Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On May 4, 2023, we informed you of imposed enforcement remedies.

On May 12, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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.

As we notified you in our letter of May 4, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), if you have not achieved substantial compliance by July 18, 2023, the remedy of denial of payment for new admissions will go into effect

and this provision will apply to your facility. Therefore, The Terrace At Crystal LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 18, 2023. 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Nathan Schreier, Unit Supervisor
Metro B District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2023 (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 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.

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) 565-9462

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

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

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 7, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 2DL611

Dear Administrator:

The above facility was surveyed on May 8, 2023 through May 12, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

An equal opportunity employer.

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

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

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

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 5/8/23to 5/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness	E 036		7/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/12/2023

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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E 036	Continued From page 1 training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036		

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E 036	Continued From page 2 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and to ensure the communication plan is compliant with the requirements of this section. This had the potential to affect all 75 residents, their families/representatives and the staff of the facility. Findings include: See 0037: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Program (EPP). See 0039: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility EPP.	E 036	1. Failure to provide a copy of the emergency preparedness plan has the potential to affect all residents in the facility if the staff are not trained on the plan. 2. Facility will provide staff with a copy of the emergency preparedness plan and a copy will be placed on each floor at the nurse's station, reception desk, administrator's office and the Human Resources office. 3. Facility staff will be trained on the emergency preparedness plan now and again annually. 4. Administrator will review and/or revise the emergency preparedness plan at least annually. Any issues found will be brought to QAPI. 5. Administrator and Human Resources are responsible for the completion of this plan of correction.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1),	E 037		7/14/23

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E 037	Continued From page 3 §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 4	E 037		

Continued From page 4

(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

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E 037	Continued From page 5	E 037		

(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency

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E 037	Continued From page 6	E 037		

procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services

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THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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E 037	Continued From page 7 under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Plan (EPP). This had the potential to affect all 75 residents, staff and visitors at the facility. Findings include: During interview 5/12/23 at 10:46 a.m., the administrator stated they they completed fire drills and code blue education and elopement and tornado drills. Documentation of education provided was requested, the administrator later stated they had not completed any emergency preparedness training since he started in October 2022, and did not have documentation of trainings or competencies completed from his predecessor. During interview 5/12/23 at 11:50 a.m., nursing assistant (NA)-O stated she has not received any training on emergency preparedness. She received training on code status, and fire drill training and had not had any training on evacuations. During interview 5/12/23 at 11:56 a.m., trained medication aide (TMA)-C stated she has worked at the facility two months and has had training on	E 037	1. Failure to provide a copy of the emergency preparedness plan has the potential to affect all residents in the facility if the staff are not trained on the plan. 2. Facility staff will be trained on the emergency preparedness plan now and again annually. 3. New staff will be trained on the emergency preparedness plan in new employee orientation. 4. HR will audit employee files monthly to ensure that each employee training is completed. Any issues found will be brought to QAPI. 5. Administrator and Human Resources are responsible for the completion of this plan of correction.	

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E 037	Continued From page 8 resident abused, but not education on emergency preparedness or emergency evacuations. During interview 5/12/23 at 12:00 p.m., NA-K stated being employed at facility for almost a year and trainings consisted of emptying catheter bags, and fire drills and added they had not received any testing following trainings.	E 037		
E 039 SS=C	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 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.	E 039		7/14/23

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E 039	Continued From page 9 (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 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,	E 039		

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E 039	Continued From page 10 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 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	E 039		

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E 039	Continued From page 11 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 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	E 039		

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E 039	Continued From page 12 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 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	E 039		

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E 039	Continued From page 13 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 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.	E 039		

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E 039	Continued From page 14 (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: (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.	E 039		

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E 039	Continued From page 15 *[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 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.	E 039		

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E 039	Continued From page 16 *[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 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	E 039	1. Failure to provide a copy of the	

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E 039	Continued From page 17 facility failed to conduct a full-scale exercise, or a facility-based exercise to test their emergency preparedness program twice per year or to document activation on their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 75 residents who currently resided in the facility, along with all staff who work in the facility. Findings include: Review of the facilities Emergency Preparedness Plan (EPP) dated 8/1/2022, did not include exercises performed from January 2022 through May 2023, additionally, there was no documentation of activation of the EPP in response to an incident or emergency event at the facility. During interview 5/12/23 at 11:02 a.m., the administrator stated he did not have last year's exercises of any full scale or other annual EPP testing exercises. The facilities Emergency Preparedness Plan, dated 8/1/22, indicated the EPP must be exercised and reviewed annually. Regulatory and centers for Medicare and Medicaid Services require the following supporting plan documents: alternate care sites, transportation contracts, communications plan, concept of operations, evacuation maps and floor plans, mutual aid agreements, organizational charts, policies and procedures, fire safety plan, hazard vulnerability analysis, incident specific appendices, and training and exercise plans.	E 039	emergency preparedness plan has the potential to affect all residents in the facility if the staff are not trained on the plan. 2. Facility will conduct a full-scale exercise of the emergency preparedness plan by July 2023 and again annually. 3. Facility will rewrite the Emergency Preparedness plan to include alternate care sites, transportation contracts, communication plan, concept of operations, evacuation maps and floor plans, mutual aid agreements, organizational charts, policies and procedures, fire safety plan, hazard vulnerability analysis, incident specific appendices and training and exercise plans. 4. Facility will assess and reassess vulnerabilities in the plan at least twice annually. Any issues found will be brought to QAPI. 5. Administrator and maintenance are responsible for the completion of this plan of correction.	

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E 041	Continued From page 18	E 041		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		7/14/23

§482.15(e) Condition for Participation:
(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e), §485.542(e)
(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life

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(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 041	Continued From page 19 Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.	E 041		

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	245289	A. BUILDING ______ B. WING ______	C 05/12/2023

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E 041	Continued From page 20 (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency generator(s) were maintained and tested in accordance with NFPA (2012 edition), the Health Care Facilities Code; and NFPA (2010 edition), the Standard for Emergency and Stand-by Power Systems. This had the potential to affect all 75 residents, staff, and visitors at the care center in a potential disaster and/or emergency situation. Findings include: Documentation was reviewed and lacked documentation of the following: monthly generator testing and maintenance, the facilities emergency power supply system (EPSS) was tested for at least four hours within the last 36 months, and that a fuel quality test had been	E 041	1. Failure to maintain and test emergency power supply system has the potential to affect all residents in the facility. 2. Facility will obtain annunciator for temporary generator. 3. Facility will obtain an emergency stop button to place on the outside of the generator. 4. Facility will conduct monthly generator testing. 5. Facility will conduct a fuel quality test. 6. Facility will conduct a four-hour test on the emergency power supply system every 36 months. 7. Facility will maintain documentation of maintenance/testing completed on the generator.	

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E 041	Continued From page 21 performed within the last year. During interview and observation 5/09/2023 between 9:15 a.m., and 5:15 p.m., it was revealed by observation that the generator annunciator had trouble lights that were illuminated. The assistant maintenance director stated, "I have no clue what the lights mean." Maintenance staff stated they have had a temporary generator onsite for four years because their generator had a bad motor. The State Fire Safety Supervisor of Health Care and Correctional Facilities stated that the temporary generator had been onsite approximately one year. The annunciator that has the trouble lights illuminated was not connected to the temporary generator, so there was no annunciator for the temporary generator located in a 24-hour monitored location. During observation 5/9/23 between 9:15 a.m., and 5:15 p.m., there was no emergency stop button located on the outside of the generator. An interview with the maintenance director and assistant maintenance director verified these deficient findings at the time of discovery.	E 041	8. Administrator or designee will audit weekly to ensure that the weekly generator tests are being performed and monthly to ensure that the monthly tests are being performed. All audits will be brought to QAPI for review. 9. Administrator and maintenance staff are responsible for the completion of this plan of correction.	
F 000	INITIAL COMMENTS On 5/8/23-5/12/23, 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:	F 000		

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F 000	Continued From page 22 H52892043C (MN93142) The following complaints were reviewed: H52892046C MN93138 with a deficiency cited at F686. H52892068C MN93102, MN93148 with a deficiency cited at F880, F921, F676. H52892120C MN92994 with a deficiency cited at F921. H52892119C MN92790 with a deficiency cited at F550, F585. H52892118C MN92368 with a deficiency cited at F676, F686. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		7/14/23

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Continued From page 23

resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to treat 1 of 4 residents with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life.

Findings include:

F 550

1. R11 was interviewed to ensure she has had no more interactions with staff in an undignified way.
2. This type of incident has the potential to affect all residents if they are spoken to/about in that manner.
3. All staff will be educated on customer

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R11's quarterly Minimum Data Set (MDS) assessment dated 8/31/2022 indicated they had severe cognitive impairments and needed extensive staff assistance with eating.

During an observation on 5/9/23 at 1:11 p.m., R11 was observed eating lunch in the dining room with supervision of an unknown nursing assistant (NA). Several residents had previously vacated the dining area and empty plates were left on the tables. Cook-A entered the dining area and shouted: "Who cleans up after these feeders?" to the unknown NA.

During an interview on 5/9/23 at 1:22 p.m., Cook-A stated that the term the staff use for residents who require assist with eating was "feeders". Cook-A further stated that she uses that term most of the time for these residents, "just like everyone else does."

During an interview on 5/9/23 at 1:57 p.m., registered nurse (RN)-C stated that staff should refer to those that need assistance with eating as such, and that he was unsure if referring to them as "feeders" was professional.

During an interview on 5/11/23 at 2:12 p.m., the director of nursing (DON) stated that his expectation is that staff would refer to these residents as "needing assistance" as respectfully as possible, and that using the term "feeder" for these residents was undignified and not the facility expectation.

A facility policy dated November 2022 indicated staff were to "speak respectfully to residents at all times, including addressing the resident by his or

service and appropriate terminology to use when referencing residents.
4. The facility will interview residents 2x/week for 4 weeks to ensure residents are being spoken to/about properly and treated with dignity and respect.
5. Facility will bring interviews to IDT during morning meetings to review and ensure that all residents are being treated with dignity and respect. Any issues found will be brought to QAPI.
6. Social services or designee is responsible for the completion of this plan of correction.

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F 550	Continued From page 25 her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs."	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R72). Findings include: R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.	F 558	1. R72's call light was placed within reach on her left side. 2. This type of incident has the potential to affect all residents if their call light is not within reach. 3. Staff will be educated on call light placement and how to read their care plan to determine a resident's needs. 4. Call light placement audits will be completed 3x/week for 4 weeks to ensure that all residents' call lights are within reach. 5. Audits will be reviewed by the administrator and IDT in QAPI. Any issues found will be discussed at that time. 6. Director of Nursing, Nurse Managers and CNA supervisor are responsible for the completion of this plan of correction.	7/14/23

F 558 Continued From page 26 F 558

R72's Care Area Assessment (CAA) dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's care plan with date of initiation 5/2/23, indicated staff were to keep the call light in reach of R72.

During observation on 5/8/23 at 12:54 p.m., and 4:00 p.m., the call light was on the floor at the head of the bed out of reach of R72.

During observation on 5/8/23 at 5:06 p.m., call light was on the floor at the head of the bed out of reach of R72. When asked if she would like to have the call light to ask for help if she needed it, she said, "yes".

During observation and interview on 5/8/23 at 7:08 p.m., registered nurse (RN)-A stated R72's call light was again not in reach and verified it was on the floor. "I picked it up from the ground when I came in today and forgot to put the call light next to her this shift". RN-A moved the call light to rest on R72's right side of body. When asked if R72 could access or press the call light on her right side RN-A stated "no" and moved it to the left side of R72's body.

During observation on 5/10/23 at 6:17 a.m., the call light was on a floor mat located on the right side of R72's bed, not in reach.

During interview with RN-B at 5/10/23 at 7:18 a.m., RN-B stated the call light "should be in reach even if she doesn't use it".

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F 558	Continued From page 27 During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated R72's call light, "needs to be in reach of her left hand". During interview with nursing assistant (NA)-A on 5/10/23 at 8:56 a.m., stated R72's call light, "should be in reach on her left side because the right side does not work". During interview with the director of nursing on 5/11/23 at 1:31 p.m., DON stated expectation staff "should place the call light in reach of the resident every time the staff leaves the room. [R72} does not have the capacity to reach for a call light if it is on the floor or her right side because her right side is not working. The call light should be in reach on her left side where she can press it." The facility policy Answering the Call Light, reviewed November 2022, identified, "the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor."	F 558		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		7/14/23

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F 585	Continued From page 28 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 29 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 1 of 1 resident (R46) grievances were documented, responded to, and resolved in a timely manner.

Findings include:

R46's Medical Diagnosis form located in the electronic medical record (EMR), indicated R46 had diagnosis of major depressive disorder and anxiety disorder.

R46's quarterly Minimum Data Set (MDS) dated 2/15/23, indicated R46 had intact cognition, did not reject cares, and was independent for all activities of daily living (ADLs).

R46's care plan dated 8/31/23, indicated R46 had a behavior problem and interventions included, to assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately.

R46's care plan dated 5/9/22, indicated R46 had depression and interventions included, R46 needed time to talk and encouragement to express feelings.

A Facility Grievance/Concern or Problem Resolution form included an area for completion of the date, resident name, the grievance/concern/suggestion, how the person completing the form would like to be contacted for

1. R46’s grievances from 2/15/23, 3/5/23, 3/18/23, 3/25/23, 3/28/23 and 3/29/23 were resolved.
2. Unresolved grievances have the potential to affect all residents.
3. Staff will be educated on the importance of timely resolution of grievances.
4. Grievances will be audited for resolutions 1x/week for 5 weeks to ensure timely resolution.
5. All grievances will be brought to the IDT within 72 hours and resolved within 5 business days from receipt of the grievance.
6. All grievances will be bought to QAPI and reviewed for timeliness of responses and proper resolutions of grievances.
7. Social Services and Administrator are responsible for the completion of this plan of correction.

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resolution, the person filing the grievance's name. The back of the form included an area to document the summary of the investigation, plan of resolution, follow up comments reviewed with the concerned party, a space to document the date and person completing the form, and who reviewed the grievance.

R46 filed three grievances on 2/15/23, a grievance on 3/5/23, 3/18/23, 3/25/23, 3/28/23, and 3/29/23, and requested in person contact regarding resolution. The back of the forms lacked documentation regarding the summary of investigation, plan of resolution, follow up comments, who the grievance was reviewed by, who completed the follow up, and the investigation.

During interview on 5/11/23 at 9:58 a.m., registered nurse (RN)-C stated the social worker (SW)-B and SW-C was in charge of the investigation and documentation on the grievance form when a grievance was filed. The social worker also followed up with the resident and regarding the resolution. RN-C added SW-B and SW-C left the facility in December, or early January, but the social work assistant and the administrator were completing the SW aspect of the grievance forms.

During interview on 5/11/23 at 10:17 a.m., social services designee stated grievance forms were outside the social worker's door on each floor. The person filing the grievance completed the form and the form was provided to the administrator to address the concern. Social services assistant did not know the turnaround time for grievances to be followed up on.

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During interview on 5/11/23 at 10:22 a.m., the administrator stated grievance forms were located on the second and third floor outside the SW door and were completed and turned in under his door. The administrator added R46 completed grievances and spoke with her regarding actions taken. Administrator stated grievance follow up was documented on the back of the forms, however stated he did not document a follow up on the grievances dated 2/15/23, 3/5/23, 3/18/23, 3/25/23, 3/28/23, and 3/29/23, and stated he should have documented the outcome adding he was not good about documenting R46's grievances, but if a resident was not a good historian, he would document.

During interview on 5/12/23, between 8:20 a.m. and 8:27 a.m., R46 stated the grievance filed 2/15/23, regarding the nurse wanting everyone to hand over their cigarettes was resolved. R46 stated nobody followed up with her regarding her grievance on 2/15/23, regarding the person not wearing the name tag. R46 stated nobody resolved the grievance filed 3/5/23, and stated the grievance filed 3/18/23 was partially resolved. R46 stated the administrator did not follow up with her on the grievance filed 3/25/23, or 3/28/23. R46 stated the administrator did not talk with her regarding the grievance filed on 3/29/23, however signage was added on the door to make the restroom public.

A policy Grievances/Complaints, Filing reviewed 1/2023 indicated the administrator and staff would make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Actions on such issues were responded to in writing, including a rationale for the response. The policy indicated the administrator delegated

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F 585	Continued From page 33 the responsibility of grievance or complaint investigation to the grievance officer who was not identified on the policy. Upon receipt of a grievance and or complaint, the grievance officer would review and investigate the allegations and submit a written report of such findings to the administrator within five working days of receiving the grievance and or complaint. The resident, or person filing the grievance and or complaint on behalf of the resident, would be informed verbally and in writing of the findings of the investigation and the actions that were be taken to correct any identified problems. A written summary of the investigation would also be provided to the resident, and a copy would be filed in the business office. The results of all grievances files, investigated and reported would be maintained on file for a minimum of three years from the issuance of the grievance decision.	F 585		
F 636 SS=E	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.	F 636		7/14/23

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(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(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

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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 facility failed to complete the comprehensive Minimum Data Set (MDS) assessments in a thorough and accurate manner to ensure cognitive and mood, needs were evaluated and addressed for 4 of 4 residents (R19, R28, R32, R72) and hearing needs were addressed for 1 of 4 residents (R32) and reviewed for comprehensive MDS assessment accuracy.

Findings include:

The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, outlined, a 5-day comprehensive assessment is "the only required PPS assessment that is used to support PPS reimbursement." The manual also indicated "The SCSA [significant change in status assessment] is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement of decline." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation, and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood

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1. BIMS and PHQ-9 assessments were completed for R19, R28, R32 and R72.
2. Hearing, Speech and Vision assessment was completed for R32.
3. ROM and Mobility assessment was completed for R72.
4. This type of inaccurate documentation has the potential to affect all residents.
5. The MDS will be completed and submitted by the due date per the MDS schedule.
6. Assessments will be completed within the 7-day look back period per the MDS schedule.
7. Assessments will be audited by Director of Clinical Reimbursement or designee 1x/week for 4 weeks, then monthly for 6 months for timeliness of completion and accuracy prior to MDS submission. All audits will be brought to QAPI for review.
8. MDS will be audited by Director of Clinical Reimbursement before submission to ensure that all sections are completed and accurate. Administrator will review audits per above schedule to ensure completion.
9. Education on timeliness will be provided to those responsible for assessment completion for MDS.
10. Director of Clinical Reimbursement is responsible for the completion of this plan of correction.

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distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable."

R28's face sheet printed 5/11/23 at 3:14 p.m. indicated that R28 had a diagnosis of depression, insomnia and sucidal ideation.

R28's 5-day PPS MDS assessment dated 5/2/23 and R 19's SCSA dated 2/25/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol indicating staff had not completed this section of the MDS.

During an interview on 05/12/23 at 10:19 a.m., the social services designee (SSD)-A stated she could not recall why sections "C" and "D" in R28's 5-day PPS assessment from 5/2/23 and section "C" and "D" on R19's SCSA from 2/25/23 were not completed. SSD-A verified the sections as incomplete.

During interview 5/11/23 at 3:23 p.m., registered nurse (RN)-D stated the social worker completed the Brief Interview for Mental Status (BIMS) and she does not complete cognitive screens or mood sections and comes to the facility to assess transfers and mobility.

During interview 5/12/23 between 9:59 a.m., and 10:19 a.m., SSD-A stated since February 2023, she completed sections C and D of the MDS. SSD-A stated the MDS is used to determine if cognition is declining or improving, and mood is also evaluated. SSD-A would document an assessment as "not assessed" if a resident indicated they would not want to participate, refused, or was unable to speak and make their

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needs known. The MDS prompts staff to complete that portion. Since nurses work directly with the resident, the nurse would complete those portions if prompted.

During interview on 5/12/23 at 10:42 a.m., the administrator stated RN-E used a calendar for when the MDS was due, and SSD-A completed sections C and D. The Administrator added if the resident refused the assessments, staff completed the staff interview in the MDS and added it was important to complete the mood section because it can provide information if a resident was triggering for depression and the facility could set up services. Aadditionally, cognition screening was important because it helps identify if cognition is intact or if the facility needed to bring in a representative during care conferences.

A policy Resident Assessments reviewed January 2023, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: admission, quarterly, annually, significant change in status, significant correction, and discharge. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.
A section labeled "Section B: Hearing, Speech, and Vision" identified the intent of the section is to

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F 636	Continued From page 38 document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons. The rationale for the Hearing section identified problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders. In addition, unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment. R32's significant change Minimum Data Set (MDS) dated 4/19/23, indicated R32 had a diagnosis of depression. Section B - Hearing, Speech, and Vision inaccurately indicated R32 had adequate hearing and did not wear hearing aids. Section C - Cognitive Patterns lacked documentation in all fields. Section D - Mood contained dashes in each field and lacked data. R32's audiology consult note dated 8/19/22, indicated R32 had severe hearing loss in his right ear and moderately sever to severe hearing loss in his left ear, and recommended bilateral hearing aids. R32's care plan dated 9/2/21, indicated R32 had a communication problem related to hearing deficit. On 5/08/23 at 2:21 p.m. R32 stated he had severe hearing loss. R72's SCSA MDS, dated 4/29/23, identified R72 admitted to the nursing home in March of 2023 from an acute care hospital. R72's diagnosis'	F 636		

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F 636	Continued From page 39 include hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data that was entered until the Staff Assessment for Mental Status section where it was marked as short term memory was "OK" and long term memory marked, "memory problem". Cognitive skills for daily decision making was marked as "Moderately impaired-decisions poor, cues/supervision required". The MDS" section labeled, "Section G-Functional Status," stated R72 required extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene, however it was marked as R72 having no impairment of upper and lower extremity range of motion. R72's medical record, and the completed MDS, lacked evidence these items had been assessed within the assessment reference date (ARD) as directed by the RAI manual to ensure a full evaluation of the resident. During interview with facility administrator on 5/10/23 at 1:14 p.m., administrator verified R72's SCSA MDS was not accurately completed and that [R72] had complete right sided paralysis.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		7/14/23

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F 638	Continued From page 40 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete the quarterly Minimum Data Set (MDS) in a thorough and accurate manner to ensure cognitive, mood, and behavior needs were evaluated and addressed for 4 of 4 residents (R14, R25, R35, R62) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, identified the quarterly MDS' was a non-comprehensive assessment to be completed at least every 92 days following the previous assessment of any type. This assessment was used, " ... to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood distress ... It is particularly important to identify signs and symptoms of mood distress	F 638	1. BIMS and PHQ-9 assessments were completed for R14, R25, R35 and R62. 2. This type of inaccurate documentation has the potential to affect all residents. 3. The MDS will be completed and submitted by the due date per the MDS schedule. 4. Assessments will be completed within the 7-day look back period per the MDS schedule. 5. Assessments will be audited by Director of Clinical Reimbursement or designee 1x/week for 4 weeks, then monthly for 6 months for timeliness of completion and accuracy prior to MDS submission. All audits will be brought to QAPI for review. 6. MDS will be audited by Director of Clinical Reimbursement before submission to ensure that all sections are completed and accurate. Administrator will review audits per above schedule to ensure completion. 7. Education on timeliness will be provided to those responsible for assessment completion for MDS. 8. Director of Clinical Reimbursement is responsible for the completion of this plan of correction.	

