exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to analyzed the facility's response and complete an after action report for their facility event when they tested their emergency preparedness plan and their tabletop exercise. This had the potential to affect all 57 residents residing in the facility, along with staff who work in the facility. Findings include: Review of the 5/12/24, tabletop exercise for Tornado included the facility's department signatures. The after action report provided identified a date of 5/12/23 which had been crossed off and changed to 5/12/24. The report identified the administrators responsibilities, provisions of evacuation which included making arrangements with the Minneapolis EMS to provide need for an extra bariatric ambulance for one resident. Additionally, the report identified there would be communication with Le Center PD, FD, EMS services as well as Le Seuer County Emergency Management and Le Seuer	E 039	Immediate Corrective Action: Appropriate documentation in regards to Tabletop exercise was found and audited to ensure compliance. Forms were added to the Emergency Preparedness book to include participants in events, and after action report follow up information. Corrective Action as it applies to others: Administrator was educated on the need to ensure that the facility is recording participants and including after-action reports after live events. Audits will be given to the Executive Director, and the Executive Director will take the audit results to QAPI for review and recommendation. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure the Emergency		

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E 039	Continued From page 19 County Sheriff's office however, The Shores of Worthington resides in Nobles county. Action plan for tabletop scenario 2, where the evacuation was due to a wildfire, the documented discussion included to evacuate outside of Le Center and activate the disaster agreements with New Prague Hospital. The after action documentation lacked information related to The Shores of Worthington. LeSeuer County is roughly 121 miles away from the facility. There was no indication the facility would utilize sources closer to their facility. Review of the 2/15/24, facility event when the fire alarm system sounded. Staff executed their roles and searched for the fire. Residents were removed from the wing in question while facility attempted to ascertain why the fire alarm was sounding. There was no identification of who participated in the event and no after action report that identified what was supposed to happen, what actually occurred, what went well, or what the facility could improve on and a plan to incorporate any improvement. Review of the 1/13/25, facility event when the fire alarm system sounded. Staff executed their roles and searched for the fire. It was identified to be a toaster that on D wing that caused the alarm system to sound. The toaster was removed and alarm system was deactivated. No residents needed to be removed from the wing. There was no identification of who participated in the event and no after action report that identified what was supposed to happen, what actually occurred, what went well, or what the facility could improve on and a plan to incorporate any improvement.	E 039	Preparedness book includes forms to track participants in events and after action report follow up information so that live events at the facility can be documented in accordance with emergency testing regulations and requirements. Corrections will be monitored by: Administrator		
F 000	INITIAL COMMENTS	F 000			

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F 000	Continued From page 20 On 2/24/25 through 3/04/25 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55968545C (MN103452), H55968546C (MN102261), and H55968842C (MN111103). 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 substantial compliance with the regulations has been attained.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578			4/3/25

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F 578	Continued From page 21 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician signed a Provider Order for Life-Sustaining Treatment (POLST) order for 1 of 15 residents (R37) following admission. Findings include: R37's 1/15/25, admission Minimum Data Set	F 578	R 37 s POLST was signed on 2/27/2025. All current residents POLSTs were reviewed and updated as needed. Upon admission, the social service designee will inquire about the resident s choice for advanced directives, and if initiated, the form will be faxed to the physician s office for signature.		

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F 578	Continued From page 22 (MDS) identified R37 was cognitively alert and required substantial/maximal assistance with activities of daily living (ADLs). R37 had a diagnoses of malnutrition, anxiety, diabetes and cirrhosis. R37's 1/08/25 POLST, identified R37 was to be full code. There was no mention on the consent R37's wishes were communicated to the primary physician and was not signed within 30 days of admisson on rounds. Interview on 2/26/25 at 8:40 a.m., with Registered nurse (RN)-B identified residents POLST would be obtained during admissions with social service department and was to be signed by the primary physician and was to be updated on the resident medical record to ensure it matched admission orders and the resident had not changed or wished to change their status upon admission. Interview on 2/26/25 at 8:46 a.m., with director of nursing (DON) identified her expectation of POLST choices were to be addressed and documented when a resident was admitted to the facility by the physician. She voiced agreement that facility had failed to follow their policy, and the signed document had not been completed since R37's admission to the facility. Interview on 2/27/25 and 2:40 p.m., with admission coordinator identified R37's POLST had not been completed and was missed during admission. She identified it was not an acceptable practice for a R37 to not have a POLST in her medical record and was not aware R37's POLST was not signed by the physician on admission.	F 578	Social services and licensed nurses will be in-serviced on the Medication and Treatment Order policy with emphasis on item #8 that orders must be signed by the prescriber at his or her next visit and on the POLST form which indicates verbal orders are acceptable with follow up signature by the physician/NP/PA. Social Service Designee is responsible for compliance. Audits on POLST signatures obtained via verbal order and signature will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 578	Continued From page 23 Interview on 3/04/25 at 8:15 a.m., with medical director would expect residents code status to be determined and confirmed upon admission. Review of the October 2022 Advance Directive Policy identified the facility would obtain resident status on the POLST upon admission. The director of nursing or designee would notify the provider of advance directives or changes to the advance directive so that appropriate orders would be documented on a residents' medical record and plan of care. The facility would place residents advance directive document in an accessible location in the medical record.	F 578			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636			4/3/25

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F 636	Continued From page 24 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the			F 636			
					R 41 s 11/24/2024 quarterly assessment		

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F 636	Continued From page 25 facility failed to ensure 1 of 1 resident (R41) was accurately and comprehensively assessed when R41 exhibited behaviors or refusal of all cares, medication, treatment and evaluation. Findings include: Review of the Resident Assessment Instrument (RAI) 3.0 manual identified The RAI process has multiple regulatory requirements. Federal regulations require the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. In addition, an accurate assessment requires collecting information from multiple sources. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the interdisciplinary team (IDT) completing the assessment. R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid	F 636	will be modified to correctly answer several sections of the MDS. R 41 MD will be made aware of the long-standing non-compliance of this resident and the MD response will be recorded in the resident record. An OHFC self-neglect will be initiated, and the facility will seek guardianship and/or admission into a psych hospital for stabilization. R 41 care plan will be reviewed and updated as needed. All current residents who are resistive to care and treatment, their MDSs, Assessments, Care Plan, family and MD will be made aware, and the resident s chart will be reviewed and updated as needed. Future residents who are admitted to the facility and have refusals of care and/or change in condition, the MD will be notified for further direction. The MDS Coordinator will be in-serviced on the MDS coordinator job description focusing on the duties that include evaluating each resident s condition and revising and/or amending the plan of care and penalties for false certification. The Director of Nursing is responsible for compliance. Audits on notification of changes in condition and documented resident refusals with MD notification will begin weekly x 1 week for 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 636	Continued From page 26 hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. The MDS identified in section: 1) C: R41 was reported to answer cognitive questions to identify his mental status. 2) D: in the field D0100 Should Resident Mood Interview be Conducted the answer was checked "yes" however; no responses were given. D0500: Staff assessment of Resident Mood was blank. D0700: Social isolation was marked "never". 3) E: Behavior: E0100 identified R41 had delusions. No behaviors were noted for physical, Verbal, or Other. Rejection of care was noted to only occur 1 to 3 days during the look-back period. E1100: Change in Behavior or Other Symptoms was left blank when asked how the residents current behavior status, care rejection, or wandering compared to his prior assessment. 4) F: Preferences for Customary Routine and Activities was not filled out. 5) H: Bladder and Bowel: H0300 identified R41 was occasionally incontinent. 6) J: Health Conditions: J0200 Should Pain Assessment Interview be Conducted? Answer is "yes". J0300 Pain Assessment Interview/Pain Presence: "Unable to answer" was checked. J0800: Indicators of Pain or Possible Pain in the last 5 days: "None of these signs observed or documented". 7) K: Swallowing/Nutritional Status: K0100 Swallowing Disorder/Signs and symptoms of	F 636			

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F 636	Continued From page 27 possible swallowing disorder is related to observations of swallowing or reports of complaints of swallowing: "None of the above" was marked. K0200 Weight was documented as 191 pounds (lbs.). K0300 and K0310 mention weight loss and gain. Both are marked "no or unknown". 8) L0200: oral/Dental Status: L0200 describes visualization of the mouth. No questions were answered. 9) M: Skin Conditions: M0100 Determination of Pressure Ulcer Risk: identified a formal assessment instrument or tool such as a Braeden score and clinical assessment were checked as completed. M150 identified R41 was at risk for pressure ulcers. M0210: Unhealed pressure ulcers: Does the resident have 1 or more unhealed pressure ulcers at Stage 1 or higher? Answer was marked "no". 10) P: Restraints: P0200 Alarms: subsection E: Wander/elopement alarm was marked with a "2" and noted to be "used daily". Notes associated with the 2/25/25, MDS assessment in progress identified on 2/19/25, R41's: 1) Fall risk was evaluated. Staff documented he had no falls in the past 3 months. R41 was noted to have intermittent confusion. R41 was ambulatory and continent of bowel and bladder. Systolic blood pressure noted there was no drop between lying and standing. R41 was listed as having adequate vision and reportedly had no change of condition in the last 14 days. R41 had no hospitalizations in the last 30 days. His gait/balance was recorded as normal. R41 was noted to have taken 1-2 medications currently or within the last 7 days and had a fall score of 6. 2) Lift/Transfer Evaluation portion was completed.	F 636			

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F 636	Continued From page 28 R41 was noted to be independent for cares and dressing. He was noted to not leave his room or have any locomotion on or off the unit. There was no indication how staff determined he was able to carry out tasks independently and/or safely. 3) Abnormal Involuntary Movement Scale (AIMS) (used to determine ill effects of anti-psychotic medications) identified R41 was noted to have no concerns with muscles of facial expression, no symptoms or effects affecting the peri-oral area (areas around the mouth), no abnormal movements of his tongue, and no abnormal movements with his upper or lower extremities. It is unknown how the facility had determined supporting facts for the assessment, since R1 had no vitals taken since admission or shortly thereafter, or how staff could determine he remained continent or had adequate vision without performing an assessment due to R41's numerous documented refusals. 4) Elopement evaluation was documented. R41 had a history of wandering at home and had no wandering in the facility noted. Notes associated with the 2/25/25, MDS in progress identified on 2/20/25, R41's: 1) Brief Interview for Mental Status (BIMS) was performed. Staff noted :Resident was unable to complete the interview and refused to answer questions. He "Sits shaking his head "no"". 2) PHQ-9 score was evaluated. R41 was noted to answer "No" or had no response at all. 3) Social Services quarterly psychosocial quarterly note identified R41 continued to reside in a private room in the facility due to behaviors. Continues to refuse to communicate with staff. States "You leave" when approached to talk. Refuses most cares and medication. He refused his COVID screening and was placed on	F 636			

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F 636	Continued From page 29 isolation, however staff noted he did not leave his room. FM-A calls often and states "there isn't anything you can do to change his behavior". The social worker noted he was "uncooperative with all assessments". He continued to talk about "My father". Staff were unable to determine if the comment was related to religion or was part of a delusion. Notes associated with the 2/25/25, MDS in progress identified on 2/23/25, a Restorative Nursing Screener/GG Evaluation note was made. His ambulation was noted to not be able to be assessed. His self-care portion identified staff noted R41 was independent with eating, toileting, showering or bathing, and personal hygiene, but also identified R41 had refused the assessment. Notes associated with the 2/25/25, MDS in progress identified on 2/25/25, R41's OBRA Interim note was documented. Staff noted his functional limitations and range of motion (ROM) assessment identified he had no impairment. His Mobility and Ambulation portions in the note were documented as "Not attempted". R41's Long Term Care Evaluation progress note (documented by the MDS nurse (RN-E)), identified the reason for the evaluation was a quarterly MDS assessment that was currently in progress. RN-E documented no falls since his last assessment occurred and no skin changes occurred. Vitals were listed as blood pressure (BP) 168/101 millimeters of mercury (mm/hg) obtained on 2/25/25 at 5:38 p.m. while R41 was seated, using his left arm. His oxygen saturation level (SpO2) was listed at 93% on room air. A vitals note was made "Resident refused assessment. Vitals are from admission. I had to put something to close the assessment".	F 636			

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F 636	Continued From page 30 R41's progress notes identified in September 2024, on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating "my father , my father, my father takes care of me. My father tells me what to do and he says no touch". R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because "God told him to". Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would "need to go to behavioral health again". The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health.." R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. Further review of R41's progress notes identified staff documented numerous refusals of all cares or assessment. R41's September 2024 through February 2025 vital signs report identified vitals were obtained on 9/9/24. Of those vitals, R41 had 1 weight measurement on 9/9/24 of 191 lbs. No other	F 636			

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F 636	Continued From page 31 weights were documented as obtained. R41 BP on 9/9/24 was listed at 168/101 mm/hg and his oxygen saturation (SpO2) was documented as 93%. On 2/25/25, the same date as the MDS note listed above, R41's BP and SpO2 readings were documented as the exact same as September 2024. No other vitals were obtained for R41 throughout his stay from September 2024 through March 2025. R41's bathing history was reviewed for the previous 30 days prior to the survey. At no time during February was R41 bathed. R41's assessment data history from September 2024 through March 2025 was obtained. R41 had only 3 assessments noted as completed. Those assessments were a Braedon pressure ulcer risk assessment. One upon admission, one at R41's 11/21/24 quarterly assessment, and then R41's currently in progress 2/19/25, MDS assessment. No other assessments were documented for R41 from September 2024 through March 2025. R41's personal hygiene task for the last 30 days prior to survey was viewed. R41 was noted by staff to be completely independent with personal hygiene. It is unclear how staff determined this to be accurate and true. R41's behavior history task, documented by staff identified staff had checked R41 exhibited no behaviors of any kind. R41's March 2025. Medication and Treatment records (MAR/TAR) identified R41 had not received medications or treatments. Corresponding progress notes made by nursing staff in the medical record identified R41 refused	F 636			

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F 636	Continued From page 32 all medications and cares. Interview on 3/03/25 at 11:28 a.m., with laundry aide (LA)-A identified LA-A had never washed any clothing for R41. She has never done R41's laundry since his admission. She assumed maybe his family washed his clothing. Observation on 3/3/25 at 11:30 a.m., of R41's room identified his door was open partially. R41 was observed to be standing in his room. Staff attempted to speak from the door. R41 waived his arm at staff to leave. No direct observations of R41 were able to be obtained. Interview on 3/03/25 at 11:35 a.m., with RN-E related to R41 identified RN-E stated R41 "refuses everything". When R41 was first admitted to the facility he would take his medication. Soon after he began refusing treatment or allowing staff into his room. R41 would tell staff god tells him he can't take his medication or that he doesn't need them. "Some staff may be able to enter his room, but it is rare... it depends on the nurse aide. R41 always says "get out!". Facility staff have spoken to FM-A and the MD. "Essentially he isn't a risk for harm to himself or others" He refuses medications that include antipsychotics. Staff are "At a point with him...he is good living here... [staff] offer everything". When asked how RN-E or others assisting with the MDS assessments were able to perform assessments such as skin, she stated "Staff cannot do skin assessments". She turns in MDS data based on what is "able to be captured". Through the facility electronic program, designed to submit information to the Centers for Medicare and Medicaid (CMS) for payment, RN-E noted she "had to put something in" to the vitals section,	F 636			

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F 636	Continued From page 33 or it would not allow her to close it within their system. RN-E stated her assessment data was based off what staff told her about R41, however did note that staff are not able to physically assess or often speak to R41 as he refuses staff entry most all days into his room when they try to either speak to him or provide any care at all, except to deliver meals. R41 allows that. RN-E agreed she is signing the MDS assessments to be accurate and true and acknowledged she is unable to accurately perform a comprehensive assessment on R41 and enters data in, so submissions are made. Interview on 3/03/25 at 4:26 p.m., with RN-A identified she was familiar with R41 and had even cared for him at the sister facility before it closed. RN-A stated R41 "refuses everything". There are very limited staff who can interact with R41. He strikes out, kicks, and has verbal behaviors. R41 will not leave his room. She thinks R41 is continent or bowel and bladder, but acknowledged without being able to assess R41, there would be no way to know. Staff provide no cares or treatments for R41. RN-A was unaware if he even allowed linens to be changed on his bed or his clothing washed. RN-A had not seen R41's skin since he was administered Haldol in September 2024. RN-A was unaware staff were documenting R41 as having no behaviors, however, she related that to not being allowed to enter R41's room or provide any cares. RN-A recalled she has been unable to perform any assessments, give medication, or provide cares to R41 since September 2024. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified RN-E is responsible for MDS data collection and	F 636			

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F 636	Continued From page 34 assessment. She was aware R41 refused all cares, assessments, or treatments. When asked how staff can accurately and comprehensively assess R41, she noted they cannot. Interview on 3/4/25 at 8:16 a.m., with the medical director (MD)-A identified he was unaware of R41's refusal of all cares. He would expect to be notified as he agreed R41 isn't capable of making an informed decision related to his health and safety. He was unaware R41 received no skilled nursing care, had only 2 baths, refused all meds, and had no laundry done. He was also unaware staff were unable to comprehensively assess R41. He agreed the assessment data included on the MDS would be false if staff could not actually assess R41. Review of the 2001, MDS/RAI Coordinator job description identified the purpose of that position is to conduct and coordinate the development and completion of resident assessment in accordance with the requirements of the state and the policies and goals of the facility. Part of the duties included to evaluate each resident's condition and pertinent medical data to determine the need for special assessment activities or the need to revise or amend the plan of care and to ensure all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions and be aware of penalties including civil money penalties for false certification.	F 636			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641			4/3/25