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among nursing home residents because these signs can be treatable." Further, a section labeled, "SECTION E: BEHAVIOR," identified the items reviewed in the section helped, " ... identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment." Additionally, RAI instructions under the heading Coding Tips on page C-16 indicated, "Occasionally, a resident can communicate but chooses not to participate in the BIMS [brief interview for mental status] and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, BIMS Summary Score, and complete the staff assessment of mental status." Under the heading D0500 Staff Assessment of Resident Mood (PHQ-9-OV) indicated, "Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9 Resident Mood Interview.

R14's quarterly MDS dated 4/6/23 sections labels, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol and no other data present.

During interview on 5/12/23 at 10:21 a.m., SSD-A verified the sections were incomplete and viewed the assessment form in the EMR and stated it was not found and did not know why the assessment was incomplete.

R25's quarterly MDS dated 4/28/23 section labeled, "Section C-Cognitive Patterns" was completed, however "Section D-Mood" indicated a "-" symbol and no other data present.

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During interview on 5/12/23 at 10:15 a.m., SSD-A verified mood was not assessed on the MDS, and added she completed the assessment under assessments in the electronic medical record (EMR), but stated the registered nurse saves and signs the assessment and transfers the assessment into the MDS.

R35's quarterly MDS dated 2/17/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" and "Section E-Behavior" indicated a "-" symbol and no other data present.

During interview 5/12/23 at 10:16 a.m., social services designee (SSD)-A stated there may not have been a nurse to answer the questions, but was not sure why the MDS sections were not completed and added there probably wasn't an assessment back then because different departments were not completing them and verified the sections were incomplete.

R62's quarterly MDS dated 4/28/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol and no other data present. The staff assessment of mental status was not documented under section C and the staff assessment of resident mood indicated "-" symbol.

During interview on 5/12/23 at 10:19 a.m., SSD-A stated R62 refused to complete sections C and D in the assessment because she didn't like to be up during the day and added she documented as "not assessed."

During interview 5/11/23 at 3:23 p.m., registered nurse (RN)-D stated the social worker completed

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the BIMS and she does not complete cognitive screens or mood sections and comes to the facility to assess transfers and mobility.

During interview 5/12/23 between 9:59 a.m., and 10:19 a.m., SSD-A stated since February 2023, she completed sections C and D of the MDS. SSD-A stated the MDS is used to determine if cognition is declining, or improving and mood is also evaluated. SSD-A stated they were going to have other departments complete section D to try and catch at different time periods. SSD-A added an assessment documented as "not assessed" indicated the residents may not want to participate and if the resident refused, it was documented as not assessed and if a resident cannot talk, it was documented not assessed and the MDS prompts for staff to complete that portion. Since nurses work directly with the resident, the nurse would complete those portions if prompted.

During interview on 5/12/23 at 10:42 a.m., the administrator stated RN-E used a calendar for when the MDS was due and SSD-A completed sections C and D. Administrator added if the resident refused the assessments, staff completed the staff interview in the MDS and added it was important to complete the mood section because it can provide information if a resident was triggered for depression and the facility could set up services, additionally cognition screening was important because it helps identify if cognition is intact or if the facility needed to bring in a representative during care conferences.

During interview on 5/12/23 at 12:30 p.m., RN-E stated section Q is not completed by the RN and

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added the SSD or administrator would complete this section and if not assessed was documented for section Q, there was not a care conference in the look back period to discuss any discharge plan. RN-E further stated the other MDS nurse completed the vision and hearing section of the MDS.

A policy Resident Assessments reviewed January 2023, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: admission, quarterly, annually, significant change in status, significant correction and discharge. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan.

F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		7/14/23

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the

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State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

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(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) level II was completed for 1 of 1 resident (R35) reviewed for PASARR.

Findings include:

R35's quarterly Minimum Data Set dated 2/17/23, indicated cognition was not assessed, mood was not assessed and R35 required extensive assist for most activities of daily living (ADLs).

R35's diagnoses included: unspecified intracranial injury with loss of consciousness of unspecified duration, unspecified dementia, mild cognitive impairment, alcohol dependence, post traumatic stress disorder (PTSD), major depressive disorder, epileptic seizures related to external causes, and aphasia.

R35's Initial Pre-Admission Screening (PAS)

1. A new PASARR was submitted for R35.
2. Failure to complete a PASARR has the potential to affect all residents.
3. Admissions Director will check all current resident files for updated PASARR and complete a new one if needed. Admissions Director will request PASARR from hospital and/or complete a PASARR on all new admissions going forward.
4. Education will be provided to the Admissions Director on the importance of having and/or completing a PASARR for all residents.
5. All new admissions will be audited by Administrator or designee 1x/week over the next 6 weeks to ensure that an accurate PASARR has been completed. All audits will be brought to QAPI for review.
6. Administrator and/or designee is responsible for the completion of this plan

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F 645	Continued From page 47	F 645	of correction.	

results dated 8/28/2017, indicated the health care record indicated a history of PTSD and the level of care result indicated it appeared R35 met level of care for purposes of MA payment of long term care. Final determination would be made once the form was received by Senior LinkAge Line. The section headed OBRA Level I developmental disability (DD) Result indicated R35 did not meet criteria for DD and a final determination of the need for further evaluation would be made by Senior LinkAge Line. Under the heading Mental Illness, R35 had a major mental disorder diagnosable as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the OBRA Level I MI (mental illness) Result indicated R35 did not meet criteria for MI and final determination of the need for further evaluation would be made by Senior LinkAge Line.

During interview on 5/9/23 at 2:45 p.m., admission director (AD)-G stated he received the PAS from the hospital. Review of the record lacked confirmation of the final determination of the need for further evaluation. Requested confirmation of R35 not requiring a level II screen.

During interview on 5/9/23 at 3:01 p.m., AD-G stated R35 would have to be reassessed by Senior LinkAge when asked if he found any confirmation of R35 not requiring a level II screen.

During interview on 5/11/23 at 12:12 p.m., the administrator stated the PAS had been completed a while ago and AD-G would not have reviewed this one. Administrator added if they don't see any clarification they assume no level II is needed. Requested a policy, but the the administrator stated the facility did not have a policy on preadmission screening and resident

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F 645	Continued From page 48 review (PASARR).	F 645		
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- (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 in interview and document review, the facility failed to ensure a care conference was conducted and residents and their representatives were involved in the revision of the plan of care for 2 of 2 (R28 and R63)	F 657	1. Care conference was scheduled for R28, at which time he was given a copy of his care plan and allowed to give input. 2. Care conference was scheduled for R63 with family members invited.	7/14/23

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residents reviewed for care plan timing and revision.

Findings include:

MDS assessment history indicated R28 admitted to the facility in June of 2022.

A 5-day Minimum Data Set (MDS) assessment dated 5/2/23 indicated R28 had a diagnosis of respiratory failure, diabetes, heart failure and depression. The assessment also revealed R28 required extensive assistance of staff for activities of daily living.

During an interview on 5/8/23 at 1:32 p.m., R28 stated they had only been involved in once care conference since their admission, but this had occurred several months ago. R28 indicated they wished to have their family member actively involved in their plan of care.

During an interview on 5/10/23 at 2:00 p.m., registered nurse (RN)-C stated the facility conducts care conferences for residents on a quarterly basis, whenever their MDS assessments are due. RN-C was unable to find evidence that a care conference had been conducted for R28 since 10/22. RN-C stated the administrator and his assistant had been conducting the care conferences, so he was unsure where the documentation would be.

During an interview on 5/11/23 at 9:59 a.m., the administrator stated care conferences for long term care residents was to occur every 92-93 days. The administrator further stated that R28's last care conference was conducted before he took over the position but was unable to see

F 657

3. Facility policy was written titled Comprehensive Care Plan, in which the resident and/or representative having say in the care planning process was addressed.
4. The facility will conduct an IDT education to reinforce to the IDT that residents and/or representatives have the right to have an active say in their cares and care planning.
5. DON or designee will audit care plans 1x/week for 4 weeks to ensure that the care plans are completed and that they have resident input. All audits will be brought to QAPI for review.
6. Administrator and Social Services are responsible for the completion of this plan of correction.

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when this occurred. He stated R28 was hospitalized during the previously scheduled care conference on 4/20/23, and one had not been rescheduled. He stated documentation was not completed to indicate the care conference had been canceled or attempted to be rescheduled.

R28's EMR indicated a quarterly MDS assessment was completed on 3/23/23.

A facility policy on care conferences was requested but was not provided.
R63's quarterly Minimum Data Set (MDS), dated 2/24/23, indicated R63 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments.

R63's Medical Diagnosis sheet indicated R63 had several medical diagnoses including Alzheimer's disease and neuromuscular dysfunction of the bladder, dated 10/18/21.

R63's electronic medical record (EMR) indicated the last care conference held for R63 was on 11/3/22.

During an interview on 5/12/23 at 9:30 a.m., family member (FM)-C stated she had not been invited to a care conference in "quite sometime" stating the last care conference she attended was "before the New Year."

During an interview on 5/11/23 at 1:14 p.m., the administrator stated care conferences should be completed within the first 48 hours of admission and quarterly. The administrator confirmed R63's

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F 657	Continued From page 51 last care conference was on 11/3/22.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		7/14/23

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F 676	Continued From page 52 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meal set up was provided for 1 of 1 resident (R35) reviewed for activities of daily living (ADLs) Findings include: R35's quarterly Minimum Data Set (MDS) dated 2/17/23, indicated cognition, mood, and behavior was not assessed, required extensive assist for most ADLs, except required set up help for eating. R35's Medical Diagnosis form in the electronic medical record (EMR) indicated the following diagnoses: unspecified intracranial injury with loss of consciousness, unspecified dementia, mild cognitive impairment, quadriplegia unspecified (partial or complete paralysis of both the arms and legs), aphasia (loss or impairment of the power to use or comprehend words), dysphagia (difficulty swallowing), muscle weakness, and apraxia (a neurological disorder characterized by the inability to perform purposeful movements and gestures despite having the physical ability and desire to perform them). R35's Clinical Physician Orders form dated 4/10/22, in the EMR indicated regular diet, regular as tolerated texture, regular thin consistency for R35 requests regular diet and understands he may choke. R35's care plan revised 9/2/22, indicated R35 had an ADL self care deficit related to traumatic brain	F 676	1. R35's care plan was updated to reflect that he needs assistance with feeding. 2. This type of incident has the potential to affect all residents that require feeding assistance. 3. Staff were educated on the importance of reading and knowing resident care plans. 4. Staff were educated on all residents that require feeding assistance and the importance of providing that assistance. 5. Audits will be done during meal times 3x/week for 4 weeks to ensure all residents who require feeding assistance are receiving that assistance. 6. Audits will be brought to QAPI to ensure residents are receiving appropriate assistance. 7. DON, Nurse Managers and Dietary Manager are responsible for the completion of this plan of correction.	

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injury and could eat independently following tray set up.

R35's care plan revised 1/16/22, indicated R35 had a communication problem due to expressive aphasia, receptive aphasia, but could communicate via use of gestures, pointing, as well as nodding head yes/no, and speaking in short phrases. The interventions indicated R35 required adequate time to respond and indicated R35 required total assist with fluid intake in order to meet his daily requirements. Further, indicated R35 had behaviors and interventions included anticipating and meeting needs, including when visiting ask about food, radio, and pop preferences as R35 changes mind often.

R35's care plan revised 12/31/22, indicated R35 was at nutritional risk related to receiving a regular diet and interventions included to assist with eating as needed and finger foods as able.

R35's Task ADL-Eating Form under question header, Eating: Support Provided from 4/10/23 to 5/9/23, indicated R35 required no set up three times, setup help only 64 times, one person physical assist 16 times, and two person physical assist four times.

R35's Task ADL-Eating form under question header, Eating: Self Performance How resident eats and drinks, regardless of skill from 4/10/23 to 5/9/23, indicated R35 required supervision, oversight, encouragement, or cueing 14 times, limited assistance 8 times, extensive assistance 3 times, and total dependence four times.

The facilities Menu Matrix form indicated for week two, Tuesday lunch was choice of juice, chicken

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taco salad, cucumber slices, gentilly angel food cake, salsa, sour cream, milk, and coffee.

During observation on 5/8/23 at 1:13 p.m., R35's shirt was soaked with liquid from the neck down and his lunch was untouched in front of him.

During observation on 5/9/23 at 12:22 p.m., R35 was in bed with his breakfast tray and a bowl of uneaten oatmeal on the bedside table. A plate on the tray contained a small amount of uneaten eggs and R35 had a small piece of bacon on his green shirt. The menu ticket on the tray indicated 4 ounces of juice, choice of cereal, one egg, one slice of bacon, one slice of toast, 1/2 cup of assorted fruit, eight ounces of milk, six ounces of coffee. R35's cover for his plate of food was located on the bed.

During observation on 5/9/23 at 12:40 p.m., an unknown staff member delivered lunch to R35's room.

During interview and observation on 5/9/23 at 12:46 p.m., R35 was in bed and his meal tray was located on his bed side table. He had a bag of unopened chips, cake with strawberries, and chicken taco salad on his tray. R35 had not attempted to eat or take any bites. R35 requested more juice and instructed to activate the call light for assistance. R35 had a cup of yellow fluid with the cover on and had not attempted to eat or drink.

During interview and observation on 5/09/23 at 12:55 p.m., an unknown staff came to answer light and turned off light. R35 stated his cup was empty. The staff did not offer to open chips.

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During interview and observation on 5/09/23 1:09 p.m., R35's bag of chips remained unopened and R35 stated "yeah" when asked if he needed help opening his chips. His food remained untouched.

During observation 5/09/23 at 1:24 p.m., R35 took the cover off his juice and drank the whole cup. No other food had been touched.

During interview and observation on 5/9/23 at 1:36 p.m., R35 stated "yes" when asked if he needed assistance to eat and instructed to activate the call light. R35 stated "yes" when asked if he liked chips.

During observation 5/9/23 at 1:42 p.m., unknown staff answered R35's call light and R35 gave unknown staff the urinal and unknown staff emptied the urinal and placed it on R35's bedside table next to his water and food tray. R35 asked for water and unknown staff took water cup and walked out of the room. The unknown staff did not offer assistance to open R35's bag of chips.

During observation 5/9/23 at 1:46 p.m., unknown staff gave R35 his fork, but did not offer to open his chips.

During interview 5/9/23 at 1:49 p.m., nursing assistant (NA)-B stated set up meant residents required more help and cueing and encouragement to eat. NA-B stated R35 required help to take covers off of cups and opening his chips, after first asking and explaining to R35 what you were going to do. NA-B further added if you let him know what you are doing with a slow friendly approach, he allows assistance.

During interview and observation on 5/9/23 at

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F 676	Continued From page 56 1:54 p.m., licensed practical nurse (LPN)-A stated R35 required meal set up. R35's chips were opened following staff interview and had the bag of chips in his left hand. During interview on 5/9/23 at 3:01 p.m., LPN-A stated having the urinal on the bedside table could contribute to lack of eating. During interview on 5/9/23 at 2:52 p.m., registered nurse (RN)-F stated the expectation is to set everything up for R35 and the NA should ask R35 if he wanted assistance and if R35 did not want assistance, the NA should reapproach and RN-F stated it was inappropriate to place a urinal on the bedside table. A policy, Activities of Daily Living (ADLs), Supporting dated November 2022, indicated residents were provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resisted care, staff would identify the underlying cause and approach the resident in a different way or time.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		7/14/23

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F 677	Continued From page 57 Based on observation, interview, and document review, the facility failed to ensure bathing assistance was provided for 1 of 1 resident (R35) reviewed for activities of daily living (ADLs) R63's quarterly Minimum Data Set (MDS), dated 2/24/23, indicated R63 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments. R63's Medical Diagnosis sheet, dated 10/18/21, indicated R63 had several medical diagnoses including Alzheimer's disease and neuromuscular dysfunction of the bladder. R63's care plan, dated 9/3/22, indicated R63 had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease. The care plan further indicated R63 needed extensive assistance from facility staff with showering on Tuesday evenings and limited assistance from facility staff with personal hygiene. R63's nursing assistance task named ADL-Bathing was reviewed for the past 30 days and indicated R63 received a shower on 4/18 and 4/25, two times in the past 30 days. During interview and observation on 5/8/23 at 6:38 p.m., R63 stated she was not getting showers or baths regularly and "really wanted one." R63 had facial hair on her upper lip and chin approximately ¼ inch long and was wearing socks with multiple red stains on them.	F 677	1. R63 received a shower and had her clothes changed. 2. This type of incident has the potential to affect all residents. 3. Nursing staff was educated on the importance of bathing residents and changing their clothes. 4. All staff were educated on the facility's dignity policy. 5. All residents were asked their bath/shower preferences. 6. Bath audits will be completed by DON or designee 3x/week for 4 weeks, then 1x/month for 6 months to ensure that residents are receiving their scheduled baths/showers. All audits will be brought to QAPI for review. 7. DON, Nurse Managers and Aide Supervisor are responsible for the completion of this plan of correction.	

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During observation on 5/9/23 at 12:40 p.m., R63 was wearing the same pair of teal shorts, salmon colored t-shirt, and red stained socks from 5/8/23. Facial hair was still present on R63's upper lip and chin.

During interview and observation on 5/10/23 at 7:55 a.m., R63 stated facility staff had not offered to give her a shower last night, (R63's scheduled shower day), and had not offered to shave her upper lip and chin hairs because facility staff are, "just too busy." R63 rubbed the hairs on her chin and stated, "it's just terrible, I really wish this hair was not here, but I need help to shave it." R63 was wearing the same teal shorts, salmon colored t-shirt and red stained socks from 5/8/23.

During interview on 5/10/23 at 9:56 a.m., nursing assistant (NA)-H stated the bath schedule for residents is posted at the nurse's station and in the electronic medical record (EMR). NA-H stated if a resident refused or missed their bath the NAs needed to let the nurse know. NA-H further stated facial hair should be shaved on shower day if a resident prefers to be shaved.

During interview on 5/10/23 at 12:23 p.m., registered nurse (RN)-G stated the NAs should be checking the bath schedule at the start of their shift. RN-G stated the NAs should be updating the nurses if a bath is missed for any reason, as it is "very important" for baths to get done weekly. RN-G further stated facial hair should be shaved during baths. RN-G confirmed R63's ADL-Bathing task indicated she had not had a shower since 4/25/23.

During interview on 5/10/23 at 12:55 p.m., the assistant director of nursing (ADON) stated the

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F 677	Continued From page 59 expectation was for residents to receive their baths every week. If a bath was missed the nurse should be notified and should make a note of the missed bath. A facility policy titled Activities of Daily Living (ADLs), Supporting, reviewed 11/2022, indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. If a resident refuses care or services they will be offered alternative interventions, informed of the risks and benefits of refusal and the refusal and reason for refusal will be documented.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and provide a bed bound resident with appropriate, resident center activities to help maintain mental, and	F 679	1. R13 could not be addressed due to no longer being in the facility. 2. This type of incident has the potential to affect all residents.	7/14/23

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F 679	Continued From page 60 psychosocial well-being for 1 of 2 residents (R13) reviewed for activities. Findings include: R13's admission Minimum Data Set (MDS), dated 3/21/23, indicated R13 had short term and long-term memory problems and her cognitive status had not been assessed. The MDs further indicated R13 needed extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. R13's electronic medical record lacked evidence an activity assessment was completed for R13. R13's Care Plan was reviewed and lacked any goals or interventions related to preferences for, or assistance needed with, activities to include group activities or one-on-one activities. During an interview on 5/8/23 at 3:31 p.m., family member (FM)-B stated the facility had not asked or assessed what activaties R13 enjoyed. FM-B stated, "she just lays in bed all day" and FM-B had not seen the facility staff offer to take R13 to activities. FM-B stated R13 enjoyed music. During observation on 5/9/23 at 1:19 p.m., R13 was laying in her bed, in a dimly lit, quiet room without music, TV or staff interaction. During continuous observation on 5/10/23, from 7:18 a.m. to 9:06 a.m., R13 was lying in bed, in a dimly lit, quiet room without music, TV or staff interaction for 1 hour and 48 minutes. R13 appeared mildly restless and was verbalizing non-sensical words.	F 679	3. Activity preference assessments will be done for all residents in the facility. 4. Resident’s care plans will be adjusted to reflect their preferences. 5. Activity preferences will be audited by Activities Director during 1x/month for 6 months during the quarterly care conference to ensure the resident preferences are documented and being adhered to. All audits will be brought to QAPI for review. 6. Activities Director and Social Services are responsible for the completion of this plan of correction.	

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During observation on 5/11/23 at 9:33 a.m., R13 was observed laying in a dimly lit room alone with the door closed. No music or TV was playing for R13.

During an interview on 5/10/23 at 12:23 p.m., registered nurse (RN)-G stated the only activity R13 received was from hospice staff that came to visit R13. RN-G confirmed that R13 enjoys music, but the facility has not provided a CD player for R13's room.

During an interview on 5/10/23 at 10:53 a.m., the activities director (AD) stated that the expectation was for residents to get assessed for activities upon admission. The AD stated they would do one-on-one activities with residents who were bed bound and further confirmed they had not assessed R13 for activities and were not providing her one-on-one activities.

During an interview on 5/11/23 at 1:14 p.m., the administrator stated the expectation was that all residents were screened for activities and bed bound residents received one-on-one activities.

A facility policy titled Activity Program, revised 1/2023, indicated the facility activity program was designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident and activities offered were based on the comprehensive resident-centered assessment and the preferences of each resident.

F 684 SS=D Quality of Care CFR(s): 483.25 F 684 7/14/23

§ 483.25 Quality of care

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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 monitor and administer ordered compression and diuretic medications for 1 of 1 residents (R32) reviewed for edema, and failed to ensure wound care was completed per orders for 1 of 1 residents (R72) reviewed for wound care.

Findings include:

R32's significant change Minimum Data Set dated 4/19/23, indicated R32 required extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, and had diagnoses of congestive heart failure (CHF), irregular heartbeat, kidney failure, and hypertension (HTN- high blood pressure).

R32's Care Area Assessment dated 4/19/23,for fluid maintenance was not triggered, however the diagnosis and conditions section indicated he had kidney disease, heart failure, and either started taking a diuretic (water pill) or had a recent increase in diuretic dose.

R32's care plan dated 9/2/21, included R32 had HTN related to heart failure and instructed staff to monitor and document any edema. The care plan included a nutrition focus related to CHF, HTN,

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1. R32's compression wraps were placed on the lower extremities as ordered.
2. Resident care sheets were updated to inform staff of resident needs.
3. The policy was updated to include instructions to weigh resident per provider orders regarding frequency.
4. R72's dressing was changed, initialed, timed and dated per the date changed.
5. This type of incident has the potential to affect all residents.
6. Facility will do an audit of all residents who have edema and compression wraps.
7. Facility will educate the staff on the importance of and proper use of compression wraps and other equipment, i.e., floating heel boots.
8. Facility will educate the staff on the importance of obtaining resident weights as ordered.
9. All resident orders will be updated to reflect correct physician order for weighing residents.
10. DON or designee will monitor weights to ensure they are completed. DON or designee will complete audits 1x/week for 4 weeks, then 1x/month for 6 months to

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and edema updated 10/22/22, and instructed staff to weigh R32 monthly or as ordered. Further, the care plan included R32 had lymphedema (sweeling of the leg) and administer treatments as ordered.

R32's Order Summary Report dated 5/11/23, included place compression (short stretch wraps in a figure-8 pattern) from forefoot to below the knee one time a day starting 4/7/23, and weights every Monday, Wednesday, and Friday starting 7/4/22. R32 also had an order for furosemide (a water pill), 80 milligrams (mg) two times per day for generalized edema.

R32's treatment administration record (TAR) for 3/1/23 - 5/10/23, indicated R32's weight was consistently 432.5 pounds on 3/22, 3/27, 4/3, 4/17, 4/21, 5/1, and 5/8/23.

On 5/8/23 at 2:32 p.m., R32 was lying in his bed with his left foot on a flat pillow. R32's feet were observed to be notably edematous and without compression wraps.

On 5/8/23 at 5:07 p.m., licensed practical nurse (LPN)-C stated R32 did not have any compression devices for his legs and feet that she was aware of.

On 5/9/23 at 11:59 p.m., nurse practitioner (NP)-A stated she ordered compression wraps for R32 several weeks prior but had never seen them on him when she came to see him. She stated the wraps could reduce edema and help prevent or improve R32's skin concerns.

On 5/10/23 at 10:17 a.m., R32 was observed lying in bed with his left leg on a flat pillow, two

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ensure resident weights are being completed per physician orders. All audits will be brought to QAPI for review.
11. Facility will educate the staff on the importance of dating and initialing wound care dressings.
12. DON or designee will audit residents that have compression wraps 3x/week for 4 weeks to ensure residents who need equipment like compression wraps have them and they are being utilized. All audits will be brought to QAPI for review.
13. DON or designee will audit residents with wound care 3x/week for 4 weeks to ensure the dressing is dated/initialed.
14. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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F 684	Continued From page 64 four-inch elastic wraps on a box on his bedside table and two compression tubular dressings on the nightstand on the opposite wall. R32 stated he had pain in his feet but was not sure of the cause. R32's feet were notably edematous. On 5/11/23 at 9:02 a.m., R32 was observed lying in bed wearing heal boots and no compression wraps on his legs. Two four-inch elastic wraps were on a box on his bedside table next to the bed, and two compression tubular dressings were on the nightstand on the opposite wall. Both of R32's feet were noticeably edematous. On 5/11/23 at 9:08 a.m., trained medication aide (TMA)-C stated R32 took medication for swelling in his legs and feet but did not have any orders for compression devices or wraps for lower extremity edema. She stated nurses would apply wraps if ordered. On 5/11/23 at 10:16 a.m., nursing assistant (NA)-G stated the nursing assistant care sheet included information regarding resident needs, including and compression stocking, elastic wraps, or boots of any type. She stated there were no residents on R32's unit who required any of these items. On 5/11/23 at 10:45 a.m., registered nurse (RN)-B stated if a resident had consistent edema she elevated their feet, informed the provider, and got an order for compression stockings or wraps. She stated staff were supposed to monitoring the edema and document in a note or on the treatment administration record (TAR), and wraps should be placed on in the morning and removed per provider orders. RN-B confirmed R32 had orders for compression wraps, but stated nurses	F 684		

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put them on when he asked for them. She stated R32 should be weighed regularly but refused and confirmed R32's record lacked weights and documentation of refusal or provider notification. She stated R32 needed to be monitored for edema, because extra fluid retention could lead to cardiac trouble and impair healing of the wound on R32's feet.

On 5/11/23 at 2:44 p.m., director of nursing stated staff should be monitoring and documenting edema, lung sounds, and weights for residents who have CHF. He stated if compression stocking, hose, or wraps were ordered he expected nurses or aides to put them on the resident and resident refusals should be documented as it was important follow orders to reduce the edema, any possible pain, and to improve the resident outcome.

The policy Weighing and Measuring the Resident dated 12/2022, indicated staff should review the resident's care plan to assess for any special needs of the resident, and document if the resident refused. The policy lacked instruction to weigh resident per provider orders regarding frequency.
R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein

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valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's physician orders dated, 3/21/23, directed staff to perform wound care to bilateral lower extremities daily by cleansing wound with normal saline (NS), pat dry, apply Xeroform (vaseline gauze), cover with ABD (abdominal pad) and hold in place with Kerlix (cotton wrap) daily.

R72's May 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) identified staff failed to document wound care to bilateral lower extremities on May 1, 2023, and May 3, 2023.

During observation on 5/8/23 at 3:56 p.m., R72's bilateral lower extremities were visible from the hallway into the room. R72 was laying on her back on her bed. The wound care dressing on the right lower extremity (from the heel to the upper shin) showed dark red wound drainage that had penetrated through the dressing and onto the pillow where the foot was resting. The wound dressing had a label attached to the dressing with the date "5/6/23".

During interview with registered nurse (RN)-A on 5/8/23 at 7:08 p.m., RN-A verified the wound care dressings to both lower extremity legs was dated

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F 684	Continued From page 67 5/6/23. In addition, RN-A stated a failure to perform daily wound care "can increase her risk of infection". During interview with licensed practical nurse (LPN)-B on 5/10/23 at 9:36 a.m., LPN-B stated wound dressings, "should always be dated and initialed by nurse that did the wound care". During interview with director of nursing (DON) on 5/11/23 at 1:31p.m., DON stated wound care dressings "should be labeled and initialed every time it is changed" and R72 is required to have wound care daily. DON stated R72 was at risk for infection if wound care is not performed daily. The DON stated, "if it was dated 5/6/23 and you observed it on 5/8/23, then it was not done from 5/6/23 to 5/8/23 and it is unacceptable." Facility policy Wound Care, reviewed November 2023, instructs staff to, "Mark tape with initials, time, and date and apply to dressing" following wound care.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 685		7/14/23

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F 685

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provision of vision or hearing assistive devices.
This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review, the facility failed to ensure assistive devices to maintain hearing abilities were provided for 1 of 1 residents (R32) reviewed for hearing devices.

Finding include:

R32's significant change Minimum Data Set (MDS) dated 4/19/23, indicated R32 required extensive assistance of two staff for bed mobility, transfers, and personal cares. The MDS indicated he had adequate hearing and did not wear hearing aids.

R32's Communication Care Area Assessment was left blank

R32's audiology consult note dated 8/19/22, indicated R32 had severe hearing loss in his right ear and moderately sever to severe hearing loss in his left ear, and recommended bilateral hearing aids.

R32's care plan dated 9/2/21, indicated R32 had a communication problem related to hearing deficit, and lacked information or instruction for R32's hearing aids.

R32's Order Summary Report dated 5/11/23, included:
- Change batteries of hearing aids every Thursday morning starting 10/13/22.
- Clean hearing aids daily, put hearing aids in the case at bedtime and make sure it is functioning properly starting 10/13/2022.

F 685

1. R32’s hearing aides were found and were determined to be in good working order.
2. R32’s care plan was updated to instructions for hearing aids.
3. This type of incident has the potential to affect all residents.
4. Facility will conduct an audit 3x a week for 4 weeks to make sure all residents that require hearing aides have them and they are in good working order.
5. Facility will bring audits to QAPI and address any audits that show residents were missing hearing aides or found hearing aides to not be in working order.
6. Education will be provided to nursing staff on understanding the importance of hearing devices for residents with hearing deficits, along with monitoring residents to determine if they need a hearing device or an appointment scheduled with audiology for hearing testing.
7. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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A progress note dated 10/13/2022 at 5:02 a.m. indicated the receptionist brought R32's hearing aids to staff who placed it into a case in a cart and the morning nurse was notified.

A progress note dated 11/7/2022 at 6:29 p.m. identified the receptionist received a call from resident's wife who indicated R32 wanted his hearing aids fixed.

On 5/08/23 at 2:21 p.m. R32 stated he had severe hearing loss, and the hearing company came in and set him up with a pair of hearing aids. He stated he could hear others with them but could not hear himself and was told to send them back. He stated he gave them to RN-C who put them in a container, but as far as he knew they were still in the building. R32 stated staff had not spoken with him about replacing his hearing aids.

On 5/11/23 at 9:08 a.m., trained medication aide (TMA)-C was observed helping R32. TMA-C raised her voice and had to repeat herself once while speaking to R32. She stated she always stood close to R32 so he could hear her.

On 5/10/23 at 7:22 a.m. nursing assistant (NA)-H stated R32 was hard of hearing sometimes but did not have hearing aids.

On 5/10/23 at 7:50 a.m. registered nurse (RN)-G stated R32 did not wear hearing aids.

On 5/10/23 at 8:52 a.m. RN-F stated R32 did not have hearing aids because they had been missing for a few months. He stated R32 told him he gave the hearing aids to RN-C to get them

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F 685	Continued From page 70 fixed and confirmed R32 needed them to hear adequately and to live a better life. On 5/10/23 at 1:02 p.m., RN-C stated R32 told him about the missing hearing aids "a couple of weeks ago" and asked him to get them fixed because they echoed. He stated he informed RN-F about it, and when asked about them a couple of days later they discovered they were lost. He confirmed they had not been replaced and was unsure why. The Lost and Found policy indicated resident or family complaints of missing items must be reported to the director of nursing services. A policy pertaining to hearing device care and replacement was requested but not provided.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary	F 686	1. R32's compression wraps were placed on the lower extremities as	7/14/23

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F 686	Continued From page 71 treatment to promote healing, reduce the risk of complications, and prevent pressure ulcer development for 2 of 3 residents (R32, R72) reviewed for pressure ulcers. Findings include: R32's significant change Minimum Data Set dated 4/19/23, indicated R32 required extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, was morbidly obese, incontinent of bowel, and had diagnoses of failure to thrive, congestive heart failure (CHF), and kidney failure. The MDS indicated he was at risk of pressure ulcers and had one stage 3 pressure ulcer. R32's Pressure Ulcer/Injury Care Area Assessment dated 4/7/23, indicated he had an existing pressure ulcer with a checkmark in the box next to "Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin, and identified risk factors of pressure, immobility, incontinence, antidepressant medications, kidney disease, heart disease, and limited range of motion. R32's Braden Scale for Predicting Pressure Sore Risk identified he was a high risk for pressure ulcers. R32's care plan updated 5/3/22, indicated he had vascular wounds on his left foot and pressure injury on his right foot and included instruction to administer treatments as ordered and monitor for effectiveness. R32's Follow-Up Progress Notes dated 4/5/23	F 686	ordered. 2. R32's heels have been floated as ordered. 3. R72 has been turned and repositioned every 2 hours as ordered. 4. R72's tasks and care plan were updated for staff to document turning and repositioning as ordered. 5. This type of incident has the potential to affect all like residents. 6. Facility will conduct an audit of all residents who have edema and compression wraps. 7. Facility will conduct an audit of all residents that require every 2-hour turning and repositioning. 8. Facility will audit 3x/week for 4 weeks, then 1x/month for 6 months to ensure residents who need equipment like compression wraps have them and they are being utilized, along with being turned and repositioned as ordered. Any issues found will be brought to QAPI. 9. Facility will educate the staff on the importance of and proper use of compression wraps and other equipment i.e., floating heel boots, along with turning and repositioning schedules. 10. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.	

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F 686	Continued From page 72	F 686		

and 5/2/23, written by nurse practitioner and wound care nurse (NP)-A included the following recommendations:
- Left lateral foot: Clean with saline/Vashe (cleanser) only, pat dry, apply skin prep/barrier film to peri-wound, allow to dry, then ABD (a thicker padded dressing), and secure with stretch gauze bandage wrap: place compression from forefoot to below knee (short stretch wraps in figure-8 pattern) or compression stockings, then pressure offloading/redistribution boot
- Bilateral lower legs: Apply tubigrip then short stretch wraps in a figure-8 pattern from just above the toes to just below the knees, ok to apply over dressings on left foot. Change with dressing changes. Continue heel protection

R32's Follow -Up Progress Note dated 5/9/23, written by NP-A included tubigrips were recommended to assist with management of fluid in lower extremities for bilateral lower legs and were initiated on 3/15/23, however had not been in place the last several weeks on rounds. In addition, the note identified "no heel protection in place for 3 weeks with rounds".

On 5/8/23 at 2:32 p.m., R32 was lying in his bed with his left foot on a flat pillow covered in a light tubular stockinette over a gauze dressing dated 5/5/23. R32 stated he wasn't sure what it was for, but it had been a while since it was changed. He was not wearing heel protection, nor were heel protectors visible in the room.

On 5/8/23 at 5:07 p.m., licensed practical nurse (LPN)-C stated R32 had a wound on his leg but did not know what type or where exactly it was because the dressing was scheduled to be changed on the day shift. LPN-C confirmed the

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dressing on R32's left foot was marked 5/5/23, reviewed R32's orders, and verified he had an order for daily dressing changed starting 4/6/26. She was not aware of heel protectors.

On 5/8/23 at 5:36 p.m. registered nurse (RN)-F stated R32 required daily dressing changes to his left foot, and he changed it on 5/5/23. He stated he was not at the facility over the weekend and was not sure why it was not changed on 5/6, 5/7, or earlier that morning on 5/8/23. He stated it needed to be changed daily to prevent infection.

On 5/9/23 at 11:59 a.m. NP-A stated R32 had vascular wounds on the side of his left foot and left fifth toe, and a pressure ulcer on his heel. She stated she expected staff to change dressings daily if ordered daily, and if not completed, the wounds could worsen or increase risk of infection. She stated she ordered heel protection and wraps for multiple weeks, but they were never on when she arrived. She stated RN-C found them in R32's closet that morning and placed them on R32's feet.

On 5/11/23 at 9:08 a.m., trained medication aide (TMA)-C confirmed R32's dressing was dated 5/9/23, two days prior, and stated it was the nurse's responsibility to change dressings. She was unaware of heel protectors for R32.

On 5/11/23 at 2:44 p.m., director of nursing (DON) stated he expected wounds to be monitored, dressings to be changed per provider orders, and any refusals to be documented to ensure they did not get worse or infected.

The Wound Care procedure dated 11/23, identified staff should verify there is an order for

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the dressing change, review the resident's care plan for any special resident needs, and document all wound assessment data and any resident refusals.

R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's care plan printed 5/11/23 failed to have a turn and reposition order until 5/10/23. In addition, R72's care plan focus dated 5/2/23, indicated "the resident has pressure ulcers r/t immobility" and an intervention to "Follow facility policies/protocols for the prevention /treatment of skin breakdown".

The transitional care unit (TCU) Nursing Assistant residents care sheet, dated 5/4/23, for R72

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directed staff to "Pls enforce repositioning q 2hrs".

R72's Weekly Wound Report progress notes dated, 3/22/23, 3/29/23, 4/4/23, 4/11/23, 4/18/23, 4/25/23, 5/2/23, and 5/9/23 identified, "Treatment Recommendations" which state, "Heel offloading per facility protocol".

Turning and Repositioning:

During observation on 5/8/23 at 3:52 p.m., R72 was observed laying in bed, flat on her back. A piece of paper posted to the wall at head of her bed indicated a Turning Schedule with the following:

7:00am-9:00am, facing the ceiling
9:00am-11:00am, facing the window
11:00am-1:00pm, facility the door
1:00pm-3:00pm, facing the ceiling
3:00-5:00pm, facing the window
5:00pm-7:00pm, facing the door
7:00pm-9:00pm, facing the ceiling
9:00-11:00pm, facing the window
11:00pm-1:00am, facing the door
1:00am-3:00am, facing the ceiling
3:00am-5:00am, facing the window

During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated the importance of repositioning R72 every two hours "because of her wounds" and immobility. NA-D stated expectation of nursing assistants to document turning and repositioning R72 every two hours in the electronic medical record (EMR). NA-D unable to find out where in the EMR the documentation was supposed to be done.

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F 686	Continued From page 76 During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated the expectation of nursing assistants was to reposition residents every two hours and to document it in the EMR. NA-A stated they were unable to see any documentation of turning and repositioning of F72 at all. During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated the expectation was R72 be turned every two hours. RN-B stated R72, "is high risk for more breakdown because she can't turn by herself". During interview with licensed practical nurse (LPN)-B on 5.10/23 at 7:33 a.m., LPN-B stated the expectation was nursing assistants are to document turning residents every two hours in the EMR. LPN-B stated R72, "should be turned because she can't do it herself." During interview with staffing coordinator (SC)-A on 5/10/23 at 10:30 a.m., SC-A stated the expectation was the nurse manager updated the nursing assistant care sheets and nurses are responsible for making sure the residents are turned on time. SC-A stated expectation each time a resident is turned the nursing assistants are to chart in the EMR to show it was completed or offered. SC-A stated R72's EMR lacked any area to document turning and repositioning and that R72 should have it "so she doesn't get pressure ulcers". During interview with RN-C on 5/10/23 at 11:53 a.m., RN-C stated he was the facility in-house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C	F 686		

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F 686	Continued From page 77 stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds. RN-C stated nurses on the units are responsible for establishing a turning schedule for residents who are at high risk for pressure ulcers. RN-C stated the expectation of an order in the EMR to turn and reposition R72. RN-C stated prior to 5/10/23 R72 EMR did not have an order to reposition or turn her. Floating Heels: During observation and interview with registered nurse (RN)-A on 5/8/23 at 7:08 p.m., R72's heels were resting on top of soiled pillowcase. RN-A stated R72's heels "should be rested off bed but they are not." During observation on 5/9/23 at 12:33 p.m., R72 laying flat on back and not on side facing door per her posted turning schedule. Both heels were resting on top of small pillow. During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated R72 heels should be on the pillow to prevent pressure ulcers. During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated R72's heels "Should be on top of the pillow and not off". During interview with NA-B on 5/10/23 at 8:56 a.m., NA-B stated R72's heels should be on the pillow and not resting off of it. During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated "heels should be resting on top of the pillow and not off of it."	F 686		

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During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated understanding that heels can rest on top of the pillow and not off.

During interview with RN-C on 5/10/23 at 11:53 a.m., RN-C stated he was the facility in-house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds including R72. RN-C stated offloading means, "relief of pressure on particular points like feet and heels". RN-C stated heels should not touch anything and should be off the pillow and not resting on the pillow.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated "I wasn't aware that there was no order to turn and reposition her. There should be an order for any person who cannot turn themselves and yes there should be one for her because she cannot turn on her own. It important to protect against skin breakdown. [R72] is vulnerable for skin breakdown". In addition, DON stated recommendations by the wound care nurse from the Weekly Wound care notes is an order should be put in the EMR.
The DON stated the in house or facility wound care nurse, RN-C was responsible for putting in the turning and repositioning order and the offloading of heels into the EMR for R72 which was not done. Furthermore, the DON stated off-loading meant the heels must be off the bed and not touching anything. Having heels resting on top of a pillow is not acceptable and the staff need education to prevent this.

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F 686	Continued From page 79 During interview with facility administrator on 5/10/23 at 1:22 p.m., administrator stated, "it is very important to turn [R72] every two hours because we don't want her to get pressure ulcer or make it get worse." The administrator stated the order to turn and reposition R72 was not in the electronic medical record (EMR) and it should have been. Facility policy titled, Repositioning, reviewed November 2023, identified a turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. In addition, it identifies residents with a Stage I or above pressure ulcer, an every two hour (q2 hour) repositioning schedule is inadequate. Also, the position in which the resident was placed, the name and title of the individual who gave care, and the signature and title of the person recording the data are expected to documented in the resident's EMR.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure safe smoking practices were consistently followed and interventions were re-evaluated and implemented	F 689	1. Administrator and DON had a conversation with R25 regarding safe smoking practices and not smoking in his room.	7/14/23

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for 1 of 1 resident (R25) reviewed for smoking and the facility failed to comprehensively assess falls, identify causal factors, and implement interventions to decrease the risk of additional falls for 1 of 1 residents (R3) reviewed for falls.

Findings include:

R25's quarterly Minimum Data Set (MDS) dated 4/28/23, indicated intact cognition, was independent for all activities of daily living (ADLs), and a diagnosis of problems related to alcohol, tobacco, and drug use. The MDS further indicated under current tobacco use was incomplete.

R25's care plan revised 2/26/23, indicated R25 was a smoker and had a history of smoking in his room. The goal indicated staff were to secure R25's smoking products for safe keeping after resident smoked. Interventions indicated to instruct R25 on risks and hazards and about smoking cessation aids available, instruct resident on the smoking policy, location, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, resident has a history of smoking in room, facility to hold resident smoking material related to safety risks, and resident refusals (SIC) to allow facility staff to secure smoking materials.

R25's Kardex form indicated R25 had a history of smoking in his room and the facility was to hold resident smoking material related to safety risks.