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F 641	Continued From page 35 resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately and thoroughly assess 1 of 1 resident (R40) for a history of trauma related to a diagnosis of Post-Traumatic Stress Syndrome (PTSD). Findings include: R40's 1/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she felt down, depressed or hopeless 2-6 days a week, and she displayed verbal behaviors directed towards others such as screaming, threatening, or cursing 1-3 days a week. R40 had a diagnosis of PTSD, anxiety, and a psychotic disorder. She was dependent on staff for all activities of daily living (ADL's). R40's 9/11/24, PTSD Resident Screening assessment identified the first question was: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide. R40 answered "no". The facility assessment indicated if the answer is no, the assessor should stop there and not ask any of the additional questions. There was no indication the facility reached out to the emergency contact or family to try and identify the cause of the PTSD so the facility could be made aware potentially of any potential triggers and plan for that.	F 641	R 40 s 1/4/2025 quarterly assessment will be modified to correctly answer several sections of the MDS. R 40 s MD will be made aware of the residents behaviors and the resident representative along with the mental health facility will be contacted for further information on the PTSD diagnosis. R 40 s care plan for mood and behavior will be reviewed and updated as needed. All current residents who have a diagnosis of PTSD, their care their MDSs, Assessments, Care Plan, will be reviewed and updated as needed. Future residents who are admitted to the facility and have PTSD, the hospital record will be obtained of care and/or change in condition, the MD will be notified for further direction. The IDT team will be in-serviced on Section Z of the MDS which explains that those members who signed the MDS are attesting to the accuracy of the assessment. The Director of Nursing is responsible for compliance. Audits on MDS verification for accuracy before MDS submission will begin weekly x 1 week for 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 641	Continued From page 36 Review of R40's care plan identified she becomes both physically and verbally aggressive during bathing and staff should administer medications as prescribed, encourage resident to verbalize cause of aggression, utilize diversion techniques, and allow personal space. The care plan made no mention that R40 had a history of an unknown traumatic event leading to a diagnosis of PTSD. Interview on 2/27/25, at 2:24 p.m., with social service designee (SSD)-B identified that she completed the trauma assessment with R40, she reported they had several challenges while transferring more than 30 residents into their facility from their sister facility that had closed. She could not recall specifically if she had reached out to the staff from the previous facility or to the family for information regarding R40's diagnosis of PTSD. She agreed they did not include anything on the care plan and was unable to find any documentation of anything that had been done to assess for triggers or appropriate care related to the diagnosis of PTSD. A policy was requested; however, none was provided by the end of the survey period.	F 641			
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F 642			4/3/25

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F 642	Continued From page 37 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R41) was accurately and comprehensively assessed as certified when it was R41 exhibited behaviors and refusal of all cares, medication, treatment and evaluation. Findings include: Review of the Resident Assessment Instrument (RAI) 3.0 manual identified The RAI process has multiple regulatory requirements. Federal regulations require the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as	F 642	R 41 2/25/2025 quarterly assessment will be modified to correctly answer several sections of the MDS. R 41 MD will be made aware of the long-standing non-compliance of this resident and the MD response will be recorded in the resident record. An OHFC self-neglect will be initiated, and the facility will seek guardianship and/or admission into a psych hospital for stabilization. R 41 care plan will be reviewed and updated as needed. All current residents who are resistive to care and treatment, their MDSs, Assessments, Care Plan, family and MD will be made aware, and the resident's chart will be reviewed and updated as needed. Future residents who are admitted to the facility and have		

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F 642	Continued From page 38 communication with the resident and direct care staff on all shifts. In addition, an accurate assessment requires collecting information from multiple sources. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the interdisciplinary team (IDT) completing the assessment. R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. The MDS identified in section: 1) C: R41 was reported to answer cognitive questions to identify his mental status. 2) D: in the field D0100 Should Resident Mood Interview be Conducted the answer was checked "yes" however; no responses were given. D0500:	F 642	refusals of care and/or change in condition, the MD will be notified for further direction. Licensed Nurses will be in-serviced on the Acute Change in Condition and Refusal of Care Policy that the nurse must assess to determine why the resident is refusing care and if there is a change in cognitive status or agitation, the MD must be notified for further direction. The MDS coordinator will refresh and verify information through the MDS scrubber before submitting to CMS. Director of Nursing is responsible for compliance. Audits on notification of changes in condition and documented resident refusals with MD notification will begin weekly x 1 week for 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 642	Continued From page 39 Staff assessment of Resident Mood was blank. D0700: Social isolation was marked "never". 3) E: Behavior: E0100 identified R41 had delusions. No behaviors were noted for physical, Verbal, or Other. Rejection of care was noted to only occur 1 to 3 days during the look-back period. E1100: Change in Behavior or Other Symptoms was left blank when asked how the residents current behavior status, care rejection, or wandering compared to his prior assessment. 4) F: Preferences for Customary Routine and Activities was not filled out. 5) H: Bladder and Bowel: H0300 identified R41 was occasionally incontinent. 6) J: Health Conditions: J0200 Should Pain Assessment Interview be Conducted? Answer is "yes". J0300 Pain Assessment Interview/Pain Presence: "Unable to answer" was checked. J0800: Indicators of Pain or Possible Pain in the last 5 days: "None of these signs observed or documented". 7) K: Swallowing/Nutritional Status: K0100 Swallowing Disorder/Signs and symptoms of possible swallowing disorder is related to observations of swallowing or reports of complaints of swallowing: "None of the above" was marked. K0200 Weight was documented as 191 pounds (lbs.). K0300 and K0310 mention weight loss and gain. Both are marked "no or unknown". 8) L0200: oral/Dental Status: L0200 describes visualization of the mouth. No questions were answered. 9) M: Skin Conditions: M0100 Determination of Pressure Ulcer Risk: identified a formal assessment instrument or tool such as a Braeden score and clinical assessment were checked as completed. M150 identified R41 was at risk for pressure ulcers. M0210: Unhealed pressure	F 642			

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F 642	Continued From page 40 ulcers: Does the resident have 1 or more unhealed pressure ulcers at Stage 1 or higher? Answer was marked "no". 10) P: Restraints: P0200 Alarms: subsection E: Wander/elopement alarm was marked with a "2" and noted to be "used daily". Notes associated with the 2/25/25, MDS assessment in progress identified on 2/19/25, R41's: 1) Fall risk was evaluated. Staff documented he had no falls in the past 3 months. R41 was noted to have intermittent confusion. R41 was ambulatory and continent of bowel and bladder. Systolic blood pressure noted there was no drop between lying and standing. R41 was listed as having adequate vision and reportedly had no change of condition in the last 14 days. R41 had no hospitalizations in the last 30 days. His gait/balance was recorded as normal. R41 was noted to have taken 1-2 medications currently or within the last 7 days and had a fall score of 6. 2) Lift/Transfer Evaluation portion was completed. R41 was noted to be independent for cares and dressing. He was noted to not leave his room or have any locomotion on or off the unit. There was no indication how staff determined he was able to carry out tasks independently and/or safely. 3) Abnormal Involuntary Movement Scale (AIMS) (used to determine ill effects of anti-psychotic medications) identified R41 was noted to have no concerns with muscles of facial expression, no symptoms or effects affecting the peri-oral area (areas around the mouth), no abnormal movements of his tongue, and no abnormal movements with his upper or lower extremities. It is unknown how the facility had determined supporting facts for the assessment, since R1 had no vitals taken since admission or shortly	F 642			

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F 642	Continued From page 41 thereafter, or how staff could determine he remained continent or had adequate vision without performing an assessment due to R41's numerous documented refusals. 4) Elopement evaluation was documented. R41 had a history of wandering at home and had no wandering in the facility noted. Notes associated with the 2/25/25, MDS in progress identified on 2/20/25, R41's: 1) Brief Interview for Mental Status (BIMS) was performed. Staff noted :Resident was unable to complete the interview and refused to answer questions. He "Sits shaking his head "no"". 2) PHQ-9 score was evaluated. R41 was noted to answer "No" or had no response at all. 3) Social Services quarterly psychosocial quarterly note identified R41 continued to reside in a private room in the facility due to behaviors. Continues to refuse to communicate with staff. States "You leave" when approached to talk. Refuses most cares and medication. He refused his COVID screening and was placed on isolation, however staff noted he did not leave his room. FM-A calls often and states "there isn't anything you can do to change his behavior". The social worker noted he was "uncooperative with all assessments". He continued to talk about "My father". Staff were unable to determine if the comment was related to religion or was part of a delusion. Notes associated with the 2/25/25, MDS in progress identified on 2/23/25, a Restorative Nursing Screener/GG Evaluation note was made. His ambulation was noted to not be able to be assessed. His self-care portion identified staff noted R41 was independent with eating, toileting, showering or bathing, and personal hygiene, but	F 642			

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F 642	Continued From page 42 also identified R41 had refused the assessment. Notes associated with the 2/25/25, MDS in progress identified on 2/25/25, R41's OBRA Interim note was documented. Staff noted his functional limitations and range of motion (ROM) assessment identified he had no impairment. His Mobility and Ambulation portions in the note were documented as "Not attempted". R41's Long Term Care Evaluation progress note (documented by the MDS nurse (RN-E)), identified the reason for the evaluation was a quarterly MDS assessment that was currently in progress. RN-E documented no falls since his last assessment occurred and no skin changes occurred. Vitals were listed as blood pressure (BP) 168/101 millimeters of mercury (mm/hg) obtained on 2/25/25 at 5:38 p.m. while R41 was seated, using his left arm. His oxygen saturation level (SpO2) was listed at 93% on room air. A vitals note was made "Resident refused assessment. Vitals are from admission. I had to put something to close the assessment". R41's progress notes identified in September 2024, on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating "my father , my father, my father takes care of me. My father tells me what to do and he says no touch". R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month	F 642			

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F 642	Continued From page 43 because "God told him to". Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would "need to go to behavioral health again". The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health.." R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. Further review of R41's progress notes identified staff documented numerous refusals of all cares or assessment. R41's September 2024 through February 2025 vital signs report identified vitals were obtained on 9/9/24. Of those vitals, R41 had 1 weight measurement on 9/9/24 of 191 lbs. No other weights were documented as obtained. R41 BP on 9/9/24 was listed at 168/101 mm/hg and his oxygen saturation (SpO2) was documented as 93%. On 2/25/25, the same date as the MDS note listed above, R41's BP and SpO2 readings were documented as the exact same as September 2024. No other vitals were obtained for R41 throughout his stay from September 2024 through March 2025. R41's bathing history was reviewed for the previous 30 days prior to the survey. At no time during February was R41 bathed. R41's assessment data history from September 2024 through March 2025 was obtained. R41 had	F 642			

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F 642	Continued From page 44 only 3 assessments noted as completed. Those assessments were a Braedon pressure ulcer risk assessment. One upon admission, one at R41's 11/21/24 quarterly assessment, and then R41's currently in progress 2/19/25, MDS assessment. No other assessments were documented for R41 from September 2024 through March 2025. R41's personal hygiene task for the last 30 days prior to survey was viewed. R41 was noted by staff to be completely independent with personal hygiene. It is unclear how staff determined this to be accurate and true. R41's behavior history task, documented by staff identified staff had checked R41 exhibited no behaviors of any kind. R41's March 2025. Medication and Treatment records (MAR/TAR) identified R41 had not received medications or treatments. Corresponding progress notes made by nursing staff in the medical record identified R41 refused all medications and cares. Interview on 3/03/25 at 11:28 a.m., with laundry aide (LA)-A identified LA-A had never washed any clothing for R41. She has never done R41's laundry since his admission. She assumed maybe his family washed his clothing. Observation on 3/3/25 at 11:30 a.m., of R41's room identified his door was open partially. R41 was observed to be standing in his room. Staff attempted to speak from the door. R41 waived his arm at staff to leave. No direct observations of R41 were able to be obtained. Interview on 3/03/25 at 11:35 a.m., with RN-E	F 642			

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F 642	Continued From page 45 related to R41 identified RN-E stated R41 "refuses everything". When R41 was first admitted to the facility he would take his medication. Soon after he began refusing treatment or allowing staff into his room. R41 would tell staff god tells him he can't take his medication or that he doesn't need them. "Some staff may be able to enter his room, but it is rare... it depends on the nurse aide. R41 always says "get out!". Facility staff have spoken to FM-A and the MD. "Essentially he isn't a risk for harm to himself or others" He refuses medications that include antipsychotics. Staff are "At a point with him...he is good living here... [staff] offer everything". When asked how RN-E or others assisting with the MDS assessments were able to perform assessments such as skin, she stated "Staff cannot do skin assessments". She turns in MDS data based on what is "able to be captured". Through the facility electronic program, designed to submit information to the Centers for Medicare and Medicaid (CMS) for payment, RN-E noted she "had to put something in" to the vitals section, or it would not allow her to close it within their system. RN-E stated her assessment data was based off what staff told her about R41, however did note that staff are not able to physically assess or often speak to R41 as he refuses staff entry most all days into his room when they try to either speak to him or provide any care at all, except to deliver meals. R41 allows that. RN-E agreed she is signing the MDS assessments to be accurate and true and acknowledged she is unable to accurately perform a comprehensive assessment on R41 and enters data in, so submissions are made. Interview on 3/03/25 at 4:26 p.m., with RN-A identified she was familiar with R41 and had even	F 642			

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F 642	Continued From page 46 cared for him at the sister facility before it closed. RN-A stated R41 "refuses everything". There are very limited staff who can interact with R41. He strikes out, kicks, and has verbal behaviors. R41 will not leave his room. She thinks R41 is continent or bowel and bladder, but acknowledged without being able to assess R41, there would be no way to know. Staff provide no cares or treatments for R41. RN-A was unaware if he even allowed linens to be changed on his bed or his clothing washed. RN-A had not seen R41's skin since he was administered Haldol in September 2024. RN-A was unaware staff were documenting R41 as having no behaviors, however, she related that to not being allowed to enter R41's room or provide any cares. RN-A recalled she has been unable to perform any assessments, give medication, or provide cares to R41 since September 2024. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified RN-E is responsible for MDS data collection and assessment. She was aware R41 refused all cares, assessments, or treatments. When asked how staff can accurately and comprehensively assess R41, she noted they cannot. Interview on 3/4/25 at 8:16 a.m., with the medical director (MD)-A identified he was unaware of R41's refusal of all cares. He would expect to be notified as he agreed R41 isn't capable of making an informed decision related to his health and safety. He was unaware R41 received no skilled nursing care, had only 2 baths, refused all meds, and had no laundry done. He was also unaware staff were unable to comprehensively assess R41. He agreed the assessment data included on the MDS would be false if staff could not actually	F 642			

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F 642	Continued From page 47 assess R41.	F 642			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644			4/3/25

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F 644	Continued From page 48 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the State Mental Health Authority (Nobles County) for 1 of 1 resident with a diagnosis of major neurocognitive disorder with known behaviors and inpatient psychiatric stay 3 months prior to admission. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had diagnoses recorded of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R141's previous Preadmission Assessment Screening and Resident Review (PASARR) Level I was done previously at the now closed sister facility on 5/23/24, prior to R41's transfer to the facility. The questions answered at that time were: 1) Has this person had any of the following: A mental illness as a primary diagnosis for hospitalization within the past 2 years? Answer: No. Does this person have a diagnosis or symptoms of mental illness that has significantly interfered with functioning in life activities within the last 6 months? Answer: no. In the ADL's section Behavior was noted to require no intervention at that time.	F 644	A new PASARR was requested through Noble County. The county Social Worker arrived to complete the Level 2 PASARR screen and was unable to complete the interview as the resident did not cooperate with the interview. Per screen dated 03/04/2025, the resident requires inpatient individual therapy services. Will await further direction from the county as resident was approved for personalized specialized services. All current and future residents will have a PASARR completed before admission and if there is a change in resident behavior, a prolonged mental health admission, Level 2 will be requested per facility policy. The facility IDT team will be in-serviced on the PASSR Screen Policy with emphasis on item #5 that a resident with newly evident or possible serious mental disorder will be referred for Level II to the appropriate state designated authority. The social service designees are responsible for compliance. Audits for PASSR screens upon admission and readmission for delayed hospital stay will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 644	Continued From page 49 R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's progress notes identified on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating "my father , my father, my father takes care of me. My father tells me what to do and he says no touch". R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because "God told him to". Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would "need to go to behavioral health again". The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do if he will not take medications, he will have to go back to behavioral health.." R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. 3) 9/16/25 at 2:09 p.m., a call was placed to the primary care physician (PCP) nurse regarding R41's worsening and refusals of cares, medications, and meals. R41 had not allowed staff to touch him. R41 advised staff he was	F 644			

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F 644	Continued From page 50 fasting for the entire month of September 2024. Staff expressed their concerns and asked for orders and suggestion. R41's PCP faxed back an order for staff to administer Haldol intramuscularly (IM) 5 milligrams (mg) every 4 hours x 2 doses. If no improvement, the order directed staff to send R41 to behavioral health "again". R41's family member (FM)-A was called and stated to staff there was nothing they could do if he wouldn't take his medications...he would have to go back to the behavioral unit. FM-A gave permission for staff to administer the medication. 4) 9/16/24 at 2:47 p.m., staff attempted to enter R41 to speak with him about fasting. R41 began to scream at staff to get out of his room. The nurse attempted to educate R41 on the need for the injection and began screaming "AHHHHHHHHHH NO injection!". R41 told staff he would not eat and is fasting for the month. He refused to allow staff to assess him and told staff to get out. The IM Haldol was given. 5) 9/17/24 at 10:12 a.m., staff noted R41 was in his room seated in his recliner. Staff offered food. R41 replied his food was "poisoned". When staff attempted to interact with him, he raised his voice and told them not to touch him. He was upset staff gave him 2 injections (the previous day). The nurse tried to reiterate why R41 received the injections due to his delusions. R41 repeated more delusions such as "I have intel". Another call was placed to R41's PCP. The PCP advised staff to proceed with a transfer to behavioral health. 6) 9/16/24 at 5:24 p.m., a call was placed for a non-emergent ambulance. EMS staff asked R41 questions and reported "NO, I am normal...go away!". EMS identified R41 knew his name, and his location and had refused transfer. EMS told staff due to his ability to answer those questions,	F 644			