R25's Smoking Review form dated 4/28/23, indicated R25 smoked and had not tried to quit recently. R25 did not have a history of smoking related incidents. R25 did not have the ability to

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2. These types of incidents have the potential to affect all residents.
3. Smoking assessment was completed on R25 and it was determined that R25 does not need supervision while smoking, but does need to wear a smoking apron.
4. R25's care plan was updated to reflect the change in his smoking assessment.
5. R25 was given a smoking policy and asked to sign a copy of the smoking policy.
6. Risk and benefit was completed with R25 on the perils of smoking in his room.
7. Facility will educate staff on smoking policy and safe smoking practices for the residents.
8. R3's fall risk management from 3/15/23 was completed with a causative factor indicated, interventions implemented and care plan updated.
9. Facility will educate staff on fall prevention policy to mitigate high fall risks.
10. Facility will complete safety checks on R25 every 2 hours while resident is in his room to assure resident is safe and not smoking in the room.
11. DON or designee will audit safety checks 3x/week for 4 weeks. All audits will be brought to QAPI for review.
12. DON or designee will audit safe smoking policy and fall prevention policy staff education 1x/week for 4 weeks, then 1x/month to ensure completion for all staff. All audits will be brought to QAPI for review.
13. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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hold a cigarette safely without a device, but the form did not indicate what kind of device R25 required, nor did R25 have the ability to extinguish a cigarette safely. The form indicated staff reviewed the policy related to smoking times and storage of smoking materials with the resident and the care plan was initiated/updated.

R25's Smoking Review form dated 2/26/23, indicated R25 smoked and had not tried to quit recently. R25 had a history of smoking related incidents of smoking in bed and in non-smoking areas, and had the ability to safely hold and extinguish a cigarette. The form further indicated staff reviewed the policy related to smoking times and storage of materials and the care plan was initiated/updated.

All R25's incidents were reviewed and lacked information of any incidents related to smoking.

R25's progress notes were reviewed from 12/1/22 to 5/10/23:

A progress note dated 12/24/22, indicated R25 was found smoking in the room around 5:15 a.m. and stopped smoking before getting there and was asked not to smoke in the room. The effectiveness of the intervention was documented as "N/A."

A progress note dated 1/12/23, indicated, "This writer noted Res smoking in his room at 24:50..." No interventions were documented regarding R25 smoking in the room.

A progress note dated 1/12/23, indicated, "Resident is repeatedly smoking cigarettes and weed in his room. He has been talked to several

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times regarding this but he's still refusing." The note further indicated the director of nursing and Associated Clinic of Psychology (ACP) were made aware and spoke with R25.

A progress noted dated 2/15/23, indicated at 7:00 p.m., a strong cigarette odor was noted in the hallway and was coming from R25's room. The note indicated three residents were in the room smoking and declined to surrender cigarettes. They were informed that smoking in the building was prohibited as there were residents who used oxygen and oxygen storage was located on the same floor.

A progress note dated 2/15/23, indicated R25 was smoking in his room and was reported as ongoing for the past few weeks and R25 declined to hand over cigarettes.

A progress note dated 3/1/23, indicated R25 was found smoking in his room and was educated about the danger associated with smoking in his room and the director of nursing was informed of the situation.

A progress note dated 3/14/23, indicated the smell of cigarette smoke was identified from R25's room and R25 acknowledged he accidentally smoked in his room, and thought he was outside. The note indicated R25 was aware of the facility policy and the floor manager was notified.

R25's care conference note dated 4/11/23, indicated R25 was spoken to about smoking in his room and the importance of not smoking in his room.

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A progress note dated 4/20/23, indicated, "Resident continues to smoke in his bedroom. I have watched him put out two cigarettes already. I spoke with him about smoking in his room and the dangers it can cause, yet he continues with the behavior." The medical record was reviewed and lacked documentation regarding any follow up.

During interview and observation 5/8/23 at 5:53 p.m., R25 was in his room and had a quarter sized burn hole on the right upper chest area of his sweatshirt. R25 stated he had a cigarette in his mouth and was outside smoking. He put the cigarette out, motioning on the wheel of his wheelchair, put the cigarette back in his mouth, and came into the facility with the cigarette butt, and stated it must have reignited and caused the burn hole after he nodded off, adding it fell out of his mouth and there it was. R25 stated this happened a month or so ago and stated he did not burn his chest. R25's room smelled like cigarette butts and when asked, R25 stated he did not smoke the whole cigarette. R25 opened his drawer and had a full carton of Marlboro cigarettes in his room.

During interview and observation 5/9/23 at 3:15 p.m., R25 was outside smoking and had the gray sweatshirt on with the burn hole located on his right chest. R25 had a lit cigarette in his right hand and dropped it on the ground and did not put the cigarette out. There were multiple cigarette butts located on the ground. R25 had a lighter located on his right leg.

During interview and observation on 5/10/23 at 7:28 a.m., an odor of cigarette smoke was identified in R25's room. R25 was wearing his

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shirt with the burn hole in the upper right chest. R25 stated he occasionally forgets and lights a cigarette in his room and puts it out motioning throwing the cigarette on the floor. R25 stated he forgets where he is. There were two Coke cans opened and a clear plastic cup with blackish sludge that filled 1/3 of the cup next to the Coke cans on R25's nightstand. When asked if R25 had just smoked, R25 stated he would do what he wanted.

During interview 5/10/23 at 7:56 a.m., nursing assistant (NA)-E stated residents were supposed to go downstairs to smoke and was not aware of any issues of residents smoking in undesignated locations.

During interview 5/10/23 at 8:07 a.m., licensed practical nurse (LPN)-D stated smoking assessments were completed to see if a resident was capable of smoking without burning themselves and added the nurse or manager completed the assessment and the assessment indicated whether a resident could hold a cigarette without burning themselves, were alert, and weather they could hold it and put it out safely. LPN-D stated she smelled cigarettes in R25's room, but has not physically seen R25 smoke, and stated she asks the nurse manager to verify what she is smelling. LPN-D added that smoking assessments were completed as needed such as a change in condition and did not have concerns of other residents smoking in their room.

During interview 5/10/23 at 9:16 a.m., NA-K stated R25 smoked in his room mostly on the p.m. shift and added that management was aware but had not seen drastic action taken to

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prevent R25 from smoking in his room and stated it was against policy to smoke in the building. NA-K was aware R25 smoked in his room because the smell of smoke was present when walking in the hallway.

During interview on 5/10/23 at 9:27 a.m., the housekeeping and laundry supervisor (HLS)-I stated she saw burn holes on R25's clothing twice and added the nurse was aware of the burn holes and the burn holes were noticed about two months ago.

During interview 5/10/23 at 10:45 a.m., registered nurse (RN)-C stated smoking assessments were completed to determine if a resident was safe to smoke independently and were completed quarterly or sooner if there were concerns such as if dexterity issues were noticed, if a resident burned themselves, or a change in condition. RN-C stated there must have been a mistake on the Smoking Review form dated 4/28/23, because R25 was independent. RN-C stated their policy indicated the building was smoke free and added they educated R25 by letting him know he is not the only resident residing at the facility and explained the risks. RN-C stated R25 smoking in his room was concerning because there were residents who had oxygen which could put them at risk and it could cause a fire or a risk of death and checks needed to be in place to prevent this from happening. RN-C stated the nurse should have followed up with staff who completed the assessment if they noticed a change because then an adjustment could be made. RN-C stated he was aware of the burn hole on R25's gray sweatshirt and added it concerned him R25 had burn holes because R25 may not be safe, but was his own representative.

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RN-C added R25 ordered his own items such as lighters and cigarettes and stated at this point R25 seemed noncompliant.

During interview on 5/10/23 at 2:34 p.m., RN-F stated smoking assessments were completed quarterly and if there was a problem. When reviewing the Smoking Review form dated 4/28/23, RN-F stated the person completing the form did not complete the form correctly and added he had personally not assessed R25 for smoking and stated smoking in resident rooms would be considered an incident and was unacceptable because it was a fire hazard and a discomfort to other residents. RN-F stated R25 was a smoker and was non-compliant. When asked how other residents are kept safe from R25 smoking in his room, RN-F stated he went with the director of nursing last week to request R25 be compliant and instructed him to smoke outside.

During interview on 5/12/23 at 8:27 a.m., R46 stated everyone knew R25 smoked in his room.

A policy, Smoking Policy-Residents reviewed November 2023, indicated the facility established and maintained safe resident smoking practices. Smoking was only permitted in designated resident smoking areas, which was located outside of the building. Smoking was not allowed inside the facility under any circumstances. Staff consult with the attending physician and the director of nursing services to determine if safety restrictions needed to be placed on a resident's smoking privileges based on the safe smoking evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the

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staff. Any smoking-related privileges, restrictions, and concerns for example need for close monitoring were noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. The facility may impose smoking restrictions on a resident at any time if it was determined that the resident cannot smoke safely with the available levels of support and supervision. Additionally, the policy indicated the facility maintained the right to confiscate smoking items found in violation of the smoking policies.

R3's quarterly Minimum Data Set (MDS) dated 3/16/23, indicated she was severely cognitively impaired, required assist of one staff for bed mobility, toilet use, and personal hygiene, assist of two staff for transfer, and was always incontinent of bowel and bladder.

R3's Medical Diagnosis dated 6/10/22, list included previous femur fracture and repeated falls.

R3's Falls Care Area Assessment dated 6/22/22, included R3 had difficulty maintaining sitting balance, impaired balance during transitions, took antipsychotics and antidepressants, and had diagnoses of arthritis, hip fracture, delirium, cognitive impairment, anxiety, and pain.

R3's fall risk care plan revised 9/10/22, indicated R3 had a fall without injury due to poor balance and unsteady gait, and included "For no apparent injury, determine and address causative factors of the fall."

R3's historical risk management forms identified she had 17 falls between 6/17/22, and 11/11/22.

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A progress notes dated 11/25/22, 11/29/22, 12/6/22, 12/15/22, 1/25/23, and 2/5/23, indicated R3 was found on the floor next to her bed. R3's record lacked a root cause analysis of the falls and any additional interventions.

R3's Resident Fall Risk dated 3/15/23, was incomplete, and included R3 had no falls in the past three months, was ambulatory and continent, and did not take medications causing lethargy or confusion.

A progress note dated 3/25/23, indicated staff found R3 in her room by the entrance on her right side in a pool of blood with her wheelchair outside the door. Staff called emergency medical services (EMS), resident decline transportation to the hospital, and EMS stayed to control the bleeding from a cut above R3's right eye and left the facility. The note identified the bleeding did not stop, EMS was called again, and R3 was transported to the hospital.

R3's After Visit Summary dated 3/25/23, indicated R3 was seen in the hospital emergency department for a head injury due to a fall.

R3's medical record lacked a root cause analysis and fall interventions after the fall on 3/25/23.

On 5/08/23 at 2:51 p.m., R3 was lying in her bed in her room with no mat on the floor. She stated she was not doing well, had diarrhea 'really bad', and had put her call light on to go to the restroom.

On 5/8/23 at 5:08 p.m., R3 was lying in bed on her right side pulling her pants down with the door open, yelling she needed to use the bathroom because she had diarrhea. She stated she was

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trying to "get it" herself. The bed was not in low position and measured approximately 30 inched from the floor to the top of the mattress. There was no mat on the floor next to the bed.

On 5/09/23 2:34 p.m., R3 was in her wheelchair in her room shifting in her seat and stated she needed a nurse because she had diarrhea and needed to use the bathroom.

On 5/10/23 at 6:57 a.m., R3 was observed lying in bed, not in lowest position, with no falls mat on the floor.

On 5/10/23 at 7:22 a.m., nursing assistant (NA)-H stated fall risk information was not in the computer or on the NA care sheet, but some resident wore a wrist band to identify if they were at risk, and others she just knew. She stated R3 was at risk for falling, and staff tried to keep an eye on her. She stated she tried to self-transfer to and from bed, and usually her bed was in low position and there was a mat on the floor any time she was in bed. NA-H looked in R3's room and confirmed R3 did not have a falls mat available and was not sure why it was not there.

On 5/10/23 at 7:50 a.m., licensed practical nurse (LPN)-A stated if a resident fell once, they were at risk from then on and she completed a risk management form on the computer which asked questions about the situation to determine appropriate interventions, which often included reminding residents to use the call light and placing mattresses on the floor nest to the bed. If the fall was unwitnessed, she completed neuro (neurological) assessments per policy to make sure they did not have a head injury. LPN-A stated R3 was at high risk for falls because she

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did things spontaneously, had weak lower extremities, could not really bear weight, and needed one staff to assist. She stated if she tried to get up by herself, she could fall forward on her face. She stated she always had a mat on the floor when she was in bed at night but was unsure about the daytime. LPN-A verified there was not a mat in R3's room and stated the NAs must bring it up every night from the basement and then bring it back down.

On 5/10/23 at 8:30 a.m., maintenance staff (MS) stated mattresses and mats stored in the basement were locked in a room and nursing staff did not have access to them, and nothing was stored in the hallways on the floors because they were hazards.

On 5/10/23 at 11:51 a.m., NA-F and NA-H both confirmed R3 used to have a falls mat but it was no longer in her room.

On 5/12/23 at 10:25 a.m., the HUC stated neuro check forms were not given to her to scan into the computer, and she had not seen any.

On 5/12/23 at 10:29 a.m., RN-H stated after an unwitnessed fall she wrote a progress note and started a neuro check form, and when the form was completed, she gave them to the HUC to upload into the computer. She stated she also completed a risk management form in the computer which identified details of any fall and interventions to add. RN-H verified R3's record did not contain neuro checks for the fall on 3/25/23, and the care plan did not include additional fall prevention interventions.

On 5/12/23 at 10:31 a.m., registered nurse

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F 689	Continued From page 91 (RN)-F stated staff completed a fall risk management form in the computer after each fall which provided potential prevention interventions appropriate to the resident's situation. Neuro checks were completed after an unwitnessed fall and documented on a paper form. He stated the form was not scanned into the medical record, and he was not sure if it was kept at the nursing station or with the health unit coordinator (HUC). RN-F stated neuro checks were completed after R3's fall on 3/25/23 but was unable to find the documentation. RN-F also confirmed a risk management form or root cause analysis was not completed. He stated R3 used to have a falls mat on the floor but did not know why it was no longer in R3's room. The Falls and Fall Risk, Managing policy dated 11/22, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. When a resident is found on the floor, a fall is considered to have occurred. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		7/14/23

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§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide routine monitoring to reduce the risk of catheter related complications for 4 of 5 residents (R14, R32, R63, R72), who had an indwelling catheter and a history of urinary tract infections (UTIs), reviewed for catheter care.

Findings include:

1. R32's and R72's orders were updated to add a location to document characteristics of urine output.
2. R32's and R72's care plans were updated to include the expectation of recording/monitoring urine output.
3. Resident care sheets were updated to include resident needs.
4. R72's orders were updated to have staff empty catheter bag every shift.

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R32's significant change Minimum Data Set dated 4/19/23, indicated R32 used an indwelling catheter, required extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, was morbidly obese, incontinent of bowel, and had diagnoses of neurogenic bladder(when the nerves from the brain to the bladder do not respond correctly), enlarged prostate, kidney failure, failure to thrive, and congestive heart failure (CHF).

R32's Diagnosis Report dated 5/11/23, indicated he had urinary tract symptoms and urine retention.

R32's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 4/27/23, indicated R32 needed extensive assistance for toileting and required and indwelling catheter. Factors contributing to catheter use included neurogenic bladder, urinary urgency and need for assistance toileting, enlarged prostate, congestive heart failure, depression, and medications. The CAA indicated this problem was addressed in the care plan but lacked narrative regarding input from R32, impact on the resident, and rationale for the decision to add to care plan. The CAA indicated this problem was addressed in the care plan but lacked narrative regarding input from R32, impact on the resident, and rationale for the decision to add to the care plan.

R32's care plan dated 9/2/21, indicated R32 had a urinary catheter and will show no signs or symptoms of urinary tract infection. Interventions included catheter care and treatment per provider orders, monitor intake and output as per facility policy, and monitor for signs and symptoms of

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5. R14's orders and care plan were updated to include changing the catheter, catheter cares and urine output monitoring.
6. R63's orders and care plan were updated to include changing the catheter, catheter cares and urine output monitoring.
7. R63's orders and care plan were updated to have a full drainage bag at night. R63 will also be monitored at night to ensure that the catheter bag is below the level of the bladder.
8. These types of incidents have the potential to affect all residents with catheters.
9. Facility will provide staff education on catheter cares, monitoring urine output and following orders.
10. DON or designee will audit residents with catheters 3x/week for 4 weeks to ensure that catheters bags are emptied and hanging below the level of the bladder. All audits will be brought to QAPI for review.
11. DON or designee will audit resident's charts that have catheters 1x/week for 4 weeks to ensure proper monitoring of urine output and catheters changed as ordered. All audits will be brought to QAPI for review.
12. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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discomfort on urination and frequency.

R32's Order Summary Report dated 5/11/23, included:
- Output every shift for urinary retention starting 8/31/19
- Encourage fluids every shift starting 9/15/21
- Monitor output every shift starting 11/17/22
- Furosemide (a water pill) 40 milligrams (mg), give 80 mg twice per day starting 4/13/23

R32's Treatment Administration Record (TAR) for March, April, and May 2023 included monitor output and contained checkmarks to identify the task was completed but lacked evidence of volume and characteristics of urine.

R32's hospital documentation dated 3/14/23, indicated he was hospitalized for septic shock, respiratory failure, and encephalopathy related to UTI from 3/2/34 - 3/24/23.

R32's hospital documentation dated 4/13/23, indicated he was hospitalized with septic shock, respiratory failure, and encephalopathy related to UTI from 4/5/23 - 4/12/23.

During an interview on 5/10/23 at 7:22 a.m., nursing assistant (NA)-H stated nurses completed catheter cares, but the NAs emptied the catheter bags. She stated there was no place to document amount or characteristics of urine, but she reported the amount to the nurse, and informed them if it "smelled weird" or if anything was "not right".

During observation on 5/11/23 at 9:08 a.m., trained medication aide (TMA)-C entered R3's room to awaken him. She emptied approximately

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400 cubic centimeters (cc's) of amber colored urine from the bag and stated she did not have a place to document it but would report it to the nurse.

During interview on 5/11/23 at 10:16 a.m., NA-G Stated she emptied catheter bags and told the nurse how much was in the bag and informed them when urine was red, yellow, or thick, but there was no place for her to document it.

During interview on 5/11/23 10:45 a.m., registered nurse (RN)-B stated the NAs emptied catheter bags and reported the amount of urine to the nurse, and the nurse documented output in the system "if there was a place to enter it". She stated staff did not document urine characteristics. RN-B verified there was no place to enter amount of urine or characteristics in R32's record. She stated it was important to monitor to detect signs of possible UTI as R32 had a history of UTIs.

During interview on 5/11/23 at 2:45 p.m., director of nursing (DON) stated the NAs monitored urinary output and characteristics and documented it in the electronic record and told the nurse if there were any changes. The DON verified there were no documentation fields for output or urine characteristics in R32's record because the orders were entered into the computer incorrectly, which prevented staff from documenting. He stated the nurses should be looking at urine output, including any sediment, color changes, or other signs of dehydration or UTI to try to identify issues early and prevent complications.

R72's Significant change Minimum Data Set

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(MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnosis' include hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairments and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's physician orders dated 4/25/23, directed staff to "flush catheter BID scheduled with 30 cc saline to assist with patency. Dx: R33.8". Also, an order for "Foley catheter size 16F/10 [cubic centimeters]cc ballon one time a day every 24 day(s) for Foley Catheter change with a start date of 4/28/23".

R72's after visit summary dated 4/26/23, indicated resident transferred to emergency room for a urinary tract infection and was started on an antibiotic and then sent back to the facility on the same day.

R72's care plan printed 5/11/23, indicated a focus of "Potential for Urinary Tract Infection r/t foley

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catheter" and "The resident has a foley catheter r/t urinary retention" with the date initiated of 5/2/23. The care plan failed to indicate expectation to record and monitor output amounts.

R72's May 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) identified no documentation or monitoring of urinary output until an order was put in on 5/10/23.

The facility's TCU Nursing Assistant residents care sheet, dated 5/4/23, failed to indicate any monitoring of R72's urine or that resident had a foley catheter at all.

During observation and interview on 5/8/23 at 7:21 p.m., R72's foley drainage bag was connected to the bed frame and held over 1200 cc of yellow urine in the bag. Registered nurse (RN)-A stated R72's foley catheter bag is "usually emptied per shift", but that it "looks like it has not been emptied this shift". RN-A could not provide if and where the amount of urine was documented in the resident electronic medical record (EMR).

During interview with nursing assistant (NA)-A on 5/10/23 at 6:32 a.m., NA-A stated nursing assistants are expected to empty foley catheters every shift and tell the nurse the amount for them to document in the EMR.

During interview with registered nurse (RN)-B on 5/10/23 at 7:18 a.m., RN-B stated the expectation was nurses are responsible for documenting urine outputs into the EMR. RN-B was unable to show in EMR where outcomes were documented.

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During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated the expectation of nursing assistants was to "tell us what volume of urine is so we can chart" in the EMR. LPN-B was unable to show in the electroic medical record (EMR) where outcomes were documented.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated the expectation was to have "outputs to be put in orders of the EMR." Also, the nurse and nurse manager are responsible for ensuring that there is an order in the EMR to document outputs for "a resident who has a foley". The DON stated R72 was "high risk for UTI and health care issues because she has a foley".

During interview with facility administrator on 5/10/23 at 1:22 p.m., administrator stated R72 was "high risk for health care outcome" such as dehydration and UTI due to not being able to show that outputs were documented. The administrator looked in R72's EMR and stated the outputs were "not being documented. It should have been."

Facility policy and/or procedure for catheter care and urinary monitoring was requested and not received.

R14's quarterly Minimum Data Set (MDS), dated 4/6/23, indicated R14 was admitted to the facility on 12/29/22 with an indwelling catheter in place and needed extensive assistance with dressing, personal hygiene, and toilet use. The MDS lacked an assessment of R14's cognition and Care Area Assessment.

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R14's Medical Diagnosis sheet, dated 12/29/22, indicated R14 had several medical diagnoses to include urinary tract infection, above the knee amputation and chronic kidney disease.

R14's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of R14's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R14's hospital discharge orders dated 2/7/23, indicated R14 had a diagnosis of severe sepsis while hospitalized from 2/1/23 - 2/7/23.

R14's physician note, dated 2/13/23, indicated R14 had recurrent urinary tract infections.