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F 644	Continued From page 51 They were unable to take R41 to behavioral health as he was "oriented correctly". EMS left without the resident due to his refusal for transfer. R41's PCP was updated. Numerous notes were made after 9/16/24, related to R41's ongoing refusal of all cares. 7) 10/1/24 at 10:47 a.m., staff noted they had called FM-A about R41's refusals of medication. Staff suggested discontinuing all medication as they felt it caused more behaviors. FM-A said "lets do it." There was no indication staff had first checked with R41's PCP, behavioral health, or the medical director at that time on how they could best provide care and services to R41 prior to requesting family approval to discontinue medication. 8) 10/21/24, R41 was seen in house by contracted behavioral health services. A fax back after the visit was received with orders to administer Abilify (antipsychotic medication) IM and continue to try and give oral medications as he allowed. They also received a new order for as needed lorazepam (anti-anxiety medication) IM for agitation and severe anxiety and follow up every 14 days. Staff were instructed to contact the clinic with any concerns. 9) 10/21/24 at 11:25 p.m., a note was placed identifying R41 was seen in house by his PCP. No new orders were given. R41 refuses to take all medication. R41 was noted to be in his room all day and getting up only to use his bathroom. Staff noted no delusional behaviors. 10) 10/22/25 at 9:15 p.m., staff noted they had received electronically signed progress notes form the PCP. Staff noted they were unable to assess R41 or obtain vital signs. Per the PCP, they will return in 2 months to recheck. Further review of the progress notes repeated the same inability of staff to provide care and	F 644			

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F 644	Continued From page 52 services to R41. Review of a R41's physician progress notes identified on: 1) 10/22/24, the PCP noted diagnoses of agitation, depression, catatonia (group of symptoms that usually involve a lack of movement and communication, and can include agitation, confusion, and restlessness), chronic anemia (low iron), high blood pressure, liver disease, enlarged prostate, mild persistent asthma, high cholesterol, and chronic obstructive pulmonary disease (COPD). R41's PCP noted he was followed by psychiatry. R41 "refused everything" including vital signs, examination and appeared to be quiet in his recliner. He was apparently in no pain but again refused to be touched or examined. The PCP noted it was a difficult assessment "because patient refused talking to us" and refused to be examined. The PCP directed staff to continue with his blood pressure medication (Amlodipine) if he accepted. Depression with catatonia, and combative behavior were identified with orders directing staff to continue Haldol every 6 hours as needed. No end date was given. Staff were instructed to give his lorazepam at bedtime, mirtazapine and Abilify (anti-depressant) and continue with escitalopram (another anti-depressant) and continue with his inhaler related to COPD as tolerated and accepted by R41. The PCP noted R41 was a "difficult patient to take care of" as he consistently refuses care...will return in 2 months to recheck should he allow us to examine him and check vitals". 2) The nurse practitioner (NP) documented R41 was refusing all cares. "Will continue current medications as patient allows" 3) 11/19/24, the PCP noted additional diagnoses	F 644			

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F 644	Continued From page 53 from the previous visit of chronic hepatitis C, allergic rhinitis, elevated fasting glucose, pre-diabetes, and bilateral knee pain. R41 was noted to "refuse everything namely examination, medications, some of his food, showering...basically spends his days on the recliner". Upon examination it was noted vitals signs were not taken because R41 refused. R41 made no complaints of pain or anything but refused his exam. Nurses reported he refused most of the time his food, although he ate some snacks, refuses showers, changing his clothing, medications, being touched, examined, or having his vital signs checked. The PCP reported they would keep insisting on seeing him "without much hope". Psychiatry also tried to see him at the facility but patient refuses. The PCP was not changing anything with his medications as R41 was not taking it the times offered. He would return the next scheduled visit to see if there was improvement. 4) 1/21/25, the PCP returned for a facility visit. He noted R41 continued to refuse everything namely examinations, medications, some to most food, showering, and spent his day in his recliner. R41 would become aggressive when approached. R41 once again refuse exam and no vitals were taken. Nursing reported his refusals of care. The PCP's plan was no changes to medication as R41 wasn't taking them. The PCP noted he would continue attempts to see R41 on scheduled visits. Psychiatry had tried to see R41 several times, but he is able to provide his name, DON, and because of that, the PCP felt R41 could not be called incompetent to make decisions and noted "psychiatry could not force the issue, neither can we". There was no indication the PCP had reached out to the medical director for guidance and his capacity to consent to refuse evaluated	F 644			

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F 644	Continued From page 54 related to refusals of all care, most food and medication as a potential risk for harm without receiving appropriate care of services exists. R41's 6/3/24, inpatient psych note from the Behavioral Health Hospital (BHH) identified R41 had diagnoses of catatonia, major neurocognitive disorder, altered mental status, and hypoxemia (lack of oxygen to the brain). R41 was identified to bat continued high risk/complexity secondary to the combination of acute on chronic psychiatric diagnoses, cormorbid medical illness, and use of multiple psychotropic medication. R41 had received electroconvulsive therapy (shock therapy) as an inpatient at the hospital. R41 had improvement there both physically and mentally. He was no longer catatonic after treatments with ECT and medication management. At that time, R1 was noted to be cooperative, well groomed and well nourished. R41 had no delusions, hallucinations, or paranoia with insight fair and improving. Upon his admission, R41 was an unreliable historian, had limited judgement in decision making in every day activities, social situations, and compliance for treatment. R41 had a previous BHH stay in April 2024, due to sever deterioration in functioning and concerns for catatonia. R41 failed to have the capacity to consent for decision making upon admission due to his mental health exacerbation. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified she was aware R41 refused all cares, assessments, or treatments. The facility was not required by State law to have updated PASARR Level 1 screening when they transferred residents from their now closed sister facility. The DON agreed staff should have had the county re-assess R41 for a	F 644			

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F 644	Continued From page 55 Level II PASARR upon admission related to his mental health diagnosis and inpatient treatment he had 3 months prior to admission.	F 644			
F 656 SS=F	No PASARR II policy was provided. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656			4/3/25

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F 656	Continued From page 56 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 9 of 15 sampled residents (R1, R5, R7, R8, R18, R20, R28, R41, and R42) care plans were developed and able to be revised as necessary. This has the potential to affect all 56 residents. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility	F 656	R1, R5, R7, R8, R 20, R 28, R 41 and R42 all had their care plans placed into review on (3/17/2025) and each interdisciplinary team member will review and personalize the resident care plan based on resident preferences and goals. R 18 discharged from the facility on 3/8/2025. All other current resident care plans will be reviewed and updated for resident preferences and goals during their quarterly and/or significant change MDS assessment schedule. Future residents will have their care plan developed, personalized and updated quarterly and as needed. The IDT team will be in-serviced on the Care Plan Comprehensive Policy with focus on item #7 that directs the team to develop measurable objectives and timeframes, services that will be furnished to attain or maintain the resident well-being that builds on the resident s strengths and reflects the standards of		

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F 656	Continued From page 57 (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C, allergic rhinitis, elevated fasting glucose, pre-diabetes, and bilateral knee pain. R41's current, undated care plan identified R41 was noted to be independent with all Activities of Daily Living (ADL), and could transfer and perform personal cares independently. Staff noted in the Behavior Management focus the goals was for undesirable behaviors to be monitored and managed. Staff were to: 1) Attempt an alternate time to provide care if refused. 2) Educate R41 and his family (FM)-A of the necessity of care. 3) Ensure the safety of R41 and others. 4) Monitor for emotional factors that may contribute to new behaviors. No other interventions were noted or documented related to how staff were to provide appropriate care to R41 with repeated refusals of medication and care. There was also no mention of interventions for additional diagnoses listed from the PCP. Interview on 3/03/25 at 11:35 a.m., with RN-E, the MDS nurse identified the care plans used to be able to be individualized. Now they are canned or pre-programmed interventions. RN-E stated it was hard to individualize the care plans. RN-E agreed R41's increased behaviors were not care-planned, nor was his Hepatitis C. It "does not allow for very accurate individualization of	F 656	practice. The VP of Clinical met with the IDT team on 3/20/25 and reviewed resident care planning and how to personalize the care plan template to reflect the resident care. The Director of Nursing and/or designee is responsible for compliance. Audits on care plan completion of focus, goals and appropriate personalized interventions will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 656	Continued From page 58 care plans". R8's Admission Record identified R8 was admitted in June of 2023 with the following diagnoses: stroke, peripheral vascular disease, overactive bladder, history of bladder infections, benign prostatic hyperplasia with urinary tract symptoms, long term use of anticoagulant, major depressive disorder, anxiety disorder, and atrial fibrillation. R8's 1/11/25, quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 had behaviors directed towards others, had other behaviors that were not directed towards others, and rejection of care that occurred 1 to 3 days during the assessment period. R8 was dependent on staff for most cares, R8 had an indwelling Foley catheter. Re had 1 stage 3 pressure ulcer and 2 unstageable pressure ulcers. R8 had 2 venous ulcers. R8 took a daily antipsychotic, antidepressant, anticoagulant, and opioid. R8's 2/26/25, Order Summary Report identified Xarelto 20 milligrams (mg) an (anticoagulant a blood thinner that prevents blood clots) one time a day for atrial fibrillation. R8 had a pressure ulcer on his right buttocks and sacral/lumbar region, and wounds on his bilateral lower extremities. R8's February Medication Administration Record identified R8 refused dressing treatments to wounds on lower extremity 12 times and other wound treatments for sacral and buttocks 15	F 656			

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F 656	Continued From page 59 times R8's undated, care plan identified R8 had pressure ulcers and staff were to educate on skin care to prevent skin breakdown. Staff were to encourage R8 to frequently shift weight and wear Prevalon boots while in bed or recliner. Staff were to provide wound care as ordered. There was no mention of a scheduled repositioning regimen to heal and prevent further pressure ulcers. There was no mention of what staff were to do if R8 refused wound care. R8 took Xarelto a blood thinner and there was no mention of the blood thinner on the care plan and what side effects staff should be monitoring for and reporting to the nurse. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident receiving medications such as anticoagulants that the nursing staff would monitor for side effects. Review of the 9/29/21, Wound Care policy identified that staff were to notify the supervisor if a resident refused wound care. R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission MDS assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis.	F 656			

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F 656	Continued From page 60 R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 would have interventions should she have any signs of complications from dialysis occur through the review date. Staff were to encourage her to attend dialysis. Staff to monitor her intake. Staff to monitor and report sign or symptoms of infection to her access site. Staff were not to draw blood or take a blood pressure in arm with graft. The care plan lacked identification and location of her access sight to be monitored and of dialysis schedule or where R18 attended dialysis at. The care plan further lacked identification of nutritional status and diet to be provided. R20's Administration Record identified R20 was admitted in August of 2024 with the following diagnoses: hemiplegia, dementia with other behavioral disturbance, history of stroke, diabetes mellitus type 2, anxiety, and insomnia. R20's 2/14/25, quarterly MDS assessment identified R20's cognition was moderately impaired. R20 had no behaviors and required extensive assistance with most cares. R20 took pain medication, insulin, antipsychotic, antianxiety, antidepressant, antiplatelet, and hypoglycemic medications. R20's Order Summary Report identified R20 had his blood sugar checked one time a day before breakfast, R20 took insulin glargine (long acting) 25 units QD for type 2 diabetes and Metformin HCl 1000 mg twice a day for type 2 diabetes. Monitoring of R20's blood sugars located in his Medication Administration Record for February 2025, identified documentation of blood sugar as low as 60 and as high as 366. There was no mention of R20's normal blood sugar range or	F 656			

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F 656	Continued From page 61 when the provider should be notified for further direction if blood sugars are low or high. R20's 2/5/25, care plan identified R20 was on a regular diet and would maintain adequate national status through the review date. The facility will provide and serve diet as ordered. There was no mention on R20's care plan that he was diabetic or for staff to monitor for hypo (low) or hyper (high) glycemia (blood sugar) and when to contact the provider for further guidance. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident diagnosed with diabetes that the nursing staff would monitor for signs and symptoms of hypo or hyper glycemia. R28's Admission Record identified R28 was admitted in January of 2021, with the following diagnoses: retention of urine, history of bladder infections, and chronic kidney disease. R28's 2/18/25, significant Minimum Data Set (MDS) identified R28's cognition was intact, she had no behaviors and was independent with cares. R28 had an indwelling catheter. Review of R28's 3/10/21, care plan identified R28 had an indwelling catheter related to urinary retention. Staff were to place a leg bag on in the morning and a drain bag placed at night. Staff were to use enhanced barrier precautions, monitor and document intake and output per facility policy. Staff were to monitor signs and symptoms of pain due to the catheter and for signs of infection. There was no mention of how staff were to care for the Foley catheter or how often staff were to provide catheter care.			F 656			

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F 656	Continued From page 62 Interview on 3/3/25 at 11:24 a.m., with registered nurse (RN)-B confirmed that R28's care plan had no mention of providing catheter care and how frequently. R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. R1's Medical Diagnosis list from 3/3/25, identified R1 had a diagnosis of chronic atrial fibrillation and acquired coagulation factor deficiency.	F 656			

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F 656	Continued From page 63 R1's 12/17/24, significant change Minimum Data Set (MDS) assessment identified she admitted to the facility in September of 2024, her cognition was severely impaired and was dependent on staff for activities of daily living (ADL)'s. R1 was taking an anticoagulant. R1's March 2025, administration record identified she was administered Warfarin daily. Administration record made no mention that staff should monitor for signs or symptoms of bleeding related to use of an anticoagulant. Review of R1's undated care plan had no mention of anticoagulant use, signs or symptoms to watch for such as bleeding or bruising, or what and when to report to the nurse. R7's 1/31/25, significant change Minimum Data Set (MDS) assessment identified her cognition was intact. R7 reported she had little interest or pleasure in doing things, she felt down and depressed, and had no energy nearly every day. R7 had physical impairments on both sides and was dependent on staff for ADL's. She had diagnosis of diabetes, dementia, anxiety, depression, pressure ulcer to the right buttock and right heal. R7 used antipsychotics and antidepressants on a routine basis, she used pain medication daily. Continuous observation on 3/3/25, from 4:00 p.m. through 6:15 p.m. 4:00 p.m., R7 was seated in her wheelchair in the common/dining area at a table. She had pressure relieving boots on her feet the right boot extends to several inches below the knee, and the left boot was misplaced above the ankle, skin was visible below the boot. She had a cushion under	F 656			

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F 656	Continued From page 64 her right elbow. Her legs were not elevated, her feet were on the floor and her chair did not have foot pedals. R7 had slid down in her chair and was leaning back with eyes closed. 4:19 p.m., R7 remained in her wheelchair, awake, and in the same position. 4:30 p.m., R7 remained in her wheelchair, awake, and in the same position. She stopped several staff to visit with them, however, none of the staff offered to reposition her and did not prompt her to adjust her position in her chair. 4:50 p.m., she remained in her wheelchair, in the same position. The facility social worker designee sat next to her, R7 complained that her wrist hurt. 4:58 p.m., staff offered R7 pain medication for her wrist. 5:21 p.m., a CNA brought a warm pack to R7 and placed it on her wrist. She did not offer to reposition her or encourage her to adjust her position in her chair. 5:24 p.m., Facility staff brought R7 her supper meal tray. R7 told staff she wanted to eat in her room, staff returned her tray to the cart. 5:28 p.m., staff are bringing her back to her room, R7's feet are dragging on the floor. They stop after about 20 feet and another staff assists by lifting her legs up and they bring R7 back to her room wheeling backwards. They were discussing that they cannot find the foot pedals for her wheelchair. Interview at 5:30 p.m., with nursing assistant (NA)-D reported R7 had another wheelchair that is larger, however, she does not like to use it unless she is going out for an appointment. She reports that she delivered her room tray and that it was unusual that she was out in the common area as she normally stays in her room. Observations continue: 5:35 p.m., R7 was in her room, she remained	F 656			

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F 656	Continued From page 65 seated in her wheelchair. She was in front of her overbed table and had her meal tray in front of her. 5:55 p.m., staff entered R7's room, nursing assistants asked her if she was going to eat anything, R7 told staff to take her tray. nursing assistant offered other food options, R7 agreed to try some pudding. The staff left the room. The nursing assistant did not offer to reposition R7. 6:15 p.m., R7 remained in her room, seated in her wheelchair. Staff were in and out of her room several times, however, they did not offer to reposition her. Interview on 3/3/25, at 6:15 p.m., With RN-B identified she was unsure how often R7 should be repositioned. She reviewed R7's care plan and identified she does not have scheduled repositioning. She reported she "thought" R7 had been up in her wheelchair since 1:00 p.m., she stated she had been out in the day room all afternoon. She identified that she would direct staff to reposition R7. R7's 2/11/25, wound consultant note identified R7's skin to left and right heel is dark red, purple, blistered, and open. Open area to right heel medial is a stage 3, the area on the right heel is a deep tissue injury the right lateral foot is also a deep tissue injury, and the left heel is a deep tissue injury all are secondary to pressure. The wound consultant note identified that in addition to the current interventions in place staff were to implement scheduled repositioning every 2 hours. Review of R7's undated care plan identified R7 had a pressure ulcer and staff should keep skin clean, monitor ulcer for signs of progression or declination, provide wound care per treatment order and encourage her to frequently shift	F 656			

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F 656	Continued From page 66 weight. Staff should reposition R7 as she allows. The care plan made no mention of how often staff should reposition her. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident receiving medications such as anticoagulants that the nursing staff would monitor for side effects, in addition he would expect residents who are at risk for or have a pressure ulcer would be repositioned or at minimum be offered repositioning on a scheduled basis. R5's 122/25, Significant Change Minimum Data Set (MDS) identified was cognitively intact and was dependent on staff with cares and was incontinent of bowel and bladder. R5 had a diagnoses of atrial fibrillation, diabetes, anxiety, depression. R5 had a unhealed, unstageable deep tissue pressure ulcer that was present upon admission/entry or re-entry and was to receive surgical wound care and application of dressing to feet. R5's, March Summary Report identified R5 was to cleanse the wound with normal saline, apply medihoney gel to both areas of the right foot and cover with foam dressing every 3 days and as needed. R5's current, undated care plan identified: 1) R5 had stage 3 pressure ulcer, and the goal was to promote wound healing. Staff nurses were to measure pressure ulcers regularly, monitor for signs and symptoms of infection and provide wound care treatment.			F 656			

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F 656	Continued From page 67 2) R5 had a right foot big toe amputation, as well as skin impairment to the lateral (side) of the 5th digit of R5's right foot. Staff nurses were to apply Prevalon boots to R5's foot in bed and in wheelchair, and to use caution for transfers and mobility to prevent striking R5's arms, legs, and hands against sharp surfaces. 3) R5 was at risk for activities of daily living (ADLS) and the goal was to monitor for R5's improvement. R5 was to ask for assistance from staff if R5 required repositioning or elevation to meet R5's needs to prevent injury. There was no mention on the care plan of R5's refusals of care or scheduled repositioning. R26's 1/08/25, quarterly Minimum Data Set (MDS) identified R26 had a moderate cognitive impairment and had a diagnoses of diabetes, hypertension, arthritis, and seizures. R26 had orders for insulin and received insulin during the last 7 days of the look back period. R26's, February Order Summary Report sheet identified R26's blood sugar was to be checked twice a day and was to receive glargine (long-acting insulin) 22 units subcutaneously (fatty layer between the skin and muscle) at bedtime. R26's current, undated care plan made no mention in R26's care plan of diabetes management, as well as, protocols for hyperglycemia or hypoglycemia monitoring. R37's 1/15/25, admission Minimum Data Set (MDS) identified R37 was cognitively alert and required substantial/maximal assistance with activities of daily living (ADLs). R37 had a diagnoses of malnutrition, anxiety, diabetes and	F 656			

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F 656	Continued From page 68 cirrhosis. Upon admission, R37 had a stage 3 and stage 4 pressure ulcer and required non-surgical dressings to R37's bilateral feet. R37's, March Order Summary identified: 1) bilateral heel wounds was to be cleansed with Vashe (wound cleanser), apply purocol plus to wound bed, cover with dry gauze, secure with kerlix and ace wrap every 2 days. 2) apply betadine swabsticks 10% povidone-iodine to right plantar (bottom surface of the foot) daily. R37's current, undated care plan identified R37 goal was to promote wound healing and staff nurses were to administer antibiotic therapy as prescribed and provide wound care treatments as ordered. There was no mention on the care plan of what wound care treatments was to be followed. The facilities 11/30/21, Care Plans, Comprehensive Person-Centered policy identified the comprehensive person-centered care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and incorporate risk factors associated with identified problems. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents condition change.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657			4/3/25

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F 657	Continued From page 69 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise 2 of 2 residents (R7 and R44) care plan after receiving new orders directing facility to ensure R44's legs were elevated as much as possible and to reposition R7 at least every 2 hours. Findings include: R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living	F 657	R 7 care plan will be updated to include repositioning as resident allows. All other residents who require repositioning, their care plan will be reviewed and updated as needed. R 44 s physician order remains for elevation of feet. R 44 s care plan will be updated to indicate compression stocking or wraps as resident allows. All other residents who require elevation of legs and compression or wraps for bilateral extremities care plan will be reviewed and updated. Future residents who return with new physician orders will		

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F 657	Continued From page 70 (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased swelling to her lower legs. The physician placed orders to add a "water pill" to decrease fluid in legs, and for staff to wrap her legs or put compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse and she identified she was not aware of the new orders but would check into it. R44's 2/19/25, physician order identified staff were to apply anti-fungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. Observation on 3/3/25 at 1:42 p.m., R44 was seated in her wheelchair with feet on the floor. She wheeled herself over to the closet and stood up to look at clothes, writer alerted staff. Nursing assistant (NA)-E went to R44's room and directed her to sit back down in her chair and then left the room.	F 657	be activated R 44and care plan reviewed and updated as needed. Licensed nurses will be in-serviced on the Care Plan Comprehensive Policy and procedure which instructs the nurse to revise the care plan information about the residents condition change. The Director of Nursing is responsible for compliance. Audits on care plan updates from physician visits and/or hospital stays will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 657	Continued From page 71 Interview on 3/3/25 at 1:47 p.m., with NA-E identified she had assisted R44 at 7:00 a.m., with morning cares and transferred her to her wheelchair. She identified that she had offered her to sit in a recliner around 10:00 a.m., but she refused. She reported the refusal to the nurse, she said the nurse told her to just try again in a little bit but reports she did not offer to sit in a recliner again. She reports that the nurse wraps her legs in the morning, the nurse would normally come in to put creams and powders on in the morning while the aids are doing morning cares, but she was not aware of anyone doing that today. She reported that normally new orders that would involve direct care staff would be passed on in shift report. It was passed on today about elevating legs but she did not hear anything about applying antifungal powder. Observation on 3/3/25 at 1:59 p.m., following interview with NA-E, she asked R44 if she would like to sit in a recliner, R44 said yes, and NA-E transferred her to the recliner and elevated her legs. Review of R44's undated care plan had no mention of lower extremity edema, wrapping legs daily, or elevating legs as much as possible. Interview on 3/4/25, at 8:47 a.m., with the facilities medical director identified he would expect staff to ensure care plans are revised to reflect the direct care needs of the residents as their condition changes. R7's 1/31/25, significant change Minimum Data Set (MDS) assessment identified her cognition was intact. R7 reported she had little interest or	F 657			

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F 657	Continued From page 72 pleasure in doing things, she felt down and depressed, and had no energy nearly every day, she had no behaviors and did not reject care. R7 had physical impairments on both sides and was dependent on staff for ADL's. She had diagnosis of diabetes, dementia, anxiety, depression, pressure ulcer to the right buttock and right heel. R7 used antipsychotics and antidepressants on a routine basis, and was administered pain medication daily. Continuous observation on 3/3/25, from 4:00 p.m. through 6:15 p.m. 4:00 p.m., R7 was seated in her wheelchair in the common/dining area at a table. She had pressure relieving boots on her feet the right boot extends to several inches below the knee, and the left boot was misplaced above the ankle, skin was visible below the boot. She had a cushion under her right elbow. Her legs were not elevated, her feet were on the floor and her chair did not have foot pedals. R7 had slid down in her chair and was leaning back with eyes closed. 4:19 p.m., R7 remained in her wheelchair, awake, and in the same position. 4:30 p.m., R7 remained in her wheelchair, awake, and in the same position. She stopped several staff to visit with them, however, none of the staff offered to reposition her and did not prompt her to adjust her position in her chair. 4:50 p.m., she remained in her wheelchair, in the same position. The facility social worker designee sat next to her, R7 complained that her wrist hurt. 4:58 p.m., staff offered R7 pain medication for her wrist. 5:21 p.m., a NA brought a warm pack to R7 and placed it on her wrist. She did not offer to reposition her or encourage her to adjust her position in her chair.	F 657			

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F 657	Continued From page 73 5:24 p.m., Facility staff brought R7 her supper meal tray. R7 told staff she wanted to eat in her room, staff returned her tray to the cart. 5:28 p.m., staff are bringing her back to her room, R7's feet are dragging on the floor. They stop after about 20 feet and another staff assists by lifting her legs up and they bring R7 back to her room wheeling backwards. They were discussing that they cannot find the foot pedals for her wheelchair. Interview at 5:30 p.m., with nursing assistant (NA)-D reported R7 had another wheelchair that is larger, however, she does not like to use it unless she is going out for an appointment. She reports that she delivered her room tray and that it was unusual that she was out in the common area as she normally stays in her room. Observations continue: 5:35 p.m., R7 was in her room, she remained seated in her wheelchair. She was in front of her over-bed table and had her meal tray in front of her. 5:55 p.m., staff entered R7's room, nursing assistants asked her if she was going to eat anything, R7 told staff to take her tray. nursing assistant offered other food options, R7 agreed to try some pudding. The staff left the room. The nursing assistant did not offer to reposition R7. 6:15 p.m., R7 remained in her room, seated in her wheelchair. Staff were in and out of her room several times, however, they did not offer to reposition her. Interview on 3/3/25, at 6:15 p.m., With RN-B identified she was unsure how often R7 should be repositioned. She reviewed R7's care plan and identified she does not have scheduled repositioning. She reported she "thought" R7 had been up in her wheelchair since 1:00 p.m., she stated she had been out in the day room all	F 657			

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F 657	Continued From page 74 afternoon. She identified that she would direct staff to reposition R7. R7's 2/11/25, wound consultant note identified R7's skin to left and right heel is dark red, purple, blistered, and open. Open area to right heel medial is a stage 3, the area on the right heel is a deep tissue injury the right lateral foot is also a deep tissue injury, and the left heel is a deep tissue injury all are secondary to pressure. The wound consultant note identified that in addition to the current interventions in place staff were to implement scheduled repositioning every 2 hours. Review of R7's undated care plan identified R7 required total assist of 2 staff for bed mobility, she had a pressure ulcer and staff should keep skin clean, monitor ulcer for signs of progression or declination, provide wound care per treatment order and encourage her to frequently shift weight. Staff should reposition R7 as she allows. The care plan made no mention of how often staff should reposition her. The facility provided policy Pressure Injuries Overview identified an avoidable pressure ulcer may be caused by not implementing interventions that are consistent with residents needs, goals, and professional standards of practice, monitoring or evaluation of the impact of the interventions or revision of the interventions as appropriate. The facilities 11/30/21, Care Plans, Comprehensive Person-Centered policy identified the comprehensive person-centered care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 657			

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F 657	Continued From page 75	F 657			
F 684 SS=D	psychosocial well-being, and incorporate risk factors associated with identified problems. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents condition change. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement physician orders for 1 of 1 resident (R44). Findings include: R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased	F 684	R 44 s attending physician was made aware of the delay in processing the medication and ace wrap orders. The physician s response and any corresponding orders will be recorded in the resident medical record. All current and future residents who return from the hospital or outside clinic appointments, their orders will be transcribed fully by the licensed nurse per facility policy. Licensed nurses will be in-serviced on the Medication and Treatment Orders, Transcription that medication and treatment orders will be processed upon return from the visit or hospital stay. The Director of Nursing is responsible for compliance. Audits on medication or treatment order processing timely will begin weekly x 1		4/3/25

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F 684	Continued From page 76 swelling to her lower legs. The physician placed orders to add a "water pill" to decrease fluid in legs, and for staff to wrap her legs or put compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse, and she identified she was not aware of the new orders but would check into it. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. R44's March 2025 medication administration record identified an order to apply ace wraps to bilateral lower extremities daily. The order entry date was 2/27/25, the order had been transcribed 8 days after it was received from the physician. Furosemide oral tablet 20 mg twice daily in addition to 20 mg for a total of 40 mg twice daily for 30 days transcribed on 2/21/25, 2 days after the order was received. R44's medication/treatment administration record lacked any direction for nursing staff to elevate lower extremities or to apply antifungal powder under abdominal folds. Observation on 3/3/25 at 1:42 p.m., R44 was seated in her wheelchair with feet on the floor. She wheeled herself over to the closet and stood up to look at clothes, writer alerted staff. Nursing assistant (NA)-E went to R44's room and directed her to sit back down in her chair and then left the room. Interview on 3/3/25 at 1:47 p.m., with NA-E identified she had assisted R44 at 7:00 a.m., with	F 684	week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 684	Continued From page 77 morning cares and transferred her to her wheelchair. She identified that she had offered her to sit in a recliner around 10:00 a.m., but she refused. She reported the refusal to the nurse, she said the nurse told her to just try again in a little bit but reports she did not offer to sit in a recliner again. She reports that the nurse wraps her legs in the morning, the nurse would normally come in to put creams and powders on in the morning while the aids are doing morning cares, but she was not aware of anyone doing that today. She reported that normally new orders that would involve direct care staff would be passed on in shift report. It was passed on today about elevating legs, but she did not hear anything about applying antifungal powder. Interview on 3/3/25, at 11:15 a.m., with RN-B and RN-D, identified their process is to review the new order upon receiving, transcribe the order, make a nursing progress note, and place the original copy in a wall pocket behind the nurses station for the medical records person to scan into the medical record. They identified the orders received following R44's 2/19/25 appointment had been transcribed late and the original order was not yet scanned into the medical record. RN-B reported they did not currently have a medical record person, and she was told they had planned to resolve that position, she stated "nursing does not have time to scan all the orders in", she further revealed that they only complete a second check on narcotic orders and admission orders. Subsequent interview on 3/3/25, at 11:58 a.m., RN-B came to the conference room with the original order. She reported she found the order in a pile of papers that were waiting to be	F 684			

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F 684	Continued From page 78 scanned in.	F 684			
F 692 SS=D	R44's 2/19/25, original physician order identified staff were to apply antifungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. A facility policy for order transcription and implementation was requested but nothing was provided by the end of the survey period. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692			4/3/25

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F 692	Continued From page 79 by: Based on interview and document review the facility failed to assess weight loss to determine the cause for 1 of 4 residents (R8) reviewed for nutrition. Findings include: R8's 1/11/25, quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 was independent with eating. R8 had behaviors and refused cares. R8 was identified to have a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. R8 was identified for weight loss that was not a physician-prescribed weight -loss regimen. R8 did not have a therapeutic diet. Section L Oral/Dental Status of the assessment was not completed. R8 had pain and took scheduled pain medication. R8 had one stage 3 pressure ulcer, two unstageable pressure ulcers and tow venous ulcers. R8's 2/26/25, Order Summary Report identified R8 was on a regular diet with regular texture. R8 was to be weighed monthly. R8 took Arginade Powder 1 packet by mouth one time a day for wound healing. There was no mention that R8 was on a supplement related to weight loss. R8's Weight Summary report identified R8's weights as follows: 8/14/24 weight 273.0 pounds using wheelchair 9/4/24 weight 270.6 pounds using wheelchair 9/7/24 weight 245.6 using mechanical lift -with a message that there had been a 10% weight change compared to 4/5/24 of 282.4 pounds, a 7.5% weight change compared to 7/5/24 of 273.4 pounds, and a 5% weight change compared to 8/14/24 of 273.0 pounds.	F 692	R 8 will have a review from the facility dietitian. Dietitian recommendations will be implemented. R 8 responsible party will be made aware of weight loss, status of wounds and dietitian recommendation. R 8 is currently on weekly weights and meal intake continues to be observed and recorded. R 8 s care plan for nutrition will be reviewed and updated as needed. All current and future residents weights will be reviewed and for weight discrepancies and a reweight will be obtained as needed and results reported to the MD and Dietitian per facility policy. Facility nurses will be in-serviced on the Weight Assessment and Intervention policy which instructs that if a weight change of 5% or more since last weight, resident will be reweighed and the dietitian will be contacted, care plan and interventions revised as needed. The Director of Nursing is responsible for compliance. Audits on obtaining weekly/monthly weights, meal consumption, fluctuations in weights being reported to the MD and dietitian will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 692	Continued From page 80 9/14/24 weight 245.4 pounds using mechanical lift 9/18/24 weight 246.9 pounds using mechanical lift with message that there had been a 10% weight change compared to 4/5/24 of 282.4 pounds, a 7.5% weight change compared to 7/5/24 of 273.4 pounds, and a 5% weight change compared to 9/4/24 of 270.6 pounds. 10/7/24 weight 246.9 pounds using mechanical lift 10/9/24 weight 247.5 pounds using wheelchair 10/23/24 weight 247.0 pounds using mechanical lift 11/7/24 weight 243.8 pounds using mechanical lift 1/8/25 weight 240.2 pounds using mechanical lift 2/7/25 weight 240.0 pounds using mechanical lift Review of nutritional progress notes identified: 10/22/24, dietician note for a follow up for weight change and skin issues. R8 was tolerating a regular diet and was independent with eating. R8 ate 25-75% of his meals and was a picky eater. Recommended Arginade supplement 1 packet for wound healing. Noted weight changes and requested re-check of his weight. 1/9/25, dietary manager note R8 was on a regular diet. Have visited with R8 about his intakes and R8 will tell dietary manager to "just go". Intakes were 25-75 % and resident had snacks in his room. Will continue to monitor and encourage intakes. 2/12/25, dietary manager note R8's average intake was 50-75%. Will continue to monitor. Interview on 2/26/25 at 8:53 a.m., with the dietary manager identified R8 was weight when he allowed. She had visited with him about meals, and he will answer what he wants. She confirmed she was aware that R8 had lost at least 10% in	F 692			