During observation and interview on 5/11/23 at 1:27 p.m., R14 was sitting on his bed with an indwelling catheter in place and a drainage bag on the floor covered in a urine-soaked pillowcase. R14 stated his catheter bag started leaking yesterday, 5/10/23, and the facility staff placed the drainage bag in a pillowcase. Two unnamed staff members walked into R14's room, looked at the drainage bag on the floor and immediately walked out.

During observation at 1:33 p.m., an unnamed staff member walked into R14's room, placed a towel over the urine-soaked pillowcase and picked up the drainage bag without wearing gloves.

R63's quarterly MDS, dated 2/24/23, indicated R63 had severe cognitive impairment and needed

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extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments.

R63's Medical Diagnosis sheet,dated 10/18/21, indicated R63 had several medical diagnoses, including Alzheimer's disease and neuromuscular dysfunction of the bladder.

R63's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of lacked evidence of R63's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R63'S EMR indicated R63 was hospitalized on 4/12/23 due to urine retention and an indwelling catheter was placed. R63 was subsequently hospitalized on 4/25/23 with a urinary tract infection.

During an observation on 5/8/23 at 6:37 p.m., R63 had an indwelling catheter in place and a drainage leg bag strapped to her left leg visible.

During observation on 5/9/23 at 12:37 p.m., R63 was wandering the facility hallway with a drainage leg bag attached to her left leg and half filled with visible yellow urine.

During observation and interview on 5/10/23 at 7:10 a.m., R63 was asleep in bed, with the drainage leg bag attached to her left leg and at the same level as her bladder. R63 stated she always sleeps with the drainage leg bag attached to her leg.

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During observation and interview on 5/11/23 at 10:05 a.m., R63 was observed laying in bed with the drainage leg bag attached to her left leg and at the same level of her bladder. R63 stated she slept with the drainage leg bag attached to her leg last night and does not like to sleep with it on because it is, "too tight."

During an interview on 5/10/23 at 9:56 a.m., nursing assistant (NA)-H stated the nursing assistants use the care plan to know what types of cares to provide each resident. NA-H further stated they do not switch R63's drainage leg bag to a full drainage bag at night (which would allow the drainage bag to be below the level of the bladder) because it is not on the care plan.

During an interview on 5/10/23 at 10:14 a.m., nursing assistant (NA)-F stated R63, "sleeps with her drainage leg bag on."

During an interview on 5/10/23 at 12:23 p.m., registered nurse (RN)-G stated residents with catheters should have orders to direct the nurses what to do with the resident's catheter, such as when to change the catheter. RN-G stated the NAs should be documenting urine output in tasks and the nurses should put in a progress note of the catheter/urine assessment. RN-G verified there were no orders in the EMR and no interventions on the medication administration record (MAR).

During an interview on 5/10/23 at 12:55 p.m., the assistant director of nursing (ADON) stated the expectation for residents with catheters was to have specific physician orders to monitor and change the catheter that would be transcribed to

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F 690	Continued From page 102 the MAR for the nurses to follow and the NAs document output in tasks. The ADON further stated he would have concerns with patency of the catheter if a resident slept with a drainage leg bag strapped to their leg. The ADON confirmed this would cause the catheter to be positioned above the level of the bladder which may increase the risk for urinary tract infections.	F 690		
F 692 SS=D	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 by: Based on observation, interview, and document review, the facility failed to ensure ongoing weight loss was identified timely, comprehensively assessed, and acted upon to stabilize or reverse	F 692	1. R3's care plan was updated to reflect dental status and that she requires feeding assistance. 2. R3 has signed onto hospice care due	7/14/23

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weight loss for 1 of 1 resident (R3) reviewed for significant weight loss.

Findings include:

R3's quarterly Minimum Data Set (MDS) dated 3/16/23, indicated she was severely cognitively impaired, required set-up assist for eating, and had diagnoses of malnutrition, anemia, and diabetes. The MDS indicated she did not have a swallowing disorder, weighed 102 pounds, and "No or unknown" weight loss in the past six months. R3's dental status lacked documentation.

R3's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 6/22/22, lacked documentation in the "Eating" section.

R3's Nutritional Status CAA dated 6/17/22, identified factors which affected R3's ability to eat and nutritional needs as: arthritis, functional range of motion, poor memory, anxiety, anemia, depression, pain, diabetes, and antipsychotic medications.

R3's Dental Care CAA dated 6/22/23, indicated R3 had no natural teeth or tooth fragments.

R3's care plan revised 3/24/23, included R3 was at nutritional risk related to a severe weight loss of 13 pounds over the past three-month period, and indicated R3 needed set-up assistance with eating, had difficulty chewing related to lack of teeth, and needed food cut into bite-sized pieces. New interventions of dietician to monitor R3 at meals as needed, and dental consult as needed were added.

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to poor meal intake and malnutrition.
3. This type of incident has the potential to affect all residents.
4. Facility will provide education on all residents that require feeding assistance and the importance of providing that assistance.
5. Facility will provide education on the importance of weighing residents and reporting any significant changes to provider.
6. Dietary Manager or designee will audit during meal times 4x/week for 5 weeks, then 1x/month for 6 months to ensure that all residents who need assistance eating are receiving that assistance. All audits will be brought to QAPI for review.
7. DON or designee will audit resident charts 1x/week for 4 weeks, then 1/month for 6 months for resident weights obtained per orders. All audits will be brought to QAPI for review.
8. Residents who need assistance eating will be reviewed during QAPI for significant weight changes.
9. DON, Nurse Managers and Dietary Manager are responsible for the completion of this plan of correction.

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R3's Nutrition Data dated 3/26/23, indicated she had an admission weight of 148 pounds, had a severe weight loss of 13 pounds over the previous three months, had dental problems, and ate over 75% of her meals.

R3's Order Summary Report dated 5/11/23, included:
- Monthly weight on the first day of the month starting 9/1/22
- Nutritional supplement between meals starting 10/26/22
- Mechanical soft diet starting 4/17/23
- RD (registered dietician) evaluate and treat ordered 4/19/23

R3's Nutrition - Amount Eaten task identified she ate over 1/2 of her food during 70% of meals during the period 4/10/23, through 5/9/23.

R3's Weights and Vitals Summary dated 5/10/23, indicated the following weights (in pounds):
- 3/2/23 = 102.2
- 3/18/23 = 102.2
- 4/1/23 = 102.1
- 5/2/23 = 83 (an 18.7% loss in one month)
- 5/10/23 = 77.4 (a 24.2% loss in five weeks)

During observation and interview on 5/8/23 at 2:52 p.m. R3 was lying in bed in her room. She stated she had diarrhea and could not keep food down, but liquids were usually ok. She stated she bought a bunch of Sprite, and it was all she could drink. During conversation she was noted to have no teeth.

During observation and interview on 5/8/23 at 6:53 p.m., R3 was seated at the dining room table with a plate containing meatloaf cut into pieces

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THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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approximately 1.5"(inches) by 1.5", a large piece of bright green, crunchy broccoli approximately 2" by 2", and mashed potatoes with gravy. She had two beverages, one milk and the other a red juice. R3 stated she couldn't eat the food at the facility because it wasn't seasoned, it was too hard, and she had no teeth. R3 took two small bites of mashed potatoes and left the table.

During an interview on 5/9/23 at 12:32 p.m. NA-I stated she documented how much each resident ate in the NA documentation system.

During and interview on 5/10/23, at 7:22 a.m. nursing assistant (NA)-H stated the NAs weighed each resident monthly and either she or the nurse documented the weight in the computer, She stated staff could see the resident's previous weight at the top of the screen, and if there was a significant difference, she reweighed the resident and notified the nurse if there was still a concern. NA-H stated R3 was not on any special diet and eating was "hit or miss" and R3 would rather go out and have a cigarette.

During an interview on 5/10/23 at 7:50 a.m. registered nurse (RN)-G stated NAs weighed residents and reported results back to her to review and record them. She looked at the previous weight every time she entered one, and if there was a large difference, she asked staff to reweigh the resident. She stated she was trained to inform the managers if a weight was still "off" so they could re-calibrate the scale, and if a resident's weight was still significantly different, she informed the provider, the kitchen, and the managers. RN-G stated she did not notice any change in R3's status. Upon review of R3's food intake documentation she stated it was not

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accurate. R3 always picked at her food, was "never a big eater", and usually ate 25-50% if she liked what was served. She stated she did not like the mechanical soft diet and cut the food herself. Upon review of R3's weights, she stated R3 could not afford to drop that much weight and stated she would have called the provider.

During an interview on 5/10/23, at 8:30 a.m. director of nursing (DON) stated all residents were weighed monthly, while others required them more often. The computer alerted staff when a weight was abnormal, and staff re-weighed the resident to ensure it was accurate and informed the provider if there was a concern or if a resident refused. The DON stated R3 had significant weight loss in the past and was given protein supplements. He stated she was refusing to eat and likely ate 10% of her meals, and dietary evaluated her and tried to implement interventions. He stated he did not think the percentages of food recorded as eaten by R3 were accurate, and the NAs may not have been given the correct information and education regarding assessing and recording that information. He stated the NAs in the dining room should cut up R3's food into bite sized pieces and needed additional education to ensure they were doing all they could to maintain R3's weight to keep her healthy.

During an observation on 5/10/23 at 9:35 a.m. NA-F was observed clearing stacks of plates in the dining room and scraping the leftover food off. She stated she received training regarding intake documentation and remembered who sat where and how much they ate at each meal and went back later to document it for all who ate in the dining room.

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During an interview on 5/10/23 at 12:19 p.m., dietary director (DD) stated she knew if a resident had a significant weight change when the computer system alerted her or the nurse manager relayed information, and she also reviewed resident weights just in case something did not get communicated. She stated she saw R3 a few weeks prior but was not notified of her significant weight loss on 5/2/23. She stated if she had known she would have requested a re-weigh at that time, and if accurate, would have gone to see her and added interventions. She stated the NAs were supposed to track intake, but R3 did not eat very much, perhaps 25-50%. She stated R3 needed set-up assistance and a mechanical soft diet because she did not have teeth. Meatloaf and other foods should have been cut up into bite-sized pieces so it could be mashed by gums. DD confirmed R3's meal ticket identified R3 needed set-up assist/assist with feeding as necessary, and all foods cut up into bite sized pieces/soft texture. She stated large pieces of food were difficult for her to eat without teeth. She stated there was a time R3 was on a mechanical soft diet, but she did not like it, so it was changed back to regular diet. R3's care plan was not accurate and needed supervision and cueing during meals.

DD stated staff told her two weeks ago R3 knew staff were concerned about her weight and she threatened not to eat if she could not go out to smoke when she wanted, but this was not documented. She stated staff had the responsibility to care for the residents, exhaust all options, and identify changes. She stated R3 had a significant weight loss and improved identification would help staff intervene and slow

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or eliminate weight loss progression.

A dietary/nutrition policy was requested but not provided.

F 726 SS=F — Competent Nursing Staff — F 726 — 7/14/23

CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced

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by:
Based on observation, interview and documentation review, the facility failed to ensure licensed nursing staff demonstrated competency and training related to pressure ulcer prevention and glucose checks (blood sugar monitoring for diabetics) for R72 who was reviewed for pressure ulcers and R28 reviewed for diabetic monitoring. This had the potential to affect 43 residents who were at risk for developing pressure ulcers and 16 residents who received glucose checks.

Findings include:

R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnosies includes hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

The facility's TCU Nursing Assistant job

F 726

1. R72's heels were properly off-loaded off the bed using a pillow with the heels not touching the pillow or bed.
2. R28's blood glucose level was taken correctly with the glucometer sanitized before and after use.
3. These types of incidents have the potential to affect all residents.
4. Resident care sheets were updated to reflect residents' needs.
5. Facility will provide education to all nursing staff on the proper way to off-load heels.
6. Facility will provide education to staff (TMA's and nurses) on proper glucometer use and disinfecting glucometer after each resident.
7. Facility will provide the appropriate staff (TMA's and nurses) with a policy for performing blood glucose checks.
8. DON or designee will conduct competencies for aides to ensure they are properly off-loading resident heels. Competencies will be completed for all aides on or before July 14, 2023. Administrator or designee will audit competencies 1x/week for 4 weeks, then monthly to ensure they are all completed. All audits will be brought to QAPI for review.
9. DON or designee will conduct competencies for TMA's and nurses to ensure they are properly completing blood glucose checks to include sanitization. Administrator or designee will audit competencies 1x/week for 4 weeks, then monthly to ensure they are all completed. All audits will be brought to QAPI for

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description for residents care sheet, dated 5/4/23 direct staff to "Pls enforce repositioning q 2hrs" and failed to mention offloading of heels to prevent pressure ulcers.

During observation and interview with registered nurse (RN)-A on 5/8/23 at 7:08 p.m., R72's heels were resting on top of soiled pillowcase. RN-A stated R72's heels "should be rested off bed but they are not."

During observation on 5/9/23 at 12:33 p.m., R72 was laying flat on their back and not on side facing door per her posted turning schedule. Both heels were resting on top of small pillow.

During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated R72 heels should be on the pillow to prevent pressure ulcers.

During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated R72's heels "Should be on top of the pillow and not off".

During interview with NA-B on 5/10/23 at 8:56 a.m., NA-B stated R72 heels should be on the pillow and not resting off if it.

During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated "heels should be resting on top of the pillow and not off it it."

During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated understanding that heels can rest on top of the pillow and not off.

During interview with RN-C on 5/10/23 at 11:53

Provider's Plan of Correction (F 726):

review.
10. Audits will be completed by DON or designee for residents who need their heels off-loaded 3x/week for 4 weeks. All audits will be brought to QAPI for review.
11. Audits will be completed by DON or designee for residents who need blood glucose checks 3x/week for 4 weeks to ensure proper sanitization is occurring between uses. All audits will be brought to QAPI for review.
12. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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a.m., RN-C stated he was the facility in house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds including R72. RN-C stated offloading means, "relief of pressure on particular points like feet and heels". RN-C stated that heels should not touch anything and should be off the pillow, not resting on the pillow.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated offloading meant, "the heels must be off the bed and not touching anything. Having heels resting on top of a pillow is not acceptable the staff need education. "
During observation on 5/10/23 at 12:18 p.m., trained medication aide (TMA)-B entered R28's room and proceeded to use a lancet and a glucometer to check the residents finger stick blood glucose levels. TMA-B placed R28's blood on the blood glucose test strip, read the results, and proceeded to pack the glucometer into a carrying tray without cleaning or disinfecting the glucometer device before leaving R28's room, so it was avaialble for other residents to use.

On 5/10/23 at 12:23 p.m., TMA-B entered the room of R27's room. TMA-B did not attempt to clean the glucometer per manufacturers recommendations, TMA-B proceeded to use the glucometer to measure R27's finger stick blood glucose levels.

During an interview on 5/10/23 at 12:24 p.m., TMA-B stated that she uses the glucometer to measure residents blood glucose levels, when

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F 726	Continued From page 112 the nurses need help. She stated the same glucometer is used with every resident and that the facility standard was to sanitize the glucometer after every two residents. During an interview on 5/10/23 at 12:28 p.m., registered nurse (RN)-C stated that TMAs were unable to perform finger stick blood glucose monitoring at the facility. During an interview on 5/11/23 at 10:13 a.m., registered nurse (RN)-F, acting as assistant director of nursing stated TMAs employed by the facility are not trained to do finger stick blood glucose monitoring, and that this treatment was to be done by nurses only. Competency evaluations for TMA-B were requested but not provided. A facility policy titled "Blood Sampling - Capillary (Finger Sticks)" dated 2/23, did not specify a title, role, or licensure requirement for the staff who measure residents blood glucose levels.	F 726		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance	F 730	1. R72's heels were properly off-loaded off the bed using a pillow with the heels	7/14/23

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F 730	Continued From page 113 reviews for 5 of 5 nursing assistants (NA-A, NA-B, NA-D, NA-F, NA-G) whose employee files were reviewed. This had the potential to affect all 75 residents who resided at the facility. Findings include: During interview with administrator on 5/10/23 at 1:01 p.m., administrator stated facility staff education, in-services and training are the responsibility of the director of nursing (DON) and human resources director (HRD). During interview and document review on 5/12/23 at 9:28 a.m., performance reviews for five nursing assistants were reviewed with the DON. The DON stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D, NA-F, and NA-F. During interview and document review on 5/12/23 at 10:34 a.m., performance reviews for five nursing assistants were reviewed with the HRD. The HRD stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D, NA-F, and NA-F. A policy related to nursing assistant evaluations and in-services was requested and not provided.	F 730	not touching the pillow or bed. 2. R28's blood glucose level was taken correctly with the glucometer sanitized before and after use. 3. These types of incidents have the potential to affect all residents. 4. Resident care sheets were updated to reflect residents' needs. 5. Facility will provide education to all nursing staff on the proper way to off-load heels. 6. Facility will provide education to staff (TMA's and nurses) on proper glucometer use and disinfecting glucometer after each resident. 7. Facility will provide the appropriate staff (TMA's and nurses) with the policy for performing blood glucose checks. 8. Audits will be completed by DON or designee for residents who need their heels off-loaded 3x/week for 4 weeks. All audits will be brought to QAPI for review. 9. Audits will be completed by DON or designee for residents who need blood glucose checks 3x/week for 4 weeks to ensure proper sanitization is occurring between uses. All audits will be brought to QAPI for review. 10. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		7/14/23

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F 755	Continued From page 114 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supply and administration of ordered medication for 1 of 1 resident (R25) reviewed for pharmacy services. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/28/23, indicated intact cognition and did not reject care.	F 755	1. R25 has received the Preparation H ointment with applicator. 2. Medications not delivered by pharmacy has the potential to affect all residents who receive medications. 3. Facility will provide education to TMA's and nurses on pharmacy procedures and the requirement of calling the provider if medications are not available.	

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R25's Medical Diagnosis form from the electronic health record (EHR), indicated the following diagnosis: other constipation.

R25's Clinical Physician Orders form indicated an order dated 4/27/23, for Preparation H ointment. Please insert per intra-rectal with applicator for intra-rectal use. Use as directed on packaging. Nurse manager call pharmacy regarding sending this as it is OTC (over the counter). Use applicator and call pharmacy if you question how to administer two times a day for hemorrhoids.

R25's Clinical Physician Orders form indicated an order for an appointment on 6/15/23, for anorectal (both the anus and rectum) surgery for hemorrhoids.

R25's medication administration record (MAR) and treatment administration record (TAR) dated April 2023, indicated the medication was ordered to be administered "7A to 11" and "HS 19." In the a.m. slot 4/27/23, a number 2 was designated indicating on the chart code the drug was refused. On the HS slot 4/27/23, there was no documentation of the medication given. There were two check marks on the a.m. slot 4/28/23 and 4/30/23, indicating the medication was given, and four time slots (4/28/23 HS 19, 4/29/23 7A-11 and HS 19, and 4/30/23 HS 19) with the number 9 designated indicating "Other/see progress notes." The progress notes were reviewed, but did not identify the reason for "9" designated in the administration time slots.

R25's MAR and TAR dated May 2023, indicated the medication was ordered to be administered "7A-11" and "HS 19". There was a check mark in

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4. DON or designee will conduct audits 5x/week for 6 weeks on all medications not given with a reason of medication unavailable. All audits will be brought to QAPI for review.
5. DON, Nurse Managers or designee are responsible for the completion of this plan of correction.

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the 7A-11 slot on 5/1/23, 5/5/23, 5/6/23, 5/7/23, and a check mark in the HS 19 slot on 5/6/23, and 5/7/23, and 5/10/23 indicating the medication was given. A number 9 was designated in the 7A-11 slot on 5/2/23, 5/3/23, 5/4/23, 5/9/23, 5/10/23, and in the HS 19 slot on 5/1/23, 5/2/23, 5/3/23, 5/4/23, 5/5/23, 5/8/23, and 5/9/23 with the number 9 indicating "Other/see progress notes." The progress notes were reviewed, but did not identify the reason for "9" designated in the administration time slots.

During interview on 5/8/23 at 6:05 p.m., R25 stated he had a bleeding hemorrhoid the facility was aware of and R25 requested the Preparation H applicator internal medication 5/5/23, and had not received the medication.

During interview on 5/8/23 at 3:15 p.m., R25 stated the medication did not come on 5/5/23, and was told the medication would arrive 5/6/23. On 5/8/23, R25 received witch hazel pads. R25 stated he spoke with registered nurse (RN)-C who informed him the medication was stolen and instead of receiving the internal applicator, received tucks.

During interview on 5/10/23 at 10:35 a.m., licensed practical nurse (LPN)-D stated she thought RN-C followed up on the Preparation H internal applicator ointment and added R25 did not get it most of the time because R25 wanted to administer the medication himself.

During interview on 5/10/23 at 11:12 a.m., RN-C stated the pharmacy could not provide the internal applicator Preparation H and stated the medication had been ordered prior to the weekend and added sometimes the pharmacy

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don't deliver timely and stated only the witch hazel came and the medication was re-ordered. RN-C stated he would follow up again.

During interview on 5/10/23 at 11:19 a.m., LPN-D verified the Preparation H ointment intra-rectal medication was not on the medication cart and contacted the pharmacy. LPN-D stated the pharmacy instructed her the medication was not covered by insurance and she requested the cost of the medication for either the facility or the resident to pay for the medication.

During interview on 5/10/23 at 1:14 p.m., pharmacist-O stated the Preparation H intra-rectal medication was first ordered 5/10/23, they sent the medication 5/10/23, and billed the facility. Pharmacist-O stated they initially received the order 4/26/23 and on 4/27/23, sent a non covered form and were waiting to hear from the facility. Pharmacist-O stated they don't send medications until they hear back from the facility and they never heard back from the facility.

During interview on 5/10/23 at 2:25 p.m., RN-F stated they utilized Thrifty White Pharmacy and if a medication was not received, the nurse on the shift collaborated with the trained medication aide (TMA) to determine why the medication was not delivered and contacts the pharmacy. RN-F stated he expected the medication to be available by the next pharmacy run after the medication was ordered. RN-F explained if the staff contacted the pharmacy at 8:00 p.m., the medication would be available the next day and if the staff contacted the pharmacy at 8:00 a.m., he expected the medication to be available the same day. RN-F stated if a medication is not covered, the cost information is provided to the

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F 755	Continued From page 118 administrator and the administrator signs a form and the pharmacy delivers the medication. RN-F stated the purpose of the medication was to help relieve itching and eliminate bleeding. RN-F stated signing medications off as administered on the MAR when they are not available was not acceptable. RN-F added it has been difficult to receive medication orders from the pharmacy in between their monthly standard deliveries. A policy, Administering Medications reviewed November 2022, indicated medications were administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI (quality assurance and performance improvement) committee to inform process changes and or the need for additional staff training.	F 755		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a palatable diet by serving cold food for 2 of 2 residents (R32, 63) reviewed for	F 804	1. R32 and R63 received meals that had a temperature of 135 degrees Fahrenheit. 2. This type of incident has the potential	7/14/23

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food. This had the ability to impact any resident on second floor who chose to eat in their room.