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F 692	Continued From page 81 the last 6 months as the electronic medical record point click care (PCC) flags a warning when there is a discrepancy in the weight. She reported that the dietician would review the weight loss and contact the provider with recommendations or have the nursing department do that. She was unaware if the provider had been notified of R8' s weight loss. She revealed the dietician had not assessed R8 "in a while". She updated the dietician monthly and R8 did not have any weight loss the last time the dietician was at the facility. She reported that she does review weights weekly and if she identified something she would report that to the director of nursing to address. She stated that the facility had tried boost supplement with R8 but she was unsure if he drinks the supplement or not as dietary does not provide that to him nursing does. Interview on 2/26/25 at 8:59 a.m., with director of nursing (DON) identified that the dietician reviewed residents for weight loss. The dietician would assess and make recommendation, and nursing would communicate that with the provider. The dietician only comes once a month however, if there was a concern outside of that time frame, the facility can call her. Nursing can also make recommendations to the provider. Interview on 2/26/25 at 3:10 p.m., with registered nurse (RN)-B who confirmed that the provider had not been updated on R8's potential weight loss. She revealed that the dietary department had lacked communication about his weight loss and the facility needed to improve their communication during their interdisciplinary meetings (IDT). RN-B reviewed R8's weights and agreed that according to the charting R8 had lost about 30 pounds over last 6 months. RN-B	F 692			

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F 692	Continued From page 82 confirmed that the discrepancy should have been investigated as there could have been multiple variables. The dietary manager should be monitoring weights and reporting to nursing who then should have notified the provider. Interview on 3/3/25 at 4:57 p.m., with registered dietician (RD) identified she would expect to be notified if there was a resident identified with weight loss so that she could assess the resident. She revealed that the dietary manager provides her with a list of residents that need to be assessed, or that were new admission, and/or had an annual assessment due. She was unaware R8 had a weight loss and would expect that she should be able to trust that the dietary manager to be monitoring weights and would notify her with concerns. The interdisciplinary team (IDT) should be discussing concerns like weight loss at their meetings and nursing also should have notified the provider. She reported it was frustrating that it seemed like no one was addressing issues when they came up like this. She further revealed the problem that she had at times was with the contracted staff who do not seem to know the residents or just "blow you off" when you ask about a resident. She was told they are contracted pool staff, and they do not know. She would have expected when the discrepancy was identified in the facilities electronic record, point click care (PCC) that someone would have re-weighed the resident and investigated to see if a different scale had been used or some other variable had taken place. She confirmed that PCC does flag discrepancies with weights within the system to alert staff and at that time should have been addressed. Interview on 3/4/25 at 8:15 a.m., with medical	F 692			

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F 692	Continued From page 83 director identified his expectation for a resident with a significant weight loss to be assessed by the dietician or nursing staff to determine the cause of the weight loss, notify the primary provider and implement appropriate interventions as needed. Review of 1/20/22, Weight Assessment and Intervention policy identified any weight change of 5% or more since last weight assessment the staff would re-weigh resident and if weight was verified the nursing staff would immediately notify the dietician. The dietician would then respond within 24 hours of notification. An assessment would be completed with the physician reviewing medication that could be causing the weight loss, care plan would be reviewed and revised as need with interventions.	F 692			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor and assess a resident for potential complications related to dialysis treatment post treatment for 2 of 2 resident (R18 and R42) reviewed for dialysis. Findings include: R18's Admission Record identified R18 was	F 698	R 18 was discharged from the facility. R 42 had dialysis observation orders entered into the electronic medical record, the post dialysis assessment completed, and the care plan reviewed and updated as needed. As of this writing, there are no other residents receiving dialysis services. Future residents who admit on dialysis services, the dialysis batch orders will be		4/3/25

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F 698	Continued From page 84 admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. Observation on 2/25/25 at 7:45 a.m., R18 showed a dialysis port in her right upper chest. R18 2/27/25, Order Summary Report identified R18 was on a renal diet and consistent carbohydrate diet. The order summary had no mention of monitoring access site for signs and symptoms of infection, no mention of location of access site, and no mention of dialysis schedule. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 would have interventions should she have any signs of complications from dialysis occur through the review date. Staff were to encourage her to attend dialysis. Staff to monitor her intake. Staff to monitor and report sign or symptoms of infection to her access site. Staff were not to draw blood or take a blood pressure in arm with graft. The care plan lacked identification and location of her access sight to be monitored. The care plan lacked identification of dialysis schedule or where R18 attended dialysis at. Review of R18's pre/post dialysis evaluation assessments identified that the assessment had been completed in January 2 out of the 4 times	F 698	activated, post assessment completed, and care plan initiated per facility policy. Facility licensed nurses will be in-serviced on the Dialysis Care External Facility that the nurse will observe the resident access site upon return from dialysis treatment for bleeding and/or other complications. The Director of Nursing is responsible for compliance. Audits on post dialysis assessment completion and dialysis orders for observation of dialysis site will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 698	Continued From page 85 and in February 4 out of 10 times reviewed. R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. Interview on 2/26/25 at 3:10 p.m., with registered nurse (RN)-B confirmed that R18 had not consistently had a pre/post dialysis assessment completed since admission. She further confirmed that R18's dialysis access was not identified on her treatment record nor her care plan. She revealed she had a right chest port and a right arm fistula and without identification of the	F 698			

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F 698	Continued From page 86 access location the nurse would not know where to look especially the contracted staff. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that a resident on dialysis should have their access site assessed at a minimum upon returning from dialysis each time. Review of 6/19/19, dialysis agreement identified the nursing facility was responsible for transportation, contacting the dialysis unit and/or nephrologist for dialysis related problems. Assessing the dialysis resident including access observation, vitals and weight if needed. Review of 11/3/21, Dialysis Care External Facility policy identified the nursing staff would observe the residents access site upon return from the dialysis treatment for bleeding and/or other complications.	F 698			
F 742 SS=D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 742	R 41 was sent to the local hospital on		4/3/25

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F 742	Continued From page 87 facility failed to notify the medical director for 1 of 1 resident (R41) who exhibited increased and ongoing behaviors since shortly after admission, with no mental health intervention to receive appropriate treatment and services and had questionable mental ability to refuse cares and treatment. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's current, undated physician orders identified R41 had 9 medication orders listed to included higher risk medications such as Apixaban (blood clot prevention medication), mirtazapine (antidepressant), and amlodipine (high blood pressure medication). R41's current, undated care plan identified R41 was noted to be independent with all Activities of Daily Living (ADL), and could transfer and perform personal cares independently. Staff			F 742	3/25/2025 on a physician hold for evaluation and potential transfer to inpatient hospital psych treatment or the resident will be placed on hospice service. The MD will be made aware of the long-standing non-compliance of this resident and the MD response will be recorded in the resident record. An OHFC self-neglect has been initiated. Upon return, R 41 care plan will be reviewed and updated as needed. All current residents who are resistive to care and treatment, their MDSs, Assessments, Care Plan, family and MD will be made aware, and the resident's chart will be reviewed and updated as needed. Future residents who are admitted to the facility and have refusals of care and/or change in condition, the MD will be notified for further direction. Licensed Nurses will be in-serviced on the Acute Change in Condition and Refusal of Care Policy that the nurse must assess to determine why the resident is refusing care and if there is a change in cognitive status or agitation, the MD must be notified for further direction. The Director of Nursing is responsible for compliance. Audits on notification of changes in condition and documented resident refusals with MD notification will begin weekly x 1 week for 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 742	Continued From page 88 noted in the Behavior Management focus the goals was for undesirable behaviors to be monitored and managed. Staff were to: 1) Attempt an alternate time to provide care if refused. 2) Educate R41 and his family (FM)-A of the necessity of care. 3) Ensure the safety of R41 and others. 4) Monitor for emotional factors that may contribute to new behaviors. No other interventions were noted or documented related to how staff were to provide appropriate care to R41 with repeated refusals of medication and care. R41's progress notes identified on: 1) 9/9/25, a clinical admission note was made. R41 was currently experiencing unwanted behaviors, chronic refusal of cares, bathing, allow his clothing to be changed, and refusing staff to obtain vitals stating "my father , my father, my father takes care of me. My father tells me what to do and he says no touch". R41 was occasionally incontinent upon admission assessment, and some physical assessment data was documented. 2) 9/14//24, R41 refused to eat his breakfast and lunch. He was reported to have not eaten the day before. R41 told staff he was fasting for a month because "God told him to". Staff noted they had expressed concerns to the physician's (MD) office and received an order to administer Haldol (powerful antipsychotic used to treat acute psychological behaviors usually reserved when there is an immediate threat to patient safety) The MD noted if there was no improvement with R41's behavior, he would "need to go to behavioral health again". The facility notified R41's family (FM)-A. FM-A stated there is nothing you can do	F 742			

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F 742	Continued From page 89 if he will not take medications, he will have to go back to behavioral health.." R41 was noted to kick out at the nurse when staff attempted to give him his Haldol injection. 3) 9/16/25 at 2:09 p.m., a call was placed to the primary care physician (PCP) nurse regarding R41's worsening and refusals of cares, medications, and meals. R41 had not allowed staff to touch him. R41 advised staff he was fasting for the entire month of September 2024. Staff expressed their concerns and asked for orders and suggestion. R41's PCP faxed back an order for staff to administer Haldol intramuscularly (IM) 5 milligrams (mg) every 4 hours x 2 doses. If no improvement, the order directed staff to send R41 to behavioral health "again". R41's family member (FM)-A was called and stated to staff there was nothing they could do if he wouldn't take his medications...he would have to go back to the behavioral unit. FM-A gave permission for staff to administer the medication. 4) 9/16/24 at 2:47 p.m., staff attempted to enter R41 to speak with him about fasting. R41 began to scream at staff to get out of his room. The nurse attempted to educate R41 on the need for the injection and began screaming "AHHHHHHHHHH NO injection!". R41 told staff he would not eat and is fasting for the month. He refused to allow staff to assess him and told staff to get out. The IM Haldol was given. 5) 9/17/24 at 10:12 a.m., staff noted R41 was in his room seated in his recliner. Staff offered food. R41 replied his food was "poisoned". When staff attempted to interact with him, he raised his voice and told them not to touch him. He was upset staff gave him 2 injections (the previous day). The nurse tried to reiterate why R41 received the injections due to his delusions. R41 repeated more delusions such as "I have intel". Another	F 742			

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F 742	Continued From page 90 call was placed to R41's PCP. The PCP advised staff to proceed with a transfer to behavioral health. 6) 9/16/24 at 5:24 p.m., a call was placed for a non-emergent ambulance. EMS staff asked R41 questions and reported "NO, I am normal...go away!". EMS identified R41 knew his name, and his location and had refused transfer. EMS told staff due to his ability to answer those questions, They were unable to take R41 to behavioral health as he was "oriented correctly". EMS left without the resident due to his refusal for transfer. R41's PCP was updated. Numerous notes were made after 9/16/24, related to R41's ongoing refusal of all cares. 7) 10/1/24 at 10:47 a.m., staff noted they had called FM-A about R41's refusals of medication. Staff suggested discontinuing all medication as they felt it caused more behaviors. FM-A said "lets do it." There was no indication staff had first checked with R41's PCP, behavioral health, or the medical director at that time on how they could best provide care and services to R41 prior to requesting family approval to discontinue medication. 8) 10/21/24, R41 was seen in house by contracted behavioral health services. A fax back after the visit was received with orders to administer Abilify (antipsychotic medication) IM and continue to try and give oral medications as he allowed. They also received a new order for as needed lorazepam (anti-anxiety medication) IM for agitation and severe anxiety and follow up every 14 days. Staff were instructed to contact the clinic with any concerns. 9) 10/21/24 at 11:25 p.m., a note was placed identifying R41 was seen in house by his PCP. No new orders were given. R41 refuses to take all medication. R41 was noted to be in his room	F 742			

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F 742	Continued From page 91 all day and getting up only to use his bathroom. Staff noted no delusional behaviors. 10) 10/22/25 at 9:15 p.m., staff noted they had received electronically signed progress notes form the PCP. Staff noted they were unable to assess R41 or obtain vital signs. Per the PCP, they will return in 2 months to recheck. Further review of the progress notes repeated the same inability of staff to provide care and services to R41. Review of a R41's physician progress notes identified on: 1) 10/22/24, the PCP noted diagnoses of agitation, depression, catatonia (group of symptoms that usually involve a lack of movement and communication, and can include agitation, confusion, and restlessness), chronic anemia (low iron), high blood pressure, liver disease, enlarged prostate, mild persistent asthma, high cholesterol, and chronic obstructive pulmonary disease (COPD). R41's PCP noted he was followed by psychiatry. R41 "refused everything" including vital signs, examination and appeared to be quiet in his recliner. He was apparently in no pain but again refused to be touched or examined. The PCP noted it was a difficult assessment "because patient refused talking to us" and refused to be examined. The PCP directed staff to continue with his blood pressure medication (Amlodipine) if he accepted. Depression with catatonia, and combative behavior were identified with orders directing staff to continue Haldol every 6 hours as needed. No end date was given. Staff were instructed to give his lorazepam at bedtime, mirtazapine and Abilify (anti-depressant) and continue with escitalopram (another anti-depressant) and continue with his inhaler related to COPD as tolerated and	F 742			

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F 742	Continued From page 92 accepted by R41. The PCP noted R41 was a "difficult patient to take care of" as he consistently refuses care...will return in 2 months to recheck should he allow us to examine him and check vitals". 2) The nurse practitioner (NP) documented R41 was refusing all cares. "Will continue current medications as patient allows" 3) 11/19/24, the PCP noted additional diagnoses from the previous visit of chronic hepatitis C, allergic rhinitis, elevated fasting glucose, pre-diabetes, and bilateral knee pain. R41 was noted to "refuse everything namely examination, medications, some of his food, showering...basically spends his days on the recliner". Upon examination it was noted vitals signs were not taken because R41 refused. R41 made no complaints of pain or anything but refused his exam. Nurses reported he refused most of the time his food, although he ate some snacks, refuses showers, changing his clothing, medications, being touched, examined, or having his vital signs checked. The PCP reported they would keep insisting on seeing him "without much hope". Psychiatry also tried to see him at the facility but patient refuses. The PCP was not changing anything with his medications as R41 was not taking it the times offered. He would return the next scheduled visit to see if there was improvement. 4) 1/21/25, the PCP returned for a facility visit. He noted R41 continued to refuse everything namely examinations, medications, some to most food, showering, and spent his day in his recliner. R41 would become aggressive when approached. R41 once again refuse exam and no vitals were taken. Nursing reported his refusals of care. The PCP's plan was no changes to medication as R41 wasn't taking them. The PCP noted he would	F 742			

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

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F 742	Continued From page 93 continue attempts to see R41 on scheduled visits. Psychiatry had tried to see R41 several times, but he is able to provide his name, DON, and because of that, the PCP felt R41 could not be called incompetent to make decisions and noted "psychiatry could not force the issue, neither can we". There was no indication the PCP had reached out to the medical director for guidance and his capacity to consent to refuse evaluated related to refusals of all care, most food and medication as a potential risk for harm without receiving appropriate care of services exists. Interview on 3/03/25 at 11:28 a.m., with laundry aide (LA)-A identified LA-A had never washed any clothing for R41. She has never done R41's laundry since his admission. She assumed maybe his family washed his clothing. Observation on 3/3/25 at 11:30 a.m., of R41's room identified his door was open partially. R41 was observed to be standing in his room. Staff attempted to speak from the door. R41 waived his arm at staff to leave. No direct observations of R41 were able to be obtained. Interview on 3/03/25 at 11:35 a.m., with RN-E, the MDS nurse related to R41 identified R41 "refuses everything". When R41 was first admitted to the facility he would take his medication. Soon after he began refusing treatment or allowing staff into his room. R41 would tell staff god tells him he can't take his medication or that he doesn't need them. "Some staff may be able to enter his room, but it is rare... it depends on the nurse aide. R41 always says "get out!". Facility staff have spoken to FM-A and the MD. "Essentially he isn't a risk for harm to himself or others" He refuses medications that include antipsychotics. Staff are	F 742			

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F 742	Continued From page 94 "At a point with him...he is good living here... [staff] offer everything". When asked how RN-E or others assisting with the MDS assessments were able to perform assessments such as skin, she stated "Staff cannot do skin assessments". She turns in MDS data based on what is "able to be captured". Through the facility electronic program, designed to submit information to the Centers for Medicare and Medicaid (CMS) for payment, RN-E noted she "had to put something in". R41's 6/3/24, inpatient psych note from the Behavioral Health Hospital (BHH) identified R41 had diagnoses of catatonia, major neurocognitive disorder, altered mental status, and hypoxemia (lack of oxygen to the brain). R41 was identified to bat continued high risk/complexity secondary to the combination of acute on chronic psychiatric diagnoses, cormorbid medical illness, and use of multiple psychotropic medication. R41 had received electroconvulsive therapy (shock therapy) as an inpatient at the hospital. R41 had improvement there both physically and mentally. He was no longer catatonic after treatments with ECT and medication management. At that time, R1 was noted to be cooperative, well groomed and well nourished. R41 had no delusions, hallucinations, or paranoia with insight fair and improving. Upon his admission, R41 was an unreliable historian, had limited judgement in decision making in every day activities, social situations, and compliance for treatment. R41 had a previous BHH stay in April 2024, due to sever deterioration in functioning and concerns for catatonia. R41 failed to have the capacity to consent for decision making upon admission due to his mental health exacerbation.			F 742			

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F 742	Continued From page 95 R41's behavior history task, documented by staff identified staff had checked R41 exhibited no behaviors of any kind. R41's September 2024 through February 2025 vital signs report identified vitals were obtained on 9/9/24. Of those vitals, R41 had 1 weight measurement on 9/9/24 of 191 lbs. No other weights were documented as obtained. R41 BP on 9/9/24 was listed at 168/101 mm/hg and his oxygen saturation (SpO2) was documented as 93%. On 2/25/25, the same date as the MDS note listed above, R41's BP and SpO2 readings were documented as the exact same as September 2024. No other vitals were obtained for R41 throughout his stay from September 2024 through March 2025. R41's bathing history was reviewed for the previous 30 days prior to the survey. At no time during February was R41 bathed. R41's assessment data history from September 2024 through March 2025 was obtained. R41 had only 3 assessments noted as completed. Those assessments were a Braedon pressure ulcer risk assessment. One upon admission, one at R41's 11/21/24 quarterly assessment, and then R41's currently in progress 2/19/25, MDS assessment. No other assessments were documented for R41 from September 2024 through March 2025. R41's personal hygiene task for the last 30 days prior to survey was viewed. R41 was noted by staff to be completely independent with personal hygiene. It is unclear how staff determined this to be accurate and true. R41's March 2025. Medication and Treatment	F 742			

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F 742	Continued From page 96 records (MAR/TAR) identified R41 had not received medications or treatments. Corresponding progress notes made by nursing staff in the medical record identified R41 refused all medications and cares. Interview on 3/03/25 at 4:26 p.m., with RN-A identified she was familiar with R41 and had even cared for him at the sister facility before it closed. RN-A stated R41 "refuses everything". There are very limited staff who can interact with R41. He strikes out, kicks, and has verbal behaviors. R41 will not leave his room. She thinks R41 is continent or bowel and bladder, but acknowledged without being able to assess R41, there would be no way to know. Staff provide no cares or treatments for R41. RN-A was unaware if he even allowed linens to be changed on his bed or his clothing washed. RN-A had not seen R41's skin since he was administered Haldol in September 2024. RN-A was unaware staff were documenting R41 as having no behaviors, however, she related that to not being allowed to enter R41's room or provide any cares. RN-A recalled she has been unable to perform any assessments, give medication, or provide cares to R41 since September 2024. Interview on 3/03/25 at 5:37 p.m., with the director of nursing (DON) identified she was aware R41 refused all cares, assessments, or treatments. When asked how staff can accurately and comprehensively assess R41, she noted they cannot. She agreed staff are providing no skilled nursing related to R41's refusals. The DON agreed the medical director should have been notified to assist with R41 when he was not able to make safe decisions regarding his care.	F 742			

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F 742	Continued From page 97 Interview on 3/4/25 at 8:16 a.m., with the medical director (MD)-A identified he was unaware of R41's refusal of all cares. He would expect to be notified as he agreed R41 isn't capable of making an informed decision related to his health and safety. He was unaware R41 received no skilled nursing care, had only 2 baths since admission, refused all meds, and had no laundry done. He was also unaware staff were unable to comprehensively assess R41. He agreed the assessment data included on the MDS would be false if staff could not actually assess R41. Review of the 10/18/21 Behavioral Health Services (BHS) policy identified BHS were to be provided as part of the interdisciplinary, person centered approach to care. Staff were to promote dignity, autonomy, privacy, socialization and safety as appropriate and were to be trained in ways to support residents. Staff were to be trained in protocols and guidelines related to mental disorders and psychosocial adjustment difficulties of residents. There was no mention what professional references staff were to use to guide decisions on what to do if current interventions were not working to ensure the health and safety of resident with poor decision making capabilities was maintained.	F 742			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758			4/3/25

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F 758	Continued From page 98 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758			

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F 758	Continued From page 99 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to include an appropriate diagnosis for the use of an antipsychotic medication for 1 of 5 residents (R6) reviewed for unnecessary medication. Findings include: R6's 12/10/24, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she had no behaviors and was dependent on staff for activities of daily living (ADL)'s. R6 had diagnosis of Alzheimer's disease late onset, non-traumatic brain disorder, and adult failure to thrive. She had been administered antipsychotic medication and antidepressant medication on a routine basis. R6's medication administration record (MAR) identified she was administered quetiapine (antipsychotic) 75 milligrams (mg) in the morning, 25 mg at noon, and 100 mg at bedtime for Alzheimer's Disease with late onset, and sertraline 50 mg daily for dementia with other behavioral disturbances. R6's electronic medical record diagnosis list identified Alzheimer's disease with late onset, and adult failure to thrive. R6's care plan identified she was taking psychotropic medication related to dementia and staff should monitor/record occurrences of target behaviors including violence/aggression, delusions, and audible hallucinations.	F 758	R6 physician will be seen on next scheduled visit tentatively scheduled for 3/28/2025 and medication diagnosis will be updated for Quetiapine and Sertraline. R6 medication orders for Quetiapine and Sertraline diagnosis will be updated, and R 6 care plan will be reviewed and updated as needed. All current residents who are taking psychotropic medications, their orders will be reviewed for the appropriate diagnosis and updated per MD order as needed. Future residents who admit with psychotropic medications, their diagnosis will be reviewed prior to admission for accuracy. Licensed nurses and social service designees will be in-serviced on the Antipsychotic Medication Use policy with emphasis on antipsychotic medication which is generally used for diagnosis of schizophrenia or delusional disorder with psychotic symptoms. The Director of Nursing is responsible for compliance. Audits on psychotropic medication with the appropriate diagnosis will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 758	Continued From page 100 The electronic medical record lacked an appropriate diagnosis for the use of psychotic medications. Interview on 2/27/25 at 1:27 p.m., with registered nurse (RN)-E identified she was responsible for completing the MDS, she reported she "should have done a better job" when pulling R6's medical information from the hospital records that had been provided to the facility. She knows there is not an appropriate diagnosis for the administration of an antipsychotic in R6's facility medical record and was not certain if R6 had a diagnosis of depression prior to admitting. Interview on 3/3/25 at 11:24 a.m., with RN-B identified contracted licensed nurses working at the facility were unable to access hospital medical records. Review of the facility provided Antipsychotic Medication Use policy dated 7/13/22, identified antipsychotic medication shall generally be used only for diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, bipolar disorder, depression with psychotic features, treatment refractory major depression, psychosis in the absence of dementia, medical illnesses with psychotic symptoms and/or treatment related psychosis of mania, Tourette's disorder, Huntington's disease, hiccups, and nausea/vomiting associated with cancer or chemotherapy. Diagnosis alone do not warrant the use of antipsychotic medication. In addition to an appropriate diagnosis, antipsychotic mediations will generally only be considered if behavioral symptoms present a danger to the resident and others.	F 758			

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure controlled medications were reconciled according to the facility protocol to prevent potential diversion for 1 of 1 emergency kits reviewed. Findings include: Observation and interview on 3/3/25 at 3:36 p.m., with registered nurse (RN)-C of the medication			F 761	The facility Medical Director was made aware of the Lorazepam not being counted and reconciled in the narcotic book or count. The Lorazepam was immediately added to the narcotic count book upon notification from the surveyor. The Medical Director's response will be recorded in the next QAPI meeting report. There were no ill effects experienced by residents for this deficient practice. For		4/3/25

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F 761	Continued From page 102 room on first floor. Observed was a refrigerator with a paddle lock on it with the key being on the nurse's key ring. Located inside the refrigerator was a clear box with 2 vials of Lorazepam 2 milligrams/milliliter (MG/ML) an antianxiety medication and a red plastic tag with the number 0501539. RN-C reported that the Lorazepam was from the emergency kit and counted each shift. The count was documented in the narcotic log located on the medication cart. Review of the narcotic logbook with RN-C found he was unable to find that the Lorazepam had been reconciled and documented. RN-C revealed that at shift change they had not checked the emergency Lorazepam from the refrigerator. RN-C confirmed that the nurses should be confirming the red plastic tag number on the box with the emergency Lorazepam each shift to monitor for diversion. Review of the emergency kit medication list identified Lorazepam 2mg/ml quantity of 2 vials. Interview on 3/3/25 at 3:45 p.m., with licensed practical nurse (LPN)-A confirmed that the emergency Lorazepam located in the refrigerator had not been getting reconciled. LPN-A agreed that the Lorazepam red tag number and amount should be monitored at each shift change. Interview on 3/3/25 at 3:50 p.m., with director of nursing (DON) confirmed that the emergency Lorazepam should be monitored each shift and that the nursing staff should be documenting the red tag number and verifying the amount to monitor for diversion. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that the nursing staff would monitor controlled medication	F 761	future controlled drugs that are stored at the facility, the facility licensed nurses will include the stored narcotic counts during shift change per facility and pharmacy policy. Licensed nurses were in-serviced on the Controlled Substances policy which instructs the oncoming nurse to reconcile the count with the off going nurse together. Discrepancies in controlled medications would be documented and reported to the director of nursing. The Director of Nursing and/or designee is responsible for compliance. Audits on accuracy of narcotic counts along to include refrigerated narcotics will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 761	Continued From page 103 to avoid the risk of medication diversion. Review of 3/3/25, Controlled Substances policy identified that the facility would reconcile controlled medication upon receipt, administration, disposition, and at the end of each shift. The nurse coming on duty and the nurse going off duty would reconcile the count together. Discrepancies in controlled medications would be documented and reported to the director of nursing. Investigations in all discrepancies of controlled medication would be completed. The discrepancies would be reviewed with the pharmacist and administrator to determine further action if needed. The director of nursing would periodically review policies and procedures for monitoring controlled medication to prevent diversion.	F 761			
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure 1 of 1 resident (R18) received ordered therapeutic diet to maintain or improve their nutritional status. Findings include:	F 808	R 18 s diet slip was updated to reflect resident current diet. There were no ill effects experienced with this deficient practice. The dietary manager will meet with the resident and review diet likes/dislikes/preferences. Resident		4/3/25

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F 808	Continued From page 104 R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. Review of the 5/14/24, Centers for Disease Control (CDC), "Diabetes and Kidney Disease: What to Eat": article located at, https://www.cdc.gov/diabetes/healthy-eating/diabetes-and-kidney-disease-food.html, identified, A healthy diabetes diet looks pretty much like a healthy diet for anyone. Eat lots of fruits, veggies, healthy fats, and lean protein. Eat less salt, sugar, and foods high in refined carbs. With a chronic kidney disease (CKD) diet, you'll avoid or limit certain foods to protect your kidneys. You'll include other foods to give you energy and keep you nourished. Your specific diet will depend on whether you're in early-stage or late-stage CKD or if you're on dialysis. Depending on your kidney disease stage, you may also need to reduce the potassium, phosphorus, and protein in your diet. Many foods that are part of a typical healthy diet may not be right for a CKD diet. Your nutrition needs will change with late-stage CKD. If you're on dialysis, you may need to eat more, especially more protein. Your appetite can change because food tastes different. R18's 1/23/25, hospital discharge orders	F 808	response will be added to the resident dietary care plan interventions. All current residents, their diet orders and diet slips were audited, and any inconsistencies will be reviewed and updated as needed. Future resident diet orders, diet slips and meals will be served per MD order. The dietary manager was in-served on the Diet and Nutrition Care for Renal Dialysis with emphasis on carbohydrate control, fluid restriction, potassium and phosphorus levels must be adjusted to maintain normal range through this type of diet. The dialysis RD will also be contacted for dietary coordination. The Dietary Manager is responsible for compliance. Audits on diet orders, meal tickets and meal delivery will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 808	Continued From page 105 identified renal consistent carbohydrate diet. R18's 2/27/25, Order Summary Report identified R18 was on a renal diet and consistent carbohydrate diet. Review of R18's diet slip from the dietary department identified diet as diabetic. There was no mention of foods to avoid or special instruction on the diet slip. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. R18 had no mention of nutritional status and diet to be provided. Interview on 2/26/25 at 3:46 p.m., with dietary aide (DA)-A who reported she was unaware of what a renal diet consisted of but could ask the cook if she knew. Interview on 2/26/25 at 4:23 p.m., with nursing assistant (NA)-A who reported R18 was on no restrictions, and she did not care for the food offered to her, so her daughter brought her food in frequently. Interview on 2/27/25 at 9:20 a.m., with registered nurse (RN)-D who reported R18's orders identified R18 was on a renal diet and consistent carbohydrate diet. Interview 2/27/25 at 9:28 a.m., with cook (C)-B who identified R18 was on a diabetic diet and not on a renal diet. The kitchen did not give her anything special for a diet, she was served the same foods as everyone else but in smaller portions. .	F 808			

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F 808	Continued From page 106 Interview on 2/27/25 at 12:21 p.m., with dietary manager identified upon admission she was given a diet slip for a diabetic diet for R18. She confirmed she knew R18 attended dialysis, so she received smaller portions. R18 was to also avoid potassium. R18 basically received the same diet as everyone else but smaller portions. R18 had no fluid restrictions, and her labs were followed by the hospital dietician. Interview on 3/3/25 at 12:14 p.m., with C-B who reported she served R18 fried chicken, mashed potatoes, and sherbet for lunch. She revealed she sent the tray up to first floor between 11:45 and 12:00 noon. R18 received smaller portion sizes verse the regular size meal as she was on a diabetic diet. Interview on 3/3/25 at 12:18 p.m., with licensed practical nurse (LPN)-A identified R18 left at 11:30 a.m., for dialysis. LPN-A reported that R18's daughter brought R18 food frequently. No dietary tray was sent up for R18 because the kitchen does not send meal trays to R18 on dialysis days as her daughter will bring her food. LPN-A was unsure how staff documented meal intakes when her daughter brings her food. Interview on 3/3/25 at 1:51 p.m., with dietary manager identified nursing communicates diet orders by filling out a diet slip. R18's daughter brings her food in frequently as R18 wants more tradition foods related to her culture. The dietary department does not send a meal tray to R18 if they know that the daughter brought her in food. Interview on 3/3/25 at 2:00 p.m., with RN-D identified a copy of the diet order upon admission was given to the dietary department and a dietary	F 808			

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F 808	Continued From page 107 slip was filled out with the diet order. If there was a new dietary order from dialysis nursing would give a copy of that order to the dietary department and fill out the dietary slip. Interview on 3/3/25 at 4:57 p.m., with registered dietician (RD) identified the dietary department should be knowledgeable about a renal diet. R18 should be on a renal diet and receive limited potatoes, and potassium rich food. R18 should be served a meal tray regardless of the daughter bringing in food for her. R18 can decline to eat the meal but should be offered the meal. Interview on 3/4/25 at 8:15 a.m., with medical director identified his expectation was that dietary department would provide the appropriate prescribed diet as ordered. A copy of the original physician diet order was request but not provided. Review of undated Diet and Nutrition Care Manual for Renal Dialysis identified carbohydrates should be controlled if needed in residents with hyper or hypo glycemia, sodium should be restricted if needed to avoid excessive fluid retention, fluid intake was individualized, potassium should be adjusted to maintain a potassium level within normal range. Phosphorus should be adjusted to maintain phosphate levels in the normal range.	F 808			
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 -	F 812			4/3/25

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F 812	Continued From page 108 §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 the ice machine, kitchen and food prep areas were kept clean and sanitary. This has the ability to affect all 56 residents. Findings include: Observation and interview on 2/25/25 at 7:15 a.m., during the initial kitchen tour a stainless-steel food prep counter across from the stove had a lower shelf directly below. The lower shelf was used to store cutting boards, oatmeal, oil, cooking spray, and small cups used for serving condiments. The shelf had a dry black/brown substance on it and a brown liquid substance covering a large area of the shelf. In addition, approximately the first 3-5 inches from the edge of the shelf nearest to the stove and covering the full length of the shelf had a greasy, sticky build-up. The area had dirt and grime stuck	F 812	The facility ice machine was emptied and thoroughly cleaned on 3/24/2025. The kitchen will be thoroughly cleaned on 3/26/2025. There were no ill effects experienced by residents for this deficient practice. Dietary staff will be in-serviced on the General Sanitation of Kitchen policy with emphasis on the dietary manager assigning tasks to a specific position for cleaning and the frequency in which cleaning will be performed. Staff will also be in-serviced that no personal items will be allowed in the resident kitchen. Dietary Manager is responsible for compliance. Audits on Ice Machine cleaning 2x monthly and kitchen cleanliness audits to include no staff items will begin 2x a week for 3 weeks, weekly x 2 week then monthly to ensure sustained compliance.		