Findings include:

R63's quarterly Minimum Data Set (MDS), dated 2/24/23, indicated R63 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments.

R63's Medical Diagnosis sheet, dated 10/18/21, indicated R63 had several medical diagnoses including Alzheimer's disease and neuromuscular dysfunction of the bladder.

Posted mealtimes at the facility were 8 a.m. to 9:30 a.m. for breakfast, 12 p.m. to 1 p.m. for lunch and 6 p.m. to 7 p.m. for dinner.

Review of the most recent resident counsel notes, dated 4/24/23, indicated residents had complaints of cold food at that time.

During interview and observation on 5/8/23 at 6:56 p.m., R63 stated her meals were often arriving cold, including today's dinner, and she waited, "a long time" for her meal tray to be delivered. R63's dinner tray arrived 6:56 p.m.

During an interview and observation on 5/9/23 at 12:56 p.m., R63's lunch tray was delivered and R63 stated the food was cold.

During an interview and observation on 5/10/23 at 9:05 a.m., R63's breakfast tray was delivered and R63 stated the food was cold.

F 804

to affect all residents.

3. Dietary staff will be educated on holding temps for hot and cold foods and the policy on reheating foods.
4. Nursing staff will be educated on the importance of delivering meal trays promptly so that food is served at the appropriate temperature and the policy on reheating foods.
5. Dietary Manager or designee will conduct temperature audits on meals 4x/week for 4 weeks. All audits will be brought to QAPI for review.
6. Facility will discuss any concerns with cold food with resident council during monthly resident council meeting.
7. DON, Nurse Managers and Dietary Manager are responsible for the completion of this plan of correction.

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R32's significant change MDS dated 4/19/23, indicated R32 required set-up assistance for eating, extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, was morbidly obese, incontinent of bowel, and had diagnoses of failure to thrive, congestive heart failure (CHF), and kidney failure.

On 5/8/23 at 2:19 p.m., R32 stated the food at the facility was never hot, and most of the time would be "pushing it" to say it was warm.

On 5/8/23 at 6:58 p.m., a staff person pushed a cart containing meal trays through the hallway to deliver to residents who ate in their rooms. There were four trays yet to be delivered, and R32 received his tray at 6:59 p.m.

On 5/10/23, at 10:17 a.m., R32 stated his breakfast of eggs and toast was served cold.

During an interview and observation on 5/10/23 at 9:02 a.m., the dietary aides had just finished prepping the meal trays to bring to residents who eat in their rooms. The metal cart used to bring meal trays to the residents in their rooms was filled with trays of scrambled eggs, oatmeal, and toast. Dietary aide (DA)-A stated the process was to feed all the residents who eat in the dining room first and then to prep all the meal trays for residents who eat in their room. Prior to the meal trays going out to the residents, the oatmeal on a resident tray was temped at 105 degrees Fahrenheit and the eggs on a resident tray were temped at 104 degrees Fahrenheit. DA-A stated the expectation was for hot foods to be held at 135 degrees Fahrenheit when served to residents.

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During observation on 5/11/23 at 12:35 p.m., DA-B temped the burgers on the lunch meal trays at 107 degrees Fahrenheit.

During an interview on 5/11/23 at 1:04 p.m., the dietary director (DD) stated the expectation was to hold hot food on the meal trays at 135 degrees Fahrenheit until it is served to the residents. The DD further stated she would have concerns with decreased food intake if food was served cold to residents.

A facility policy titled Food Preparation and Service, reviewed on 11/2022, indicated proper hot and cold temperatures must be maintained during food service (135 degrees Fahrenheit for hot foods).

F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/14/23

§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,

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F 880	Continued From page 122 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure a urinary drainage bag was kept off the floor to prevent contamination for 1 of 2 residents (R14). In addition, the facility failed to ensure a contaminated urinal was properly stored to prevent contamination for 1 of 1 residents (R35). In addition, the facility failed to adhere to proper infection control practices during routine blood glucose monitoring. This had the potential to affect 16 residents residing in the facility who received finger stick blood glucose monitoring.

Findings include:

During observation on 5/10/23 at 12:18 p.m., trained medication aide (TMA)-B entered R28's room and proceeded to use a lancet and a glucometer to check the residents finger stick blood glucose levels. The glucometer was not cleaned, was placed back into a carrying tray, and TMA-B left the room.

During observation on 5/10/23 at 12:23 p.m., TMA-B entered the room of R27. Without cleaning the glucometer per manufacturers recommendations, TMA-B proceeded to use the glucometer to measure R27's finger stick blood glucose levels.

1. R28's blood glucose level was taken correctly with the glucometer sanitized before and after use.
2. R35's urinal was removed from his tray table.
3. R14's drainage bag was removed from the floor and replaced with a non-leaking bag.
4. This type of incident has the potential to affect all residents that require blood glucose checks and have a catheter.
5. Facility will educate staff on proper infection control procedures and catheter hygiene.
6. Nursing staff will round daily to ensure that all residents with urinals have them away from tray tables and in places that the residents prefer.
7. DON or designee will complete audits for residents who need blood glucose checks 3x/week for 4 weeks to ensure proper sanitization is occurring between uses. All audits will be brought to QAPI for review.
8. DON or designee will conduct audits on catheter bags 3x/week for 4 weeks to ensure they are not leaking. All audits will be brought to QAPI for review.
9. Infection Control Nurse, DON, Nurse

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F 880	Continued From page 124	F 880	Managers or designee are responsible for the completion of this plan of correction.	

During an interview on 5/10/23 at 12:24 p.m., TMA-B stated that she uses the glucometer with every resident and the facility standard was to sanitize the glucometer after every two residents.

During an interview on 5/10/23 at 12:28 p.m., registered nurse (RN)-C stated glucometers are to be cleaned after every use before they are used on another resident to prevent the spread of bloodborne pathogens.

The glucometer used was the Assure Prism Multi Blood Glucose Monitoring System. The quality assurance/quality control reference manual dated 2/16 indicated "The meter should be cleaned and disinfected after use on each patient. The Assure Prism multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed ...The disinfection procedure is needed to prevent the transmission of blood-borne pathogens."

A facility policy titled "Blood Sampling - Capillary (Finger Sticks)" dated 2/2023 indicated staff should "always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses."

R35's quarterly Minimum Data Set (MDS) dated 2/17/23, indicated cognition, mood, and behavior was not assessed, required extensive assist for most ADLs, was occasionally incontinent of bladder and frequently incontinent of bowel.

R35's Medical Diagnosis form in the electronic

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F 880		F 880		

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medical record (EMR) indicated the following diagnoses: unspecified intracranial injury with loss of consciousness, unspecified dementia, quadriplegia unspecified (partial or complete paralysis of both the arms and legs), muscle weakness, and apraxia (a neurological disorder characterized by the inability to perform purposeful movements and gestures despite having the physical ability and desire to perform them).

R35's care plan revised 1/16/22, indicated an intervention to offer to toilet and or use the urinal every two hours.

During observation on 5/8/23 at 1:13 p.m., R35's lunch was untouched in front of him with a dirty urinal on the table next to his lunch tray.

During observation on 5/9/23 at 1:42 p.m., an unidentified staff came in to R35's room to answer the call light. R35 gave the staff person the urinal and the staff person emptied the urinal and at 1:43 p.m., the staff person put the urinal on the bedside table next to R35's water and food tray.

During interview on 5/9/23 at 1:54 p.m., licensed practical nurse (LPN)-A stated the bedside table was for food and the urinal should not have been placed on the bedside table.

During interview on 5/9/23 at 2:52 p.m., registered nurse (RN)-F stated it was not appropriate to set the urinal on the bedside table next to R35's food and water.

R14's quarterly Minimum Data Set (MDS), dated

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F 880	Continued From page 126	F 880		

4/6/23, indicated R14 was admitted to the facility on 12/29/22 with an indwelling catheter in place and needed extensive assistance with dressing, personal hygiene, and toilet use. The MDS lacked an assessment of R14's cognition and Care Area Assessment.

R14's Medical Diagnosis sheet, dated 12/29/22, indicated R14 had several medical diagnoses to include urinary tract infection, above the knee amputation and chronic kidney disease.

R14's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of R14's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R14's hospital discharge orders, dated 2/7/23, indicated R14 had a diagnosis of severe sepsis while hospitalized from 2/1/23 - 2/7/23.

R14's physician note, dated 2/13/23, indicated R14 had recurrent urinary tract infections.

During observation and interview on 5/11/23 at 1:27 p.m., R14 was sitting on his bed with an indwelling catheter in place and a drainage bag on the floor covered in a urine-soaked pillowcase. R14 stated his catheter bag started leaking yesterday, on 5/10/23, and the facility staff placed the drainage bag in a pillowcase. Two unnamed staff members walked into R14's room, looked at the drainage bag on the floor and immediately walked out.

During observation at 1:33 p.m., an unnamed

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F 880	Continued From page 127 staff member walked into R14's room, placed a towel over the urine-soaked pillowcase and picked up the drainage bag without wearing gloves.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program, with established monitoring, to help reduce unnecessary antibiotic use, reduce potential drug resistance, and help prevent the spread of infectious diseases. The lack of an antibiotic stewardship program had the potential to affect all 75 residents residing in the facility. Findings include: Review of R72's admission record, dated 5/12/23, indicated R72 was admitted to facility on 3/17/23. A quarterly, Minimum Data Set (MDS) dated 4/29/23, indicated R72 had moderate cognitive impairment. R72 needed limited assistance of one to eat and required extensive assistance of 2 with bed mobility, transfers, dressing, toileting and personal hygiene. MDS indicated R72 had an	F 881	1. R72 and R63 were added to the antibiotic surveillance log. 2. Appropriate information was added to the surveillance log to include resident's room number, admission date, existing infections from previous months, infection risk factors, diagnostic test date, type of test, specimen source, results, antimicrobial prescription origin, other antimicrobials prescribed and the date symptoms resolved. 3. The lack of an updated antibiotic surveillance log has the potential to affect all residents by not effectively monitoring residents for unnecessary antibiotic use and helping prevent infection. 4. Facility will educate Infection Control Nurse on the appropriate use and tracking of antibiotics and the importance of the antibiotic stewardship program.	7/14/23

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F 881	Continued From page 128 urinary indwelling catheter and she was incontinent of bowel. Diagnoses included cerebral infarction (stroke) due to embolism (blood clot) of left middle cerebral artery, urinary tract infection, aphasia (loss of ability to understand or express speech caused by brain damage), hemiplegia (paralysis of one side of the body), urinary retention, a stage three pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed). R72's progress note dated 4/26/23 at 4:02 p.m., indicated R72 was sent to the Hennepin County Medical Center's emergency room on 4/26/22. A progress note on 4/26/23 at 11:50 p.m., indicated R72 returned from the hospital and also indicated R72 was started on an antibiotic at the hospital. A progress note dated 4/27/23 at 1:22 am, indicated a new order for cefuroxime axetil (antibiotic) oral tablets 500 milligrams (mg) by mouth twice a day for ten days. A progress note dated 4/27/23 at 5:27 p.m., indicated R72 started to take cefuroxine axetil for an urinary infection. A progress note on 5/3/23 at 4:20 p.m. indicated a new order for doxycycline hyclate (antibiotic) oral tablet 100 mg twice a day until 5/13/23. Review of R63's admission record dated 5/12/23, indicated R63 was admitted to facility on 10/18/21. R63's quarterly assessment, MDS dated 2/24/23 indicated R63 as cognitively impaired. MDS indicated R63 needed extensive assistance of one person with bed mobility, transfers, dressing, toileting, and personal hygiene. Diagnoses included anemia (A condition in which the blood doesn't have enough healthy red blood cells), heart failure, neurogenic bladder (Lack of bladder control due to spine or nerve	F 881	5. Antibiotic surveillance log will be updated as required and audited by DON or designee 1x/week for 4 weeks, then 1x/month for 6 months to ensure completion and accuracy. All audits will be brought to QAPI for review. 6. Infection Control Nurse is responsible for the completion of this plan of correction.	

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F 881	Continued From page 129	F 881		

injuries), Alzheimer's disease, anxiety and gastroesophageal disease (GERD-Chronic disease that occurs when stomach acids or bile flows back into the tube connecting your mouth and stomach).

R63's progress note, dated 4/29/23 at 10:54 a.m., indicated an order for ciprofloxacin (antibiotic) HCL 500 mg tablets twice a day until 5/5/23, prescribed for urinary infection.

During document review on 5/11/23 at 11:00 a.m., there was no record of R72 on the antibiotic surveillance log and R63 was not identified in either, April or May's antibiotic's surveillance logs.

During an interview on 5/11/23 at 8:46 a.m., the assistant director of nursing (ADON) who, along with the director or nursing (DON) shared the role of Infection Preventionist (IP) stated he would review resident medication administration records (MARs) and/or the nursing staff would notify him when a resident started on a new antibiotic. The ADON also stated there was no written record completed to track resident signs or symptoms of a possible infection or their antibiotic use. The ADON further stated there was no written procedure for notifying the provider when a resident began having sign or symptoms of a possible infection.

During an interview on 5/11/23 at 1:07 p.m., the director of nursing (DON) stated the facility did not have an antibiotic stewardship program and had not been tracking residents for possible infections. During interview DON stated the facility did not have antibiotic surveillance forms prior to April 2023

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F 881	Continued From page 130 During an interview on 5/10/23 at 2:30 p.m., the administrator stated the DON would enter residents information regarding possible infections and new antibiotic use onto a surveillance tracking form. The administrator provided an infection log for the months of April and May 2023. The facility's infection surveillance log tracked unit name, resident name, infection type, body system of infection, surveillance definition met, symptoms, onset date, device types diagnostic performed, antibiotic resistance organism, antibiotic name, class, dose, route, frequency, antibiotic start date, antibiotic end date, antibiotic reassessment, and transmission based precautions. The facility's surveillance tracking form lacked documentation of resident's room number, admission date, existing infections from previous months, infection risk factors, diagnostic test date, type of test, specimen source, results, antimicrobial prescription origin, other antimicrobials prescribed, and the date symptoms resolved. The facility Antibiotic Stewardship Policy dated 12/2016, indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy indicated the purpose of their antibiotic stewardship program is to monitor the use of antibiotics in their residents and the education of the staff will include how inappropriate use of antibiotics affects individual residents and the overall community.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		7/14/23

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F 883	Continued From page 131	F 883		

§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative

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F 883	Continued From page 132 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to offer influenza vaccine to 1 of 5 residents (R33). Findings include: R33's quarterly review assessment, Minimum Data Set (MDS), dated 2/15/23, indicated R33 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS). R33 needed extensive assistance of two staff members with bed mobility, transfers, dressing, toileting and personal hygiene and extensive assistance of staff to eat. R33's diagnoses included Alzheimer's dementia, seizure disorder, hypertension, anxiety and depression. R33's Immunization record indicated R33 received the influenza vaccine in 11/2021; however, the record lacked indication R33 received the influenza vaccine in 2022, R33's electronic medical record (EMR) lacked indication R33 was offered and/or refused the influenza vaccine.	F 883	1. R33 was offered the influenza vaccine. 2. Not offering the influenza vaccine has the potential to affect all residents by failing to prevent/control the spread the seasonal influenza. 3. All residents' charts will be audited to verify influenza vaccine status. Any residents that have not received the influenza vaccine will be offered at that time. 4. Facility will educate nursing staff on the importance of offering the influenza vaccination to all residents that have not yet received it. 5. DON or designee will conduct audits on vaccination status on all new admissions and all residents 1x/month for 6 months to ensure completion and accuracy. All audits will be brought to QAPI for review. 6. Infection Control Nurse is responsible for the completion of this plan of correction.	

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F 883	Continued From page 133	F 883		

During an interview on 5/11/23 at 1:07 p.m., the director of nursing (DON) verified R33's immunization record and EMR lacked indication R33 had been offered, received, or refused the 2022 influenza vaccine.

The facility Prevention and Control of Seasonal Influenza dated 3/2022, indicated the facility followed current guidelines and recommendations for the prevention and control of seasonal influenza. The policy indicated all residents and staff are offered the vaccine prior to the onset of the influenza season

F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		7/14/23

§483.80(i)
COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and

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F 888	Continued From page 134 (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely	F 888		

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F 888	Continued From page 135 documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of	F 888		

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F 888	Continued From page 136 staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 9 of 134 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of 93.8% and had the potential to affect all 75 residents in the facility. Findings include: The Centers for Medicare and Medicaid (CMS) QSO-23-02-ALL, dated 10/26/22, identified the revised guidance for staff vaccination requirements. The QSO memo outlined the requirement for full staff vaccination had been	F 888	1. Facility verified Covid-19 vaccination status of 9 noted staff. 2. All residents have the potential to be affected by this type of situation if the facility does not have 100% compliance for vaccination rates or take the proper precautions for those not fully vaccinated. 3. HR will request updated vaccination and/or exemption information from all staff and maintain a copy in their employee file. HR will require vaccination status for all new hires going forward. 4. HR or designee will conduct audits to ensure vaccination compliance rates. Audits will be conducted 1x/week for 4 weeks, then 1x/month. Any issues found	

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F 888	Continued From page 137	F 888		

enforced since February 2022, and listed a section labeled, "Vaccination Enforcement," which outlined, "CMS expects all providers' and suppliers' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by the CDC [Centers for Disease Control]. Facility staff vaccination rates under 100% constitute noncompliance under the rule."

During document review and interview on 5/10/23 at 2:30 p.m., The administrator provided the COVID-19 Staff Vaccinations Status for Providers Form. The form indicated, 116 employees were completely vaccinated, 9 employees had granted exemptions and 9 were partially vaccinated. There was no additional information presented demonstrating why the 9 partially vaccinated employees were not completely vaccinated.

During an interview on 5/11/23 at 1:07 p.m, the director of nursing (DON) reviewed the COVID-19 Staff Vaccinations Status for Providers Form completed by the administrator and stated the facility did not have further documentation regarding why the 9 partially vaccinated employees and stated he did not know why they were not fully vaccinated.

The facility's Coronavirus Disease (COVID-19)-Vaccination of Staff, dated 11/2021, indicated all staff are required to be fully vaccinated for COVID-19 in accordance with 483.80(i). Policy indicated "Fully vaccinated" means it has been two weeks or longer since the individual completed a primary vaccination series for COVID-19, Policy also indicated staff who are fully vaccinated must provide documentation of

Provider's plan of correction (continued):

will be brought to QAPI.
5. Infection preventionist and DON are responsible for the completion of this plan of correction.

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F 888	Continued From page 138 vaccination.	F 888		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain resident rooms in a clean and sanitary condition for 4 of 4 resident rooms (RM 210, RM 213, RM 226, RM 227) and 1 of 3 kitchenette common use areas. This had the potential to affect 27 residents residing on the locked dementia unit. Findings include: During interview on 5/11/23 at 9:40 a.m., housekeeper (HK)-A indicated he had been with the facility for two to three weeks. He stated R62 only wanted her room cleaned two to three times per week, but the other resident rooms were cleaned every day. During interview on 5/11/23 at 1:36 p.m., family member (FM)-A stated R426's (room 210) was dirty and she had spoken to the director of nursing about her concerns. On 5/12/23 at 12:31 p.m., the floor of room 210 was observed to have a clear, tan discoloration approximately four inches wide, around the edges of all of the walls with a buildup of dust and dirt concentrated in the corners of the room and behind the door. At 12:33 p.m. t,he floor of room	F 921	1. Rooms 210, 213, 226 and 227 were cleaned and sanitized by the housekeeping staff. All other areas were inspected for cleanliness and information provided to housekeeping. 2. All residents have the potential to be affected by this type of situation. All resident rooms and common areas inspected/will be inspected for potential unsanitary conditions. 3. Housekeeping staff will continue to make a visual inspection of resident rooms and common areas to ensure cleanliness. Resident rooms will be cleaned at least 3x/week and more often as needed. Common areas will be cleaned daily and more often as needed. Housekeeping supervisor will create a room cleaning schedule and common area cleaning schedule for the housekeeping staff to follow daily. 4. Cleaned rooms and common areas will be audited daily by housekeeping supervisor or designee to ensure cleanliness. Audits will be conducted daily x2 weeks, then 2x/week for 2 weeks until compliance is met. Any issues found will be brought to QAPI.	7/14/23

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F 921	Continued From page 139 213 and the adjoining bathroom were noted to have a tan discoloration approximately four inches wide, around the edges of the walls, with a build up of dust and dirt concentrated in the corners of the room, behind the door, and under the nightstand. During observation and interview on 5/12/23 at 12:24 p.m., room 210 was reviewed with the maintenance director (MAIN). He stated it looked like the floor of the room had glue from the mopboards which had collected dust and debris and needed to be cleaned. During observation on 5/12/23 at 12:39 p.m., the floors of room 227 and 226 had similar buildup noted around the edges of the room with dust and debris collected along the perimeter of the room approximately four inches wide and concentrated in the corners and behind the door. During a tour of the facility on 5/12/23 at 12:45 p.m., the housekeeping/laundry supervisor (HLS) stated housekeeping staff provided deep cleaning of resident rooms Monday through Friday. They washed the bed, walls, tray tables, dusted and swept and mopped the floor. Each room was cleaned once per week and as needed. Staff provided a deeper cleaning when a resident was discharged. HLS observed the floors in room 210, 213, 226 and 227 and stated the floors were dirty around the edges and under items and needed to be cleaned. During observation on 5/10/23 at 12:45 p.m., the second floor dining room counter top sink area with the upper and lower cabinets contained three drawers stained with a dripping sticky dry red matter. The handles on the drawers were sticky.	F 921	5. Housekeeping Supervisor or designee is responsible for the completion of this plan of correction.	