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F 812	Continued From page 109 to the greasy area. The shelf had a plastic container containing condiment cups, the container was visibly dirty with unknown brown substance. Food crumbs could be seen laying in the bottom of the container. On 2/25/25 at 4:45 p.m., during a follow up observation of the kitchen, identified cook-C was sitting on the freezer using her cellular phone. Interview on 2/25/25 at 4:45 p.m., with cook-C agreed with the above finding and identified they were not supposed to be sitting on the freezer as this area was at times used to set food on, in addition she identified they were not supposed to use their cell phones in the kitchen as this could be a source of cross contamination. Interview on 2/26/25, at 10:28 a.m., with the dietary manager (DM), she agreed with the concerns regarding the cleanliness of the kitchen, she identified that staff are signing off that they completed the cleaning, she reported that she may need to do some re-training with staff and she may have to be more specific on her cleaning logs as to what staff are expected to clean. Interview on 3/3/25 at 4:45 p.m., with the registered dietitian (RD), identified she would expect staff to only use their cell phone while on break and in the staff break room. Personal items such as cell phones should be left in a locker and not brought into the kitchen. She identified this practice could potentially cause cross contamination with food. In addition, she would not expect staff to use the chest freezer as a seating area. She identified that she has not completed any visual audits of the kitchen and was not aware of the lack of cleanliness. She	F 812	Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 812	Continued From page 110 would expect the dietary manager to be auditing regularly and ensuring the daily cleaning is completed properly. Observation on 2/26/25, at 8:40 a.m., of the ice machine located in a hallway connecting the main building with a house where offices were located. The ice machine had a white crusty buildup (like mineral deposits) visible from the outside of the machine located between the plastic hinged lid/door and the machine. inside the door at the top of the opening just above the ice bin, a strip of metal had a black/gray/brown spotty build up going all the way across. Some of the buildup was removable with a dry paper towel and friction rubbing the area. Interview on 2/25/25 at 8:40 a.m., with the Maintenance director identified he had been working in the building since last fall when they closed the other facility. He reported he does not keep a log of when he cleans and de-scales the ice machine, when it "comes up in tells" I clean it. He cleans it about every 6 months and does a deep clean about once a year. He reported it had been de-scaled last August of 2024 and cleaned a little before thanksgiving. Review of the Manitowok Indigo Ice Machine Manufacturer Installation, Use, and Care Manual identified the ice machine should be cleaned and sanitized every 6 months. Review of the General Sanitation of Kitchen policy identified the kitchen cleaning schedule with be outlined in writing, tasks will be assigned to the responsibility of a specific position, frequency of cleaning for each task will be defined. Employees will initial, and date when the	F 812			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2025
NAME OF PROVIDER OR SUPPLIER THE SHORES OF WORTHINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187		
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F 812	Continued From page 111	F 812			
F 838 SS=F	task was completed. Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations	F 838			4/3/25

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F 838	Continued From page 112 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process:			F 838			

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F 838	Continued From page 113 (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not	F 838			

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F 838	Continued From page 114 limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement 1 of 1 facility assessment protocol related to ensuring staff competencies were identified and completed respective to staff duties performed. This has the ability to affect all 56 residents. Findings include: Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to review, identify and determine appropriate interventions and oversight of outcomes brought forth Interview on 3/04/25 at 2:26 p.m., with administrator identified the merge of two nursing homes, that included residents and staff, added an extra layer of challenges the facility was currently navigating. He identified updates of the facility assessment, had not yet been implemented, including staff education. However, He identified there was decisions made in relation to resident cares, resources and services that were to relay to all staff the facility's operational goals and performance improvement projects (PIP). Review of August 2024 Facility Assessment Tool identified the leadership team would discuss goals to ensure direct care staff are trained to provide services to residents. The facility identified staff education, training, certifications, testing, and facility policies to support the care	F 838	Facility Assistant Director of Nursing began competency for new employees on 2/10/2025. The remaining employees will be audited and those that are needing competency for March will have competency completed and this process will continue monthly. The facility assessment will be updated to include roles and duties that are assigned to the clinical leadership. There have been no ill effects experienced by residents for this deficient practice. The Administrator will be in-serviced on the Facility Assessment tool which indicates that the leadership team will discuss goals to ensure direct care staff are trained to provide services to residents. The Assistant Director of Nursing is responsible for compliance. Audits on facility staff competency completion will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 838	Continued From page 115 needed for the residents. In addition, the facility would gather input from residents, family members and staff of concerns and expectations that would meet residents needs through regulatory, operational, maintenance and staff training requirements. Lastly, the facility would review resources annually, and would evaluate day to day operations, including emergencies, to identify and act on opportunities for improvement and to ensure residents care maintain their highest practicable physical, mental and psychosocial well-being.	F 838			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842			4/3/25

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F 842	Continued From page 116 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842			

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F 842	Continued From page 117 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to include the run/communication report from dialysis in the facility medical record for 2 of 2 residents (R18 and R42) reviewed for dialysis, in addition the facility failed to transcribe physician order for 1 of 1 resident (R44) following an appointment. Findings include: R18's Admission Record identified R18 was admitted to the facility at the end of January 2025. R18 had the following diagnoses of chronic kidney disease stage 5, anemia, type 2 diabetes mellitus, and vitamin D deficiency. R18's 1/29/25, admission Minimum Data Set (MDS) assessment identified R18's cognition was intact. R18 had no behavior and required moderate assistance with cares. R18 took a daily anticoagulant, diuretic, and antiplatelet. R18 attended dialysis. R18's 1/24/25, care plan identified R18 required hemodialysis related to renal failure. Staff were to encourage her to attend dialysis. The care plan lacked identification of dialysis schedule or where R18 attended dialysis. R18's electronic medical record, point click care (PCC) identified R18 had 2 copies of her dialysis run/communication report. One report was dated 1/24/25 and the second report was dated 1/27/25. The facility electronic medical lacked all other dialysis run/communication reports from dialysis.	F 842	Dialysis Report R 18 was discharged from the facility. R 42 had dialysis observation orders entered into the electronic medical record, the post dialysis assessment completed, and the care plan reviewed, the treatment facility report uploaded and updated as needed. As of this writing, there are no other residents receiving dialysis services. Future residents who admit receiving dialysis services, the dialysis batch orders will be activated, post assessment completed, post dialysis run facility report uploaded, and care plan initiated per facility policy. Facility licensed nurses will be in-serviced on the Dialysis Care External Facility so that the nurse will observe the resident access site upon return from dialysis treatment for bleeding and/or other complications. The Director of Nursing is responsible for compliance. Audits on post dialysis assessment completion and dialysis orders for observation of dialysis site will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Resident Order R 44 s attending physician was made aware of the delay in processing the		

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F 842	Continued From page 118 R42's Admission Record identified R42 was admitted to the facility in August of 2024. R42 had the following diagnoses of type 2 diabetes mellitus, end stage renal disease, cirrhosis of liver, and history of traumatic fractures. R42's 2/19/25, quarterly MDS assessment identified R42's cognition was intact. R42 was dependent on staff for most cares. R42 had some behaviors towards others and rejection of care. R42 took insulin daily, an antidepressant and antiplatelet daily. R42 attended dialysis. R42's undated, care plan identified nutritional status as resident will consume 75% of meals and to modify diet as appropriate according to the resident's food tolerances and preferences. R42's care plan lacked identification that R42 was on dialysis, the location of an access site, any precaution that may be needed, or for any monitoring of an access site. The care plan lacked R42's dialysis schedule or where R42 attended dialysis. R42's 3/4/25, Order Summary Report identified R42 was on a renal diet. The order summary lacked identification of dialysis access site monitoring and lacked dialysis schedule. R42's electronic medical record PCC identified the last dialysis run/communication report was from 1/27/25 with no further reports in R42's facility medical record. Interview on 3/3/25 at 11:24 a.m., with registered nurse (RN)-B identified contracted licensed nurses working at the facility were unable to access hospital medical records. We used to	F 842	medication and ace wrap orders. The physician's response and any corresponding orders will be recorded in the resident medical record. All current and future residents who return from the hospital or outside clinic appointments, their orders will be transcribed fully by the licensed nurse per facility policy. Licensed nurses will be in-serviced on the Medication and Treatment Orders, Transcription that medication and treatment orders will be processed upon return from the visit or hospital stay. The Director of Nursing is responsible for compliance. Audits on medication or treatment order processing timely will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 842	Continued From page 119 have a medical records person, that could obtain and add records from the hospital to the facility medical record, but we no longer have the position. Review of 6/19/19, Dialysis Agreement identified communication would be shared between dialysis and the nursing home regarding the run summary, any related dialysis complications, new orders, and any changes in condition or concerns related to the vascular access site. Review of 11/3/21, Dialysis Care External Facility policy identified shared communication between the dialysis center and the nursing home would be coordinated by the director of nursing or designee. The communication would include post weight, blood pressure and dialysis site condition. Nutritional management will be coordinated between the dialysis dietitian and the facility dietician with recommendation initiated when received. R44's 1/28/25, admission Minimum Data Set assessment identified her cognition was moderately impaired. She required extensive assistance with her activities of daily living (ADL)'s. R44 had diagnosis of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), heart failure, renal insufficiency, dementia, anxiety, depression, and morbid obesity. Interview on 2/27/25 at 9:18 a.m., with FM-H identified that R44 had seen a physician last week and at the appointment R44 had increased swelling to her lower legs. The physician placed orders to add a "water pill" to decrease fluid in legs, and for staff to wrap her legs or put	F 842			

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F 842	Continued From page 120 compression stocking on daily. He reported that on 2/23/25 he went to the facility to visit and R44 did not have any leg wraps on. FM-H spoke with the charge nurse, and she identified she was not aware of the new orders but would check into it. Observation on 3/3/25 at 9:50 a.m., R44 is seated in a wheelchair, head facing downward with eyes closed. Legs are wrapped from her feet to just below the knee in ace bandages and feet are down on the floor. R44's March 2025 medication administration record identified an order to apply ace wraps to bilateral lower extremities daily. The order entry date was 2/27/25, the order had been transcribed 8 days after it was received from the physician. Furosemide oral tablet 20 mg twice daily in addition to 20 mg for a total of 40 mg twice daily for 30 days transcribed on 2/21/25, 2 days after the order was received. R44's medication/treatment administration record lacked any direction for nursing staff to elevate lower extremities or to apply antifungal powder under abdominal folds. Interview on 3/3/25, at 11:15 a.m., with RN-B and RN-D, identified their process is to review the new order upon receiving, transcribe the order, make a nursing progress note, and place the original copy in a wall pocket behind the nurse's station for the medical records person to scan into the medical record. They identified the orders received following R44's 2/19/25 appointment had been transcribed late and the original order was not yet scanned into the medical record. RN-B reported they did not currently have a medical record person, and she was told they had planned to resolve that position, she stated	F 842			

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F 842	Continued From page 121 "nursing does not have time to scan all the orders in", she further revealed that they only complete a second check on narcotic orders and admission orders. Subsequent interview on 3/3/25, at 11:58 a.m., RN-B came to the conference room with the original order. She reported she found the order in a pile of papers that were waiting to be scanned in. R44's 2/19/25, original physician order identified staff were to apply antifungal powder under abdominal folds, apply compression stockings or ace wraps to lower extremities daily, keep lower extremities elevated as much as possible, and increase Lasix to 40 milligrams (mg) twice daily for 30 days. Interview on 3/4/25 at 8:15 a.m., with the facility medical director identified he would expect facility staff to transcribe and implement physician orders upon receipt. A facility policy for order transcription was requested but nothing was provided by the end of the survey period.	F 842			
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:	F 865			4/3/25

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F 865	Continued From page 122 §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life,			F 865			

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F 865	Continued From page 123 and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and	F 865			

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F 865	Continued From page 124 §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 56 residents. Findings include: Review QAPI minutes from February 2024 through January 2025, identified department heads were bringing data forth to QAPI on various topics such as infection control, falls, incident reports, vaccinations, etc. However, there was no documented benchmarks for goals the facility was trying to achieve, nor monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to	F 865	QAPI Program/Plan It is the policy and procedure for The Shores of Worthington to ensure ongoing QAPI committee oversight, review of operations, identify opportunities for improvement, determine root causes, and implement a performance improvement project. All residents have the potential to be affected by the deficient practice. The QAPI committee will monthly utilize such resources as Point Click Care, CMS, Nursing Home Compare, Pharmacy Vendor Reports, Customer satisfaction and other facility internal tracking reports to analyze data to identify, prioritize, and implement actionable plans. The committee members will be retrained on the QAPI policy. QAPI concerns will be reviewed monthly by the Regional Nurse Consultant and/or VP of Operations prior to the QAPI		

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F 865	Continued From page 125 review, identify and determine appropriate interventions and oversight of outcomes brought forth. Interview on 3/04/25 at 2:09 p.m., with administrator identified the merge of two nursing homes, that includes residents and staff, added an extra layer of challenges the facility was currently navigating. He identified there was no measurable goals set, or if goals were met to improve areas identified in QAPI. He and the QAPI committee would need to formalize a process to identify improvements that would reflect changes as needed in QAPI. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources and services.	F 865	meeting and any ongoing concerns will be forwarded to the Governing Board for review to ensure resolution. MD recommendations will also be forwarded for review by the Governing Board. The facility administrator was in-serviced on the QAPI process, form and necessary elements for reporting by the regional nurse consultant. The monthly QAPI report will be reviewed by the governing board to ensure deficient practice is being corrected. Compliance: 04/03/2025		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867			4/3/25

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F 867	Continued From page 126 procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,	F 867			

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F 867	Continued From page 127 and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope	F 867			

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F 867	Continued From page 128 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement an action plan to correct the identified concerns or to ensure the committee participated in the development and oversight of implementation of systems, and to ensure quality of life and quality of care were maintained for 57 residents residing in the facility. Findings include:	F 867	The IDT team will conduct an emergency QAPI on 3/25/2026 to identify facility concerns, implement an action plan to correct identified concerns with the overall goal to ensure that the quality of life and care is maintained for the facility residents. The IDT team and facility staff will be in-serviced on the QAPI Plan Policy that provides a means to identify and resolve potential negative outcomes related to resident care.		

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F 867	Continued From page 129 Review of QAPI minutes from February 2024 to January 2025, identified on 4/19/24 the facility was to implement a performance improvement project (PIP) of abuse allegations. There was no mention on how the facility would meet goals, monitor progress or evaluate current measures to ensure compliance. Interview on 3/04/5 at 8:15 a.m., with medical director voiced agreement the facility was to review, identify and determine appropriate interventions and oversight of outcomes brought forth. Interview on 3/04/25 at 2:26 p.m., with administrator identified the merge of two nursing homes, that includes residents and staff, added an extra layer of challenges the facility was currently navigating. He identified there were challenges and improvements related to resident cares, resources and services to be streamlined and identified in QAPI. He identified the facility had no performance improvement projects in place at this time. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources	F 867	The Facility Administrator is responsible for compliance. Audits on identified areas of concern and action plan from the monthly QAPI report for each will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 867	Continued From page 130	F 867			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880			4/3/25

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F 880	Continued From page 131 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 off document and interview, the facility failed to ensure 1 of 1 resident (R41) with a highly infectious disease (Hepatitis C) was placed into the infection control (IC) surveillance data for monitoring. In addition, the facility failed to ensure oversight of the IC program was maintained for tracking, trending, and analysis of data to prevent potential spread of infection. The facility also	F 880	Transmission Based Precaution R41 was admitted to and remains in a single room. R 41 was placed on enhanced precautions on 3/17/2025 and an infection control case was initiated. R 41 MD will be made aware that the resident was not on the proper precautions and the MD response will be		

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F 880	Continued From page 132 failed to include staff return to work information in surveillance to identify if they were appropriately vetted before their return for 1 of 3 months (January 2025) reviewed. This has the potential to affect all 56 residents. Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C. R41's current, undated care plan identified there was also no mention of his Hepatitis C diagnosis. Review of the surveillance for February and March identified infections were getting logged into the tracking system in the facility electronic medical records system (Point Click Care (PCC) by facility staff. R41 was not listed as being included in surveillance for his diagnosis of	F 880	recorded in the resident record. R41's care plan will be initiated for risk for infection and the necessary interventions will be initiated. There were no ill effects experienced by residents or staff for this deficient practice. All current residents will be reviewed for enhanced precautions and their infection control case listing will be reviewed and updated as needed. Future residents with active diagnosis and history of MDRO will be placed in the proper transmission-based precautions. Licensed nurses will be in-serviced on the Transmission Based Precaution Categories with emphasis on item #5 that when a resident is suspected of having an infection, they are placed in transmission-based precautions and the proper signage will be placed to indicate the need for the proper precautions and the CIP will ensure that laboratory results, tracking of infections, care plan and the appropriate documentation is present. The Infection Preventionist and/or designee is responsible for compliance. Audits on identifying s/s of infection, placing residents in the appropriate transmission-based precautions, every shift documentation on resident infection status, infection control line listing, and MD documentation of completion of resident signs and symptoms will begin 2 x week for 3 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation.		