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F 921	Continued From page 140	F 921		

The first drawer contained individual sized plastic containers of peanut butter, jelly, packets of Italian fat free dressing, ketchup, mustard, syrup, sugar packets and butter. The drawer had a couple quarter sized area covered with a sticky amber fluid on the bottom right side of the drawer. There were visible stains of sticky matter on several packets. The cabinet above and next to the refrigerator was noted with debris which contained disposable plastic lids and plastic bags and on the upper shelf there was a tray containing small paper packets of salt and pepper.

During interview on 5/10/23 at 12:50 p.m., nursing assistant (NA)-N stated the kitchen was responsible for the refrigerator and counter and added she never used the drawers or handles any of the items for the resident because that was the kitchen staff's job.

During interview and observation on 5/12/23 at 11:36 a.m., the cabinet drawers on the second floor kitchenette next to the refrigerator had red liquid dripping down the front and pooled on the top of the drawers was a red and brown liquid substance. There were packaged ketchup, apple sauce, sugar packets, butter, and jelly in the top drawer and the front of the drawers and handles were sticky to the touch. Janitor-B stated he was not responsible for cleaning the kitchenette and did not know who was responsible.

During interview and observation on 5/12/23 at 1:05 p.m., the second floor cabinet had a small amount of pink dried substance and there was brown debris on the corner of the cabinet. The HLS verified the dirty cabinet and stated it was the housekeeper's responsibility to clean and

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F 921	Continued From page 141	F 921		

expected the area to be cleaned.

A policy, Cleaning and Disinfection of Environmental Surfaces reviewed February 2023, indicated environmental surfaces are cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) bloodborne pathogens standard. The policy defined non-critical items as those that came in contact with skin but not mucous membranes and non-critical environmental surfaces included bed rails, some food utensils, bedside tables, furniture, and floors. Housekeeping surfaces for example floors, and tabletops were cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environment surfaces are disinfected or cleaned on a regular basis (e.g., daily, three times per week) and when surfaces were visibly soiled. Walls, blinds, and window curtains in resident areas are cleaned when surfaces were visibly contaminated or soiled. Horizontal surfaces are wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an EPA (Environmental Protection Agency)-registered hospital disinfectant or detergent.

A policy, Cleaning and Disinfecting Residents' Rooms, reviewed February 2023, indicated housekeeping surfaces for example floors and tabletops are cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas are cleaned when surfaces are visibly contaminated or soiled. Horizontal surfaces example bedside tables, overbed tables, and chairs are cleaned daily with a cloth

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F 921	Continued From page 142 moistened with disinfectant solution.	F 921		
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse and/or vulnerable adult training and Alzheimer's/dementia training was completed for 8 of 8 employees (NA-A, NA-B, NA-D, NA-F, NA-G, TMA-B, LPN-B, RN-B) reviewed. This had the potential to affect all 75 residents who were currently residing in the facility. Findings include: During interview with administrator on 5/10/23 at 1:01 p.m., administrator stated facility staff education, in-services and training are the responsibility of the director of nursing (DON) and human resources director (HRD).	F 943	1. Facility purchased a new online training program to allow each staff member to login and complete their in-service training for abuse/vulnerable adults and Alzheimer's/dementia by the due date (July 7, 2023) as assigned by HR. 2. All staff have the potential to be affected by this type of situation, which could in turn affect the residents if the staff are not properly trained on each of these items. 3. HR will assign each staff member a list of online training that needs to be completed, along with a due date (July 7, 2023). This information will be given to	7/14/23

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F 943	Continued From page 143 During interview and document review on 5/12/23 at 9:28 a.m., staff training and education regarding abuse and/or vulnerable adult training and Alzheimer's/Dementia training for five nursing assistants, one TMA, one LPN, and one RN were reviewed with the DON. The DON stated there were no abuse and/or vulnerable adult training documentation for NA-A, NA-B, NA-D, NA-F, NA-G, TMA-B, LPN-B, and RN-B. During interview and document review on 5/12/23 at 10:34 a.m., staff training and education regarding abuse and/or vulnerable adult training and Alzheimer's/Dementia training for five nursing assistants, one TMA, one LPN, and one RN were reviewed with the HRD. The HRD stated there were no abuse and/or vulnerable adult training documentation for NA-A, NA-B, NA-D, NA-F, NA-G, TMA-B, LPN-B, and RN-B. Facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, reviewed October 2022, identified, "staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior". Facility policy on Alzheimer's training was requested and not received.	F 943	each staff member, along with their supervisor, to ensure timely completion. The training will be assigned to existing staff starting on or around June 26, 2023. All new hires will have online training assigned and must be completed prior to their start date at the facility. All staff will have online training assigned annually on/around their annual review date. 4. HR or designee will conduct audits to ensure timely completion of staff training. Audits will be conducted 1x/week for 4 weeks, then 1x/month for 6 months. Any issues found will be brought to QAPI. 5. Administrator or designee is responsible for the completion of this plan of correction.	
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-	F 947		7/14/23

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F 947	Continued From page 144 §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 5 of 5 nursing assistants (NA-A, NA-B, NA-D, NA-F, NA-G) reviewed for annual training. Findings include: During interview with administrator on 5/10/23 at 1:01 p.m., administrator stated facility staff education, in-services and training are the responsibility of the director of nursing (DON) and human resources director (HRD). During interview and document review on 5/12/23 at 9:28 a.m., performance reviews and in-service records for five nursing assistants were reviewed with the DON. The DON stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D,	F 947	1. Facility purchased a new online training program to allow each staff member to login and complete their annual in-service training of at least 12 hours by the due date as assigned by HR. 2. All nurses aides have the ability to be affected by this type of situation, which could in turn affect the residents if the staff are not properly trained. 3. HR will assign each staff member a list of online training that needs to be completed, along with a due date. This information will be given to each staff member, along with their supervisor, to ensure timely completion. The training will be assigned to existing staff starting on or around June 26, 2023. All new hires will have online training assigned and must be completed prior to start date at the facility. All staff will have online	

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F 947	Continued From page 145 NA-F, and NA-G. During interview and document review on 5/12/23 at 10:34 a.m., performance reviews and in-service records for five nursing assistants were reviewed with the DON. The DON stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D, NA-F, and NA-G. A policy related to nursing assistant evaluations and in-services was requested and not provided.	F 947	training of at least 12 hours assigned annually on/around their annual review date. 4. HR or designee will conduct audits to ensure timely completion of staff training. Audits will be conducted 1x/week for 4 weeks, then 1x/month for 6 months. Any issues found will be brought to QAPI. 5. HR or designee is responsible for the completion of this plan of correction.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/8/23-5/12/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaints were reviewed during the survey and no licensing orders were issued:
H52892043C (MN93142)

The following complaints were reviewed during the survey:
H52892046C MN93138 with licensing orders issued at 0900 (F686).
H52892068C MN93102, MN93148 with licensing orders issued at 1375 (F880), 1695 (F921), 0915 (F676).
H52892120C MN92994 with licensing orders issued at 1695 (F921).
H52892119C MN92790 with licensing orders issued at 1880 (F550, F585).
H52892118C MN92368 with licensing orders issued at 0915 (F676), 0900 (F686).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin

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2 000	Continued From page 2 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

Minnesota Department of Health

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2 000	Continued From page 3 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 5 of 5 nursing assistants (NA-A, NA-B, NA-D, NA-F, NA-G) reviewed for annual training. Findings include: During interview with administrator on 5/10/23 at 1:01 p.m., administrator stated facility staff education, in-services and training are the responsibility of the director of nursing (DON) and human resources director (HRD). During interview and document review on 5/12/23	2 285	Corrected.	7/14/23

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2 285	Continued From page 4 at 9:28 a.m., performance reviews and in-service records for five nursing assistants were reviewed with the DON. The DON stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D, NA-F, and NA-G. During interview and document review on 5/12/23 at 10:34 a.m., performance reviews and in-service records for five nursing assistants were reviewed with the DON. The DON stated there were no orientation checklists, in-service records, or performance reviews for NA-A, NA-B, NA-D, NA-F, and NA-G. A policy related to nursing assistant evaluations and in-services was requested and not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to nurse aide annual training. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance The facility could report those findings to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents'	2 300		7/14/23

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2 300	Continued From page 5 needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure licensed nursing staff demonstrated competency and training related to pressure ulcer prevention and glucose checks (blood sugar monitoring for diabetics) for R72 who was reviewed for pressure ulcers and R28 reviewed for diabetic monitoring. This had the potential to affect 43 residents who were at risk for developing pressure ulcers and 16 residents who received glucose checks. Findings include: R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnosies includes hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs. R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairment and	2 300	Corrected.	

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2 300	Continued From page 6	2 300		

physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

The facility's TCU Nursing Assistant job description for residents care sheet, dated 5/4/23 direct staff to "Pls enforce repositioning q 2hrs" and failed to mention offloading of heels to prevent pressure ulcers.

During observation and interview with registered nurse (RN)-A on 5/8/23 at 7:08 p.m., R72's heels were resting on top of soiled pillowcase. RN-A stated R72's heels "should be rested off bed but they are not."

During observation on 5/9/23 at 12:33 p.m., R72 was laying flat on their back and not on side facing door per her posted turning schedule. Both heels were resting on top of small pillow.

During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated R72 heels should be on the pillow to prevent pressure ulcers.

During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated R72's heels "Should be on top of the pillow and not off".

During interview with NA-B on 5/10/23 at 8:56 a.m., NA-B stated R72 heels should be on the pillow and not resting off if it.

During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated "heels should be resting on top of the pillow and not off it it."

During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated

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understanding that heels can rest on top of the pillow and not off.

During interview with RN-C on 5/10/23 at 11:53 a.m., RN-C stated he was the facility in house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds including R72. RN-C stated offloading means, "relief of pressure on particular points like feet and heels". RN-C stated that heels should not touch anything and should be off the pillow, not resting on the pillow.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated offloading meant, "the heels must be off the bed and not touching anything. Having heels resting on top of a pillow is not acceptable the staff need education. "

During observation on 5/10/23 at 12:18 p.m., trained medication aide (TMA)-B entered R28's room and proceeded to use a lancet and a glucometer to check the residents finger stick blood glucose levels. TMA-B placed R28's blood on the blood glucose test strip, read the results, and proceeded to pack the glucometer into a carrying tray without cleaning or disinfecting the glucometer device before leaving R28's room, so it was avaialble for other residents to use.

On 5/10/23 at 12:23 p.m., TMA-B entered the room of R27's room. TMA-B did not attempt to clean the glucometer per manufacturers recommendations, TMA-B proceeded to use the glucometer to measure R27's finger stick blood glucose levels.

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During an interview on 5/10/23 at 12:24 p.m., TMA-B stated that she uses the glucometer to measure residents blood glucose levels, when the nurses need help. She stated the same glucometer is used with every resident and that the facility standard was to sanitize the glucometer after every two residents.

During an interview on 5/10/23 at 12:28 p.m., registered nurse (RN)-C stated that TMAs were unable to perform finger stick blood glucose monitoring at the facility.

During an interview on 5/11/23 at 10:13 a.m., registered nurse (RN)-F, acting as assistant director of nursing stated TMAs employed by the facility are not trained to do finger stick blood glucose monitoring, and that this treatment was to be done by nurses only.

Competency evaluations for TMA-B were requested but not provided.

A facility policy titled "Blood Sampling - Capillary (Finger Sticks)" dated 2/23, did not specify a title, role, or licensure requirement for the staff who measure residents blood glucose levels.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating

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2 300	Continued From page 9 and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		7/14/23

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2 302	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff were provided information regarding Alzheimer's disease or related disorders. This had the potential to affect all 75 residents who were currently residing in the facility. Findings include: During interview with administrator on 5/10/23 at 1:01 p.m., administrator stated facility staff education, in-services and training regarding Alzheimer's disease or related disorders are the responsibility of the director of nursing (DON) and human resources director (HRD). During interview and document review on 5/12/23 at 9:28 a.m., staff training and education regarding Alzheimer's disease or related disorders was reviewed with the DON. The DON stated there was no documentation provided to staff regarding Alzheimer's disease or related disorders. During interview and document review on 5/12/23 at 10:34 a.m., staff training and education regarding Alzheimer's disease or related disorders were reviewed with the HRD. The HRD stated there were no documentation provided to staff regarding Alzheimer's disease or related disorders. Facility policy on Alzheimer's disease or related disorders was requested and not received.	2 302	corrected	

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2 302	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet, so consumers were aware of this information. The DON or designee could conduct audits to ensure compliance, and the audits could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status;	2 540		7/14/23

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H. discharge potential;
I. dental condition;
J. activities potential;
K. rehabilitation potential;
L. cognitive status;
M. drug therapy; and
N. resident preferences.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to complete the comprehensive Minimum Data Set (MDS) assessments in a thorough and accurate manner to ensure cognitive and mood, needs were evaluated and addressed for 4 of 4 residents (R19, R28, R32, R72) and hearing needs were addressed for 1 of 4 residents (R32) and reviewed for comprehensive MDS assessment accuracy.

Corrected

Findings include:

The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, outlined, a 5-day comprehensive assessment is "the only required PPS assessment that is used to support PPS reimbursement." The manual also indicated "The SCSA [significant change in status assessment] is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement of decline." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation, and ability to register and recall new information. These items

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are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable."

R28's face sheet printed 5/11/23 at 3:14 p.m. indicated that R28 had a diagnosis of depression, insomnia and sucidal ideation.

R28's 5-day PPS MDS assessment dated 5/2/23 and R 19's SCSA dated 2/25/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol indicating staff had not completed this section of the MDS.

During an interview on 05/12/23 at 10:19 a.m., the social services designee (SSD)-A stated she could not recall why sections "C" and "D" in R28's 5-day PPS assessment from 5/2/23 and section "C" and "D" on R19's SCSA from 2/25/23 were not completed. SSD-A verified the sections as incomplete.

During interview 5/11/23 at 3:23 p.m., registered nurse (RN)-D stated the social worker completed the Brief Interview for Mental Status (BIMS) and she does not complete cognitive screens or mood sections and comes to the facility to assess transfers and mobility.

During interview 5/12/23 between 9:59 a.m., and 10:19 a.m., SSD-A stated since February 2023, she completed sections C and D of the MDS. SSD-A stated the MDS is used to determine if cognition is declining or improving, and mood is also evaluated. SSD-A would document an

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assessment as "not assessed" if a resident indicated they would not want to participate, refused, or was unable to speak and make their needs known. The MDS prompts staff to complete that portion. Since nurses work directly with the resident, the nurse would complete those portions if prompted.

During interview on 5/12/23 at 10:42 a.m., the administrator stated RN-E used a calendar for when the MDS was due, and SSD-A completed sections C and D. The Administrator added if the resident refused the assessments, staff completed the staff interview in the MDS and added it was important to complete the mood section because it can provide information if a resident was triggering for depression and the facility could set up services. Aadditionally, cognition screening was important because it helps identify if cognition is intact or if the facility needed to bring in a representative during care conferences.

A policy Resident Assessments reviewed January 2023, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: admission, quarterly, annually, significant change in status, significant correction, and discharge. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.

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A section labeled "Section B: Hearing, Speech, and Vision" identified the intent of the section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons. The rationale for the Hearing section identified problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders. In addition, unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

R32's significant change Minimum Data Set (MDS) dated 4/19/23, indicated R32 had a diagnosis of depression.
Section B - Hearing, Speech, and Vision inaccurately indicated R32 had adequate hearing and did not wear hearing aids.
Section C - Cognitive Patterns lacked documentation in all fields.
Section D - Mood contained dashes in each field and lacked data.

R32's audiology consult note dated 8/19/22, indicated R32 had severe hearing loss in his right ear and moderately sever to severe hearing loss in his left ear, and recommended bilateral hearing aids.

R32's care plan dated 9/2/21, indicated R32 had a communication problem related to hearing deficit.

On 5/08/23 at 2:21 p.m. R32 stated he had severe hearing loss.

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2 540	Continued From page 16 R72's SCSA MDS, dated 4/29/23, identified R72 admitted to the nursing home in March of 2023 from an acute care hospital. R72's diagnosis' include hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs. The MDS' section labeled, "Section C: Cognitive Patterns," however, had no data that was entered until the Staff Assessment for Mental Status section where it was marked as short term memory was "OK" and long term memory marked, "memory problem". Cognitive skills for daily decision making was marked as "Moderately impaired-decisions poor, cues/supervision required". The MDS" section labeled, "Section G-Functional Status," stated R72 required extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene, however it was marked as R72 having no impairment of upper and lower extremity range of motion. R72's medical record, and the completed MDS, lacked evidence these items had been assessed within the assessment reference date (ARD) as directed by the RAI manual to ensure a full evaluation of the resident. During interview with facility administrator on 5/10/23 at 1:14 p.m., administrator verified R72's SCSA MDS was not accurately completed and that [R72] had complete right sided paralysis.	2 540		

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2 540	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete the quarterly Minimum Data Set (MDS) in a thorough and accurate manner to ensure cognitive, mood, and behavior needs were evaluated and addressed for 4 of 4 residents (R14, R25, R35, R62) reviewed for MDS accuracy. Findings include:	2 550	Corrected	7/14/23

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2 550	Continued From page 18 The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, identified the quarterly MDS' was a non-comprehensive assessment to be completed at least every 92 days following the previous assessment of any type. This assessment was used, " ... to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored." A section labeled, "SECTION C: COGNITIVE PATTERNS," identified the items reviewed in the section were, " ... intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions." A subsequent section labeled, "SECTION D: MOOD," identified the items reviewed in the section, " ... address mood distress ... It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs can be treatable." Further, a section labeled, "SECTION E: BEHAVIOR," identified the items reviewed in the section helped, " ... identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment." Additionally, RAI instructions under the heading Coding Tips on page C-16 indicated, "Occasionally, a resident can communicate but chooses not to participate in the BIMS [brief interview for mental status] and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, BIMS Summary Score, and complete the staff assessment of mental status." Under the heading D0500 Staff Assessment of Resident Mood (PHQ-9-OV)	2 550		

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indicated, "Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9 Resident Mood Interview.

R14's quarterly MDS dated 4/6/23 sections labels, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol and no other data present.

During interview on 5/12/23 at 10:21 a.m., SSD-A verified the sections were incomplete and viewed the assessment form in the EMR and stated it was not found and did not know why the assessment was incomplete.

R25's quarterly MDS dated 4/28/23 section labeled, "Section C-Cognitive Patterns" was completed, however "Section D-Mood" indicated a "-" symbol and no other data present.

During interview on 5/12/23 at 10:15 a.m., SSD-A verified mood was not assessed on the MDS, and added she completed the assessment under assessments in the electronic medical record (EMR), but stated the registered nurse saves and signs the assessment and transfers the assessment into the MDS.

R35's quarterly MDS dated 2/17/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" and "Section E-Behavior" indicated a "-" symbol and no other data present.

During interview 5/12/23 at 10:16 a.m., social services designee (SSD)-A stated there may not have been a nurse to answer the questions, but was not sure why the MDS sections were not completed and added there probably wasn't an

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assessment back then because different departments were not completing them and verified the sections were incomplete.

R62's quarterly MDS dated 4/28/23 sections labeled, "Section C-Cognitive Patterns" and "Section D-Mood" indicated a "-" symbol and no other data present. The staff assessment of mental status was not documented under section C and the staff assessment of resident mood indicated "-" symbol.

During interview on 5/12/23 at 10:19 a.m., SSD-A stated R62 refused to complete sections C and D in the assessment because she didn't like to be up during the day and added she documented as "not assessed."

During interview 5/11/23 at 3:23 p.m., registered nurse (RN)-D stated the social worker completed the BIMS and she does not complete cognitive screens or mood sections and comes to the facility to assess transfers and mobility.

During interview 5/12/23 between 9:59 a.m., and 10:19 a.m., SSD-A stated since February 2023, she completed sections C and D of the MDS. SSD-A stated the MDS is used to determine if cognition is declining, or improving and mood is also evaluated. SSD-A stated they were going to have other departments complete section D to try and catch at different time periods. SSD-A added an assessment documented as "not assessed" indicated the residents may not want to participate and if the resident refused, it was documented as not assessed and if a resident cannot talk, it was documented not assessed and the MDS prompts for staff to complete that portion. Since nurses work directly with the resident, the nurse would complete those portions

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if prompted.

During interview on 5/12/23 at 10:42 a.m., the administrator stated RN-E used a calendar for when the MDS was due and SSD-A completed sections C and D. Administrator added if the resident refused the assessments, staff completed the staff interview in the MDS and added it was important to complete the mood section because it can provide information if a resident was triggered for depression and the facility could set up services, additionally cognition screening was important because it helps identify if cognition is intact or if the facility needed to bring in a representative during care conferences.

During interview on 5/12/23 at 12:30 p.m., RN-E stated section Q is not completed by the RN and added the SSD or administrator would complete this section and if not assessed was documented for section Q, there was not a care conference in the look back period to discuss any discharge plan. RN-E further stated the other MDS nurse completed the vision and hearing section of the MDS.

A policy Resident Assessments reviewed January 2023, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: admission, quarterly, annually, significant change in status, significant correction and discharge. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. All resident assessments completed within the previous 15 months are maintained in the

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2 550	Continued From page 22 resident's active clinical record. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on MDS completion to ensure accuracy; revise any polices as needed; then educate staff to ensure accuracy. They could then audit to ensure ongoing compliance and assessment accuracy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure safe smoking practices were consistently followed and interventions were re-evaluated and implemented	2 830	Corrected	7/14/23

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for 1 of 1 resident (R25) reviewed for smoking and the facility failed to comprehensively assess falls, identify causal factors, and implement interventions to decrease the risk of additional falls for 1 of 1 residents (R3) reviewed for falls.

Findings include:

R25's quarterly Minimum Data Set (MDS) dated 4/28/23, indicated intact cognition, was independent for all activities of daily living (ADLs), and a diagnosis of problems related to alcohol, tobacco, and drug use. The MDS further indicated under current tobacco use was incomplete.

R25's care plan revised 2/26/23, indicated R25 was a smoker and had a history of smoking in his room. The goal indicated staff were to secure R25's smoking products for safe keeping after resident smoked. Interventions indicated to instruct R25 on risks and hazards and about smoking cessation aids available, instruct resident on the smoking policy, location, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, resident has a history of smoking in room, facility to hold resident smoking material related to safety risks, and resident refusals (SIC) to allow facility staff to secure smoking materials.

R25's Kardex form indicated R25 had a history of smoking in his room and the facility was to hold resident smoking material related to safety risks.