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F 880	Continued From page 133 Hepatitis C. Review of the facility's previous revisit directed plan of correction for a deficiency cited in January 2025 identified the facility was to have contracted with a contracted infection preventionist (CIP). The contract began 2/17/25, The CIP was to have begun working immediately with the facility in assisting with the root cause analysis of the program related to the deficient practice, review the program as a whole, review the plan of correction, and support the facility in developing audit tools. Interview on 3/3/25 at 11:00 a.m., with the administrator identified the infection preventionist was out on medical leave and registered nurse (RN)-B was to oversee the program in her absence. Interview on 3/3/25 at 2:15 p.m., with RN-B identified she was never told to assist in oversight of the IC program. She had no knowledge of what was being inputted into the PCC program for tracking infections. Review of the employee line listings for December 2024 through February 2025 identified in January, 2025, there were 3 staff illnesses reported. The symptoms resolved category and the return to work column were left blank. Illnesses recorded were coughs, fever, and abdominal pain. During follow-up email correspondence with the director of nursing (DON) on 3/4/25, The DON had to check with payroll for 2 staff, however she was also listed as having been ill that month. She noted she had forgot to put in her return to work date into the IC surveillance. The DON agreed all data needed to	F 880	Compliance: 04/03/2025 Employee Tracking Employee Tracking line listing for January through present, all employee illnesses will be recorded. From survey exit to present, employee illnesses will be entered into the line listing and resolution of symptoms will be recorded. Monthly, employee illnesses will be calculated for tracking and trending and reported to monthly QAPI reporting. Facility staff will be in-serviced on the Employee Pre/Post Respiratory with emphasis on item #1 that employees must notify the Infection Preventionist of reportable conditions and will be notified not to work until symptoms are resolved. Director of Nursing and/or designee is responsible for compliance. Audits on employee illness line listing and infection preventionist supplemental notes for employee return will begin weekly x 2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Compliance:04/03/2025		

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F 880	Continued From page 134 be inputted to ensure illnesses were tracked and staff were kept off work for the appropriate amount of time. Interview on 3/03/25 at 5:37 p.m., with the DON identified the IP was off work beginning right after the State Agency revisit on 2/14/25. They had not had a meeting with a consultant until last week. The CIP had not yet reviewed or provided assistance with the IC program. The DON agreed R41's Hepatitis C was a highly infectious disease and should be on the surveillance. The facility had no one to cover IC during the IP continued absence. The facility had only first spoken to the hired consultant last week. They did not have a plan to cover the IP while on medical leave. Agreed IC needed appropriate oversight at all times to review data. Interview on 3/4/25 at 8:16 a.m. with the medical director (MD)-A identified he was unaware that facility had no active IP due to medical leave and no staff had replaced her. He agreed the IC program required direct oversight. He was also unaware the CIP was not advised of the facility's inability to designate an IP in IP-A's absence. R41's Hepatitis C should be included on the facility's surveillance as it is a highly infectious disease. There was no policy related to oversight of the IC program provided by the end of survey.	F 880			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)	F 882			4/3/25

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F 882	Continued From page 135 (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based off document and interview, the facility failed to ensure oversight of the IC program was maintained to provide appropriate oversight for tracking, trending, and analysis of data to prevent potential spread of infection. This had the ability to affect all 56 residents. Based off document and interview, the facility failed to ensure 1 of 1 resident (R41) with a highly infectious disease (Hepatitis C) was placed into the infection control (IC) surveillance data for monitoring. In addition, the facility failed to ensure oversight of the IC program was maintained for tracking, trending, and analysis of data to prevent potential spread of infection. The facility also failed to include staff return to work information in surveillance to identify if they were appropriately vetted before their return for 1 of 3 months (January 2025) reviewed. This has the potential to affect all 56 residents.	F 882	The facility has designated a new Infection Preventionist (IP) designee on 2/10/2025. IP training began March 21, 2025, and will be ongoing tentatively until May 2, 2025. The CIP (DON and ADON) will oversee the IP in training until training is completed. R41 was admitted to and remains in a single room. R 41 was placed on enhanced precautions on 3/17/2025 and an infection control case was initiated. R 41 MD will be made aware that the resident was not on the proper precautions and the MD response will be recorded in the resident record. There were no ill effects experienced by residents or staff for this deficient practice. All current residents will be reviewed for enhanced precautions and their infection control case listing will be reviewed and updated as needed. Future residents with active diagnosis and history of MDRO will be placed in the proper		

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F 882	Continued From page 136 Findings include: R41's face sheet identified he was admitted to the facility in September 2024. R41 had a recent hospital stay 11/4/24 through 11/6/24 and had diagnoses of hypoparathyroidism (parathyroid glands do not produce enough parathyroid hormone and treated with medication), history of a lumbar spinal fracture, right leg fracture, right artificial hip, hypothyroidism (thyroid gland does not produce enough thyroid hormone), generalized anxiety disorder, and multiple fractures of ribs. R41's 11/25/24, quarterly Minimum Data Set (MDS) identified R41 was admitted to the facility (from the now closed sister facility) in September 2024. R1 was noted to have delusions with no behaviors identified. R41's 11/19/24, physician progress note identified the PCP noted additional diagnoses from the previous visit of chronic hepatitis C. R41's current, undated care plan identified there was also no mention of his Hepatitis C diagnosis. Review of the surveillance for February and March identified infections were getting logged into the tracking system in the facility electronic medical records system (Point Click Care (PCC) by facility staff. R41 was not listed as being included in surveillance for his diagnosis of Hepatitis C. Review of the facility's previous revisit directed plan of correction for a deficiency cited in January 2025 identified the facility was to have contracted with a contracted infection preventionist (CIP).	F 882	transmission-based precautions. Employee Tracking line listing for January through present, all employee illnesses will be recorded. From the survey to present, employee illnesses will be entered into the line listing and resolution of symptoms will be recorded. Monthly, employee illnesses will be calculated for tracking and trending and reported to monthly QAPI reporting. Facility staff will be in-serviced on the Employee Pre/Post Respiratory with emphasis on item #1 that employees must notify the Infection Preventionist of reportable conditions and will be notified not to work until symptoms are resolved. Director of Nursing and/or designee is responsible for compliance. Audits on employee illness line listing and infection preventionist supplemental notes for employee return will begin weekly x 2 weeks, then monthly to ensure sustained compliance. In addition, audits on identifying s/s of infection, placing residents in the appropriate transmission-based precautions, every shift documentation on resident infection status, infection control line listing, and MD documentation of completion of resident signs and symptoms will begin 2 x week for 3 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Compliance: 04/03/2025		

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F 882	Continued From page 137 The contract began 2/17/25, The CIP was to have begun working immediately with the facility in assisting with the root cause analysis of the program related to the deficient practice, review the program as a whole, review the plan of correction, and support the facility in developing audit tools. Interview on 3/3/25 at 11:00 a.m., with the administrator identified the infection preventionist was out on medical leave and registered nurse (RN)-B was to oversee the program in her absence. Interview on 3/3/25 at 2:15 p.m., with RN-B identified she was never told to assist in oversight of the IC program. She had no knowledge of what was being inputted into the PCC program for tracking infections. Review of the employee line listings for December 2024 through February 2025 identified in January, 2025, there were 3 staff illnesses reported. The symptoms resolved category and the return to work column were left blank. Illnesses recorded were coughs, fever, and abdominal pain. During follow-up email correspondence with the director of nursing (DON) on 3/4/25, The DON had to check with payroll for 2 staff, however she was also listed as having been ill that month. She noted she had forgot to put in her return to work date into the IC surveillance. The DON agreed all data needed to be inputted to ensure illnesses were tracked and staff were kept off work for the appropriate amount of time. Interview on 3/03/25 at 5:37 p.m., with the DON identified the IP was off work beginning right after	F 882			

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F 882	Continued From page 138 the State Agency revisit on 2/14/25. They had not had a meeting with a consultant until last week. The CIP had not yet reviewed or provided assistance with the IC program. The DON agreed R41's Hepatitis C was a highly infectious disease and should be on the surveillance. The facility had no one to cover IC during the IP continued absence. The facility had only first spoken to the hired consultant last week. They did not have a plan to cover the IP while on medical leave. Agreed IC needed appropriate oversight at all times to review data. Interview on 3/4/25 at 8:16 a.m. with the medical director (MD)-A identified he was unaware that facility had no active IP due to medical leave and no staff had replaced her. He agreed the IC program required direct oversight. He was also unaware the CIP was not advised of the facility's inability to designate an IP in IP-A's absence. R41's Hepatitis C should be included on the facility's surveillance as it is a highly infectious disease.	F 882			
F 944 SS=F	There was no policy related to oversight of the IC program provided by the end of survey. QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 944	The facility general orientation includes		4/3/25

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F 944	Continued From page 139 facility failed to provide mandatory training on 1 of 1 facility specific Quality Assurance Performance Improvement (QAPI) Program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. This had the ability to affect all 57 residents. Findings include: Interview on 3/03/25 at 2:58 p.m., with Registered nurse (RN)-B and RN-D identified the facility held scheduled meetings for residents and staff. Both RN-B and RN-D had not attended QAPI meetings and was not aware of any facility specific performance improvement projects. Interview on 3/03/25 at 3:04 p.m., with admission coordinator identified the facility plan was to prevent further infection control outbreaks related to COVID and respiratory syncytial virus (RSV). Interview on 3/03/25 at 3:09 p.m., with licensed practical nurse (LPN)-A identified she was not aware of QAPI meetings held and/or specific QAPI goals. Interview on 3/03/25 at 4:10 p.m., with RN-A identified she was aware the facility had monthly QAPI meetings and had not attended them. There were care areas and services the facility would need to address, but she could not identify any specific QAPI goals the facility had in place. Interview on 3/03/25 at 4:23 p.m., with nursing assistant (NA)-A identified she has attended	F 944	the invitation for all employees to participate in the facility QAPI committee and join a PIP. The facility will post the QAPI meeting time and will encourage employees to participate. In addition, the facility Administrator will make QAPI notes available after each meeting for facility staff to review. At the next and subsequent general orientation sessions, this invitation will be emphasized. The IDT team along with the HR designee will be in-serviced on the Staff Development Policy with emphasis on item #5 that QAPI is required training and staff are introduced to the elements and goals of the QAPI program. In addition, employees will continue to be invited to participate in QAPI meetings and encouraged to join a performance improvement program. The Administrator is responsible for compliance. Audits on monthly QAPI announcement, QAPI attendance and QAPI reports being available after the meeting will begin weekly x 1 week then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 04/03/2025		

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F 944	Continued From page 140 QAPI meetings, in the past, if her schedule allowed, but was not aware of any QAPI goals the facility was monitoring. Review of email correspondence on 3/04/24 at 9:15 a.m., with director of nursing identified there was no formal education for employees of QAPI training. Interview on 3/04/25 at 2:09 p.m., with administrator identified the facility provided QAPI education to staff upon employment and would work towards formalizing QAPI requirements for all employees going forward. Review of December 20219 Quality Assurance and Performance Improvement (QAPI) policy identified the facility would review clinical and nonclinical systems to determine areas of improvement. The facility's performance improvement project (PIP) was identified in areas that were unique to the facility's needs. The QAPI committee would establish benchmarks to determine facility improvements, analyze data for accuracy and determine root cause. Lastly, the QAPI committee would modify QAPI template, as well as the facility assessment as needed to identify complexities and/or evolving resources and services. Employee QAPI training was requested and not provided during survey.	F 944			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/27/2025. At the time of this survey, South Shore Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This 2-story with partial basement facility was built in 1962, with building additions constructed in 1964 and 1968; All are fully sprinklered and were determined to be of Type I (332) construction. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2 The facility has a capacity of 69 beds and had a census of 57 at the time of the survey.			K 000			
K 271 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.7.4, and 7.1.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 AM to 12:00 PM, it was revealed by observation that the exit discharge sidewalk from the D wing back door was heaved causing the walking surface to not be level. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 271	Waiver requested through MDH Waiver Compliance date:09/30/2025		4/3/25
K 324	Cooking Facilities			K 324			4/3/25

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K 324 SS=F	Continued From page 3 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.			K 324	K324 Cooking Facilities Immediate Corrective Action: Interruption in monitoring was caused by a scheduling issue. The issue was rectified, and the inspection was completed in December of 2024. Facility continued monitoring has been scheduled with Midwest Mechanical. Corrective Action as it applies to others:		

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K 324	Continued From page 4 This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed during documentation review that the facility could not provide documentation that the range hood suppression system was being inspected every 6 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	The Administrator and Maintenance Director were educated on the need to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 Edition) Life Safety Code, sections 19.3.2.5, 9.2.3, and NFPA 96 (2014 Edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that range hood ventilation inspections are scheduled, and documentation of past inspections is on-hand. Corrections will be monitored by: Administrator and Maintenance Director		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353			4/3/25

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K 353	Continued From page 5 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that there was PVC piping zip tied to the sprinkler pipe in the elevator room. 2. On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the sprinkler head in the dishwashing room was heavily corroded. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	K353- Sprinkler Maintenance and Testing Immediate Corrective Action: PVC pipe was removed on 2/28, sprinkler head in the dishwashing room was replaced on 3/10. Corrective Action as it applies to others: The Administrator and Maintenance Director were educated on the need to maintain the fire sprinkler system per NFPA 101 (2012 Edition) Life Safety Code, section 9.7.5, and NFPA 25 (2011 Edition) Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that sprinkler heads are in compliance with NFPA 101 (2012 Edition) Life Safety Code, section 9.7.5, and NFPA 25 (2011 Edition) Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. Corrections will be monitored by: Administrator and Maintenance Director		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363			4/3/25

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

PRINTED: 03/26/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245596		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2025	
NAME OF PROVIDER OR SUPPLIER THE SHORES OF WORTHINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187			
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K 363	Continued From page 6 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. These deficient findings			K 363	Immediate Corrective Action: The B wing utility room door latch was replaced, and the A wing door catch was repaired on 2/28.		

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K 363	Continued From page 7 could have an patterned impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 and 12:00 PM, it was revealed by observation that the doors to soiled utility rooms in the A and B wing did not positively latch when closed using the self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 363	Corrective Action as it applies to others: Administrator and Maintenance Director were educated on the need to maintain corridor doors per NFPA 101 (2012 Edition) Life Safety Code, sections 19.3.6.3., and 19.3.6.3.5. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that all utility room doors are latching properly and are in compliance with NFPA 101 (2012 Edition) Life Safety Code, sections 19.3.6.3., and 19.3.6.3.5. Corrections will be monitored by: Administrator and Maintenance Director		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This	K 712	Immediate Corrective Action: Fire Drills have been regularly scheduled and conducted under varied times and conditions since August of 2024, and will continue to be regularly scheduled going	4/3/25	

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K 712	Continued From page 8 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility had not performed a fire drill for the months of April, May, June, July, or August. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	forward. Fire Drill was conducted on 3/11/25 on NOC shift. Corrective Action as it applies to others: Administrator and Maintenance Director were educated on the need to conduct fire drills under varied times and conditions per NFPA 101 (2012 Edition) Life Safety Code, sections 19.7.1.6., 4.7.4., and 4.6.1.1. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that fire drills are being conducted under varied times and conditions per NFPA 101 (2012 Edition) Life Safety Code, sections 19.7.1.6., 4.7.4., and 4.6.1.1. Corrections will be monitored by: Administrator and Maintenance Director		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		4/3/25	

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K 761	Continued From page 9 by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 and 12:00 PM, it was revealed by a review of available documentation that a fire door inspection has not been conducted within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Immediate Corrective Action: The B wing utility room door latch was replaced, and the A wing door catch was repaired on 2/28. Corrective Action as it applies to others: Administrator and Maintenance Director were educated on the need to maintain corridor doors per NFPA 101 (2012 Edition) Life Safety Code, sections 19.3.6.3., and 19.3.6.3.5. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that all utility room doors are latching properly and are in compliance with NFPA 101 (2012 Edition) Life Safety Code, sections 19.3.6.3., and 19.3.6.3.5. Corrections will be monitored by: Administrator and Maintenance Director		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient	K 911	Immediate Corrective Action: Electrical Panel on C-Wing was secured on 2/28/2025 Corrective Action as it applies to others:	4/3/25	

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K 911	Continued From page 10 findings could have a isolated impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the electrical panel located in the C wing were not secured from being opened by unauthorized personnel. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 911	Administrator and Maintenance Director were educated on the need to maintain electrical systems per NFPA 99 (2012 Edition) Health Care Facilities Code, section 6.3.2.2.1.3. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that the electrical panels are secured in accordance with NFPA 99 (2012 Edition) Health Care Facilities Code, section 6.3.2.2.1.3. Corrections will be monitored by: Administrator and Maintenance Director		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		4/3/25	

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K 914	Continued From page 11 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/27/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide updated documentation for resident room electrical receptacle testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Immediate Corrective Action: Electrical Receptacle testing was conducted on 3/21/25. Corrective Action as it applies to others: Administrator and Maintenance Director were educated on the need to conduct electrical systems maintenance and testing per NFPA 99 Standards for Health Care Facilities 2012 Edition section 6.3.3.2., 6.3.4.1.3., and 6.3.4.2.1.2. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that the electrical receptacle testing has been conducted and is scheduled to be conducted in accordance with NFPA 99 Standards for Health Care Facilities 2012 Edition section 6.3.3.2., 6.3.4.1.3., and 6.3.4.2.1.2. Corrections will be monitored by: Administrator and Maintenance Director		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced	K 926		4/3/25	

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K 926	Continued From page 12 by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/27/2025, between 9:00 and 12:00 PM, it was revealed by review of available documentation and staff interview that the facility could not provide evidence of training provided to personnel on the application and maintenance of medical gases, and the potential risks associated with their handling and use. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	Immediate Corrective Action: Medical Gas Training was added to the new staff onboarding process and added to the annual training completed by appropriate staff. Licensed nurses will be in-serviced on Department of Respiratory and Safe Oxygen Cylinder Storage Policy and Procedure. Corrective Action as it applies to others: Administrator and Maintenance Director were educated on the need to implement medical gas training for staff per NFPA 99 (2012 Edition) Health Care Facilities Code, section 11.5.2.1.1. Date of Compliance: 4/3/25 Recurrence will be prevented by: Audits will be conducted 1x per month for 3 months to ensure that new hires within that time period have received their medical gas training per NFPA 99 (2012 Edition) Health Care Facilities Code, section 11.5.2.1.1. Corrections will be monitored by: Administrator and Maintenance Director		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 22, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: March 4, 2025

Dear Administrator:

On April 22, 2025, we notified you a remedy was imposed. On May 14, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 14, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 4, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 22, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 14, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Your request for a temporary waiver involving the deficiency cited under K271 at the time of the March 4, 2025 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

An equal opportunity employer.

The Shores Of Worthington

May 22, 2025

Page 2

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 22, 2025

Administrator
The Shores Of Worthington
1307 South Shore Drive
Worthington, MN 56187

Re: Reinspection Results
Event ID: MNH711

Dear Administrator:

On May 16, 2025 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 April 11, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112