R25's Smoking Review form dated 4/28/23, indicated R25 smoked and had not tried to quit recently. R25 did not have a history of smoking related incidents. R25 did not have the ability to hold a cigarette safely without a device, but the

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form did not indicate what kind of device R25 required, nor did R25 have the ability to extinguish a cigarette safely. The form indicated staff reviewed the policy related to smoking times and storage of smoking materials with the resident and the care plan was initiated/updated.

R25's Smoking Review form dated 2/26/23, indicated R25 smoked and had not tried to quit recently. R25 had a history of smoking related incidents of smoking in bed and in non-smoking areas, and had the ability to safely hold and extinguish a cigarette. The form further indicated staff reviewed the policy related to smoking times and storage of materials and the care plan was initiated/updated.

All R25's incidents were reviewed and lacked information of any incidents related to smoking.

R25's progress notes were reviewed from 12/1/22 to 5/10/23:

A progress note dated 12/24/22, indicated R25 was found smoking in the room around 5:15 a.m. and stopped smoking before getting there and was asked not to smoke in the room. The effectiveness of the intervention was documented as "N/A."

A progress note dated 1/12/23, indicated, "This writer noted Res smoking in his room at 24:50..." No interventions were documented regarding R25 smoking in the room.

A progress note dated 1/12/23, indicated, "Resident is repeatedly smoking cigarettes and weed in his room. He has been talked to several times regarding this but he's still refusing." The note further indicated the director of nursing and

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Associated Clinic of Psychology (ACP) were made aware and spoke with R25.

A progress noted dated 2/15/23, indicated at 7:00 p.m., a strong cigarette odor was noted in the hallway and was coming from R25's room. The note indicated three residents were in the room smoking and declined to surrender cigarettes. They were informed that smoking in the building was prohibited as there were residents who used oxygen and oxygen storage was located on the same floor.

A progress note dated 2/15/23, indicated R25 was smoking in his room and was reported as ongoing for the past few weeks and R25 declined to hand over cigarettes.

A progress note dated 3/1/23, indicated R25 was found smoking in his room and was educated about the danger associated with smoking in his room and the director of nursing was informed of the situation.

A progress note dated 3/14/23, indicated the smell of cigarette smoke was identified from R25's room and R25 acknowledged he accidentally smoked in his room, and thought he was outside. The note indicated R25 was aware of the facility policy and the floor manager was notified.

R25's care conference note dated 4/11/23, indicated R25 was spoken to about smoking in his room and the importance of not smoking in his room.

A progress note dated 4/20/23, indicated, "Resident continues to smoke in his bedroom. I have watched him put out two cigarettes already.

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I spoke with him about smoking in his room and the dangers it can cause, yet he continues with the behavior." The medical record was reviewed and lacked documentation regarding any follow up.

During interview and observation 5/8/23 at 5:53 p.m., R25 was in his room and had a quarter sized burn hole on the right upper chest area of his sweatshirt. R25 stated he had a cigarette in his mouth and was outside smoking. He put the cigarette out, motioning on the wheel of his wheelchair, put the cigarette back in his mouth, and came into the facility with the cigarette butt, and stated it must have reignited and caused the burn hole after he nodded off, adding it fell out of his mouth and there it was. R25 stated this happened a month or so ago and stated he did not burn his chest. R25's room smelled like cigarette butts and when asked, R25 stated he did not smoke the whole cigarette. R25 opened his drawer and had a full carton of Marlboro cigarettes in his room.

During interview and observation 5/9/23 at 3:15 p.m., R25 was outside smoking and had the gray sweatshirt on with the burn hole located on his right chest. R25 had a lit cigarette in his right hand and dropped it on the ground and did not put the cigarette out. There were multiple cigarette butts located on the ground. R25 had a lighter located on his right leg.

During interview and observation on 5/10/23 at 7:28 a.m., an odor of cigarette smoke was identified in R25's room. R25 was wearing his shirt with the burn hole in the upper right chest. R25 stated he occasionally forgets and lights a cigarette in his room and puts it out motioning throwing the cigarette on the floor. R25 stated he

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forgets where he is. There were two Coke cans opened and a clear plastic cup with blackish sludge that filled 1/3 of the cup next to the Coke cans on R25's nightstand. When asked if R25 had just smoked, R25 stated he would do what he wanted.

During interview 5/10/23 at 7:56 a.m., nursing assistant (NA)-E stated residents were supposed to go downstairs to smoke and was not aware of any issues of residents smoking in undesignated locations.

During interview 5/10/23 at 8:07 a.m., licensed practical nurse (LPN)-D stated smoking assessments were completed to see if a resident was capable of smoking without burning themselves and added the nurse or manager completed the assessment and the assessment indicated whether a resident could hold a cigarette without burning themselves, were alert, and weather they could hold it and put it out safely. LPN-D stated she smelled cigarettes in R25's room, but has not physically seen R25 smoke, and stated she asks the nurse manager to verify what she is smelling. LPN-D added that smoking assessments were completed as needed such as a change in condition and did not have concerns of other residents smoking in their room.

During interview 5/10/23 at 9:16 a.m., NA-K stated R25 smoked in his room mostly on the p.m. shift and added that management was aware but had not seen drastic action taken to prevent R25 from smoking in his room and stated it was against policy to smoke in the building. NA-K was aware R25 smoked in his room because the smell of smoke was present when walking in the hallway.

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During interview on 5/10/23 at 9:27 a.m., the housekeeping and laundry supervisor (HLS)-I stated she saw burn holes on R25's clothing twice and added the nurse was aware of the burn holes and the burn holes were noticed about two months ago.

During interview 5/10/23 at 10:45 a.m., registered nurse (RN)-C stated smoking assessments were completed to determine if a resident was safe to smoke independently and were completed quarterly or sooner if there were concerns such as if dexterity issues were noticed, if a resident burned themselves, or a change in condition. RN-C stated there must have been a mistake on the Smoking Review form dated 4/28/23, because R25 was independent. RN-C stated their policy indicated the building was smoke free and added they educated R25 by letting him know he is not the only resident residing at the facility and explained the risks. RN-C stated R25 smoking in his room was concerning because there were residents who had oxygen which could put them at risk and it could cause a fire or a risk of death and checks needed to be in place to prevent this from happening. RN-C stated the nurse should have followed up with staff who completed the assessment if they noticed a change because then an adjustment could be made. RN-C stated he was aware of the burn hole on R25's gray sweatshirt and added it concerned him R25 had burn holes because R25 may not be safe, but was his own representative. RN-C added R25 ordered his own items such as lighters and cigarettes and stated at this point R25 seemed noncompliant.

During interview on 5/10/23 at 2:34 p.m., RN-F stated smoking assessments were completed

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quarterly and if there was a problem. When reviewing the Smoking Review form dated 4/28/23, RN-F stated the person completing the form did not complete the form correctly and added he had personally not assessed R25 for smoking and stated smoking in resident rooms would be considered an incident and was unacceptable because it was a fire hazard and a discomfort to other residents. RN-F stated R25 was a smoker and was non-compliant. When asked how other residents are kept safe from R25 smoking in his room, RN-F stated he went with the director of nursing last week to request R25 be compliant and instructed him to smoke outside.

During interview on 5/12/23 at 8:27 a.m., R46 stated everyone knew R25 smoked in his room.

A policy, Smoking Policy-Residents reviewed November 2023, indicated the facility established and maintained safe resident smoking practices. Smoking was only permitted in designated resident smoking areas, which was located outside of the building. Smoking was not allowed inside the facility under any circumstances. Staff consult with the attending physician and the director of nursing services to determine if safety restrictions needed to be placed on a resident's smoking privileges based on the safe smoking evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns for example need for close monitoring were noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. The facility may impose smoking restrictions on a resident at any time if it was determined that the resident cannot smoke safely

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with the available levels of support and supervision. Additionally, the policy indicated the facility maintained the right to confiscate smoking items found in violation of the smoking policies. R3's quarterly Minimum Data Set (MDS) dated 3/16/23, indicated she was severely cognitively impaired, required assist of one staff for bed mobility, toilet use, and personal hygiene, assist of two staff for transfer, and was always incontinent of bowel and bladder.

R3's Medical Diagnosis dated 6/10/22, list included previous femur fracture and repeated falls.

R3's Falls Care Area Assessment dated 6/22/22, included R3 had difficulty maintaining sitting balance, impaired balance during transitions, took antipsychotics and antidepressants, and had diagnoses of arthritis, hip fracture, delirium, cognitive impairment, anxiety, and pain.

R3's fall risk care plan revised 9/10/22, indicated R3 had a fall without injury due to poor balance and unsteady gait, and included "For no apparent injury, determine and address causative factors of the fall."

R3's historical risk management forms identified she had 17 falls between 6/17/22, and 11/11/22.

A progress notes dated 11/25/22, 11/29/22, 12/6/22, 12/15/22, 1/25/23, and 2/5/23, indicated R3 was found on the floor next to her bed. R3's record lacked a root cause analysis of the falls and any additional interventions.

R3's Resident Fall Risk dated 3/15/23, was incomplete, and included R3 had no falls in the past three months, was ambulatory and

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continent, and did not take medications causing lethargy or confusion.

A progress note dated 3/25/23, indicated staff found R3 in her room by the entrance on her right side in a pool of blood with her wheelchair outside the door. Staff called emergency medical services (EMS), resident decline transportation to the hospital, and EMS stayed to control the bleeding from a cut above R3's right eye and left the facility. The note identified the bleeding did not stop, EMS was called again, and R3 was transported to the hospital.

R3's After Visit Summary dated 3/25/23, indicated R3 was seen in the hospital emergency department for a head injury due to a fall.

R3's medical record lacked a root cause analysis and fall interventions after the fall on 3/25/23.

On 5/08/23 at 2:51 p.m., R3 was lying in her bed in her room with no mat on the floor. She stated she was not doing well, had diarrhea 'really bad', and had put her call light on to go to the restroom.

On 5/8/23 at 5:08 p.m., R3 was lying in bed on her right side pulling her pants down with the door open, yelling she needed to use the bathroom because she had diarrhea. She stated she was trying to "get it" herself. The bed was not in low position and measured approximately 30 inched from the floor to the top of the mattress. There was no mat on the floor next to the bed.

On 5/09/23 2:34 p.m., R3 was in her wheelchair in her room shifting in her seat and stated she needed a nurse because she had diarrhea and needed to use the bathroom.

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On 5/10/23 at 6:57 a.m., R3 was observed lying in bed, not in lowest position, with no falls mat on the floor.

On 5/10/23 at 7:22 a.m., nursing assistant (NA)-H stated fall risk information was not in the computer or on the NA care sheet, but some resident wore a wrist band to identify if they were at risk, and others she just knew. She stated R3 was at risk for falling, and staff tried to keep an eye on her. She stated she tried to self-transfer to and from bed, and usually her bed was in low position and there was a mat on the floor any time she was in bed. NA-H looked in R3's room and confirmed R3 did not have a falls mat available and was not sure why it was not there.

On 5/10/23 at 7:50 a.m., licensed practical nurse (LPN)-A stated if a resident fell once, they were at risk from then on and she completed a risk management form on the computer which asked questions about the situation to determine appropriate interventions, which often included reminding residents to use the call light and placing mattresses on the floor nest to the bed. If the fall was unwitnessed, she completed neuro (neurological) assessments per policy to make sure they did not have a head injury. LPN-A stated R3 was at high risk for falls because she did things spontaneously, had weak lower extremities, could not really bear weight, and needed one staff to assist. She stated if she tried to get up by herself, she could fall forward on her face. She stated she always had a mat on the floor when she was in bed at night but was unsure about the daytime. LPN-A verified there was not a mat in R3's room and stated the NAs must bring it up every night from the basement and then bring it back down.

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2 830	Continued From page 33 On 5/10/23 at 8:30 a.m., maintenance staff (MS) stated mattresses and mats stored in the basement were locked in a room and nursing staff did not have access to them, and nothing was stored in the hallways on the floors because they were hazards. On 5/10/23 at 11:51 a.m., NA-F and NA-H both confirmed R3 used to have a falls mat but it was no longer in her room. On 5/12/23 at 10:25 a.m., the HUC stated neuro check forms were not given to her to scan into the computer, and she had not seen any. On 5/12/23 at 10:29 a.m., RN-H stated after an unwitnessed fall she wrote a progress note and started a neuro check form, and when the form was completed, she gave them to the HUC to upload into the computer. She stated she also completed a risk management form in the computer which identified details of any fall and interventions to add. RN-H verified R3's record did not contain neuro checks for the fall on 3/25/23, and the care plan did not include additional fall prevention interventions. On 5/12/23 at 10:31 a.m., registered nurse (RN)-F stated staff completed a fall risk management form in the computer after each fall which provided potential prevention interventions appropriate to the resident's situation. Neuro checks were completed after an unwitnessed fall and documented on a paper form. He stated the form was not scanned into the medical record, and he was not sure if it was kept at the nursing station or with the health unit coordinator (HUC). RN-F stated neuro checks were completed after R3's fall on 3/25/23 but was unable to find the documentation. RN-F also confirmed a risk	2 830		

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2 830	Continued From page 34 management form or root cause analysis was not completed. He stated R3 used to have a falls mat on the floor but did not know why it was no longer in R3's room. The Falls and Fall Risk, Managing policy dated 11/22, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. When a resident is found on the floor, a fall is considered to have occurred. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and	2 835		7/14/23

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considerate treatment at all times. Privacy must be respected and safeguarded.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide routine monitoring to reduce the risk of catheter related complications for 4 of 5 residents (R14, R32, R63, R72), who had an indwelling catheter and a history of urinary tract infections (UTIs), reviewed for catheter care.

Corrected

Findings include:

R32's significant change Minimum Data Set dated 4/19/23, indicated R32 used an indwelling catheter, required extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, was morbidly obese, incontinent of bowel, and had diagnoses of neurogenic bladder(when the nerves from the brain to the bladder do not respond correctly), enlarged prostate, kidney failure, failure to thrive, and congestive heart failure (CHF).

R32's Diagnosis Report dated 5/11/23, indicated he had urinary tract symptoms and urine retention.

R32's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 4/27/23, indicated R32 needed extensive assistance for toileting and required and indwelling catheter. Factors contributing to catheter use included neurogenic bladder, urinary urgency and need for assistance toileting, enlarged prostate, congestive heart failure, depression, and medications. The CAA indicated

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this problem was addressed in the care plan but lacked narrative regarding input from R32, impact on the resident, and rationale for the decision to add to care plan. The CAA indicated this problem was addressed in the care plan but lacked narrative regarding input from R32, impact on the resident, and rationale for the decision to add to the care plan.

R32's care plan dated 9/2/21, indicated R32 had a urinary catheter and will show no signs or symptoms of urinary tract infection. Interventions included catheter care and treatment per provider orders, monitor intake and output as per facility policy, and monitor for signs and symptoms of discomfort on urination and frequency.

R32's Order Summary Report dated 5/11/23, included:
- Output every shift for urinary retention starting 8/31/19
- Encourage fluids every shift starting 9/15/21
- Monitor output every shift starting 11/17/22
- Furosemide (a water pill) 40 milligrams (mg), give 80 mg twice per day starting 4/13/23

R32's Treatment Administration Record (TAR) for March, April, and May 2023 included monitor output and contained checkmarks to identify the task was completed but lacked evidence of volume and characteristics of urine.

R32's hospital documentation dated 3/14/23, indicated he was hospitalized for septic shock, respiratory failure, and encephalopathy related to UTI from 3/2/34 - 3/24/23.

R32's hospital documentation dated 4/13/23, indicated he was hospitalized with septic shock, respiratory failure, and encephalopathy related to

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UTI from 4/5/23 - 4/12/23.

During an interview on 5/10/23 at 7:22 a.m., nursing assistant (NA)-H stated nurses completed catheter cares, but the NAs emptied the catheter bags. She stated there was no place to document amount or characteristics of urine, but she reported the amount to the nurse, and informed them if it "smelled weird" or if anything was "not right".

During observation on 5/11/23 at 9:08 a.m., trained medication aide (TMA)-C entered R3's room to awaken him. She emptied approximately 400 cubic centimeters (cc's) of amber colored urine from the bag and stated she did not have a place to document it but would report it to the nurse.

During interview on 5/11/23 at 10:16 a.m., NA-G Stated she emptied catheter bags and told the nurse how much was in the bag and informed them when urine was red, yellow, or thick, but there was no place for her to document it.

During interview on 5/11/23 10:45 a.m., registered nurse (RN)-B stated the NAs emptied catheter bags and reported the amount of urine to the nurse, and the nurse documented output in the system "if there was a place to enter it". She stated staff did not document urine characteristics. RN-B verified there was no place to enter amount of urine or characteristics in R32's record. She stated it was important to monitor to detect signs of possible UTI as R32 had a history of UTIs.

During interview on 5/11/23 at 2:45 p.m., director of nursing (DON) stated the NAs monitored urinary output and characteristics and

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documented it in the electronic record and told the nurse if there were any changes. The DON verified there were no documentation fields for output or urine characteristics in R32's record because the orders were entered into the computer incorrectly, which prevented staff from documenting. He stated the nurses should be looking at urine output, including any sediment, color changes, or other signs of dehydration or UTI to try to identify issues early and prevent complications.
R72's Significant change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnosis' include hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairments and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's physician orders dated 4/25/23, directed staff to "flush catheter BID scheduled with 30 cc saline to assist with patency. Dx: R33.8". Also, an order for "Foley catheter size 16F/10 [cubic centimeters]cc ballon one time a day every 24

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day(s) for Foley Catheter change with a start date of 4/28/23".

R72's after visit summary dated 4/26/23, indicated resident transferred to emergency room for a urinary tract infection and was started on an antibiotic and then sent back to the facility on the same day.

R72's care plan printed 5/11/23, indicated a focus of "Potential for Urinary Tract Infection r/t foley catheter" and "The resident has a foley catheter r/t urinary retention" with the date initiated of 5/2/23. The care plan failed to indicate expectation to record and monitor output amounts.

R72's May 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) identified no documentation or monitoring of urinary output until an order was put in on 5/10/23.

The facility's TCU Nursing Assistant residents care sheet, dated 5/4/23, failed to indicate any monitoring of R72's urine or that resident had a foley catheter at all.

During observation and interview on 5/8/23 at 7:21 p.m., R72's foley drainage bag was connected to the bed frame and held over 1200 cc of yellow urine in the bag. Registered nurse (RN)-A stated R72's foley catheter bag is "usually emptied per shift", but that it "looks like it has not been emptied this shift". RN-A could not provide if and where the amount of urine was documented in the resident electronic medical record (EMR).

During interview with nursing assistant (NA)-A on 5/10/23 at 6:32 a.m., NA-A stated nursing

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assistants are expected to empty foley catheters every shift and tell the nurse the amount for them to document in the EMR.

During interview with registered nurse (RN)-B on 5/10/23 at 7:18 a.m., RN-B stated the expectation was nurses are responsible for documenting urine outputs into the EMR. RN-B was unable to show in EMR where outcomes were documented.

During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated the expectation of nursing assistants was to "tell us what volume of urine is so we can chart" in the EMR. LPN-B was unable to show in the electroic medical record (EMR) where outcomes were documented.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated the expectation was to have "outputs to be put in orders of the EMR." Also, the nurse and nurse manager are responsible for ensuring that there is an order in the EMR to document outputs for "a resident who has a foley". The DON stated R72 was "high risk for UTI and health care issues because she has a foley".

During interview with facility administrator on 5/10/23 at 1:22 p.m., administrator stated R72 was "high risk for health care outcome" such as dehydration and UTI due to not being able to show that outputs were documented. The administrator looked in R72's EMR and stated the outputs were "not being documented. It should have been."

Facility policy and/or procedure for catheter care and urinary monitoring was requested and not received.

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R14's quarterly Minimum Data Set (MDS), dated 4/6/23, indicated R14 was admitted to the facility on 12/29/22 with an indwelling catheter in place and needed extensive assistance with dressing, personal hygiene, and toilet use. The MDS lacked an assessment of R14's cognition and Care Area Assessment.

R14's Medical Diagnosis sheet, dated 12/29/22, indicated R14 had several medical diagnoses to include urinary tract infection, above the knee amputation and chronic kidney disease.

R14's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of R14's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R14's hospital discharge orders dated 2/7/23, indicated R14 had a diagnosis of severe sepsis while hospitalized from 2/1/23 - 2/7/23.

R14's physician note, dated 2/13/23, indicated R14 had recurrent urinary tract infections.

During observation and interview on 5/11/23 at 1:27 p.m., R14 was sitting on his bed with an indwelling catheter in place and a drainage bag on the floor covered in a urine-soaked pillowcase. R14 stated his catheter bag started leaking yesterday, 5/10/23, and the facility staff placed the drainage bag in a pillowcase. Two unnamed staff members walked into R14's room, looked at the drainage bag on the floor and immediately walked out.

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During observation at 1:33 p.m., an unnamed staff member walked into R14's room, placed a towel over the urine-soaked pillowcase and picked up the drainage bag without wearing gloves.

R63's quarterly MDS, dated 2/24/23, indicated R63 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments.

R63's Medical Diagnosis sheet,dated 10/18/21, indicated R63 had several medical diagnoses, including Alzheimer's disease and neuromuscular dysfunction of the bladder.

R63's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of lacked evidence of R63's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R63'S EMR indicated R63 was hospitalized on 4/12/23 due to urine retention and an indwelling catheter was placed. R63 was subsequently hospitalized on 4/25/23 with a urinary tract infection.

During an observation on 5/8/23 at 6:37 p.m., R63 had an indwelling catheter in place and a drainage leg bag strapped to her left leg visible.

During observation on 5/9/23 at 12:37 p.m., R63 was wandering the facility hallway with a drainage leg bag attached to her left leg and half filled with visible yellow urine.

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During observation and interview on 5/10/23 at 7:10 a.m., R63 was asleep in bed, with the drainage leg bag attached to her left leg and at the same level as her bladder. R63 stated she always sleeps with the drainage leg bag attached to her leg.

During observation and interview on 5/11/23 at 10:05 a.m., R63 was observed laying in bed with the drainage leg bag attached to her left leg and at the same level of her bladder. R63 stated she slept with the drainage leg bag attached to her leg last night and does not like to sleep with it on because it is, "too tight."

During an interview on 5/10/23 at 9:56 a.m., nursing assistant (NA)-H stated the nursing assistants use the care plan to know what types of cares to provide each resident. NA-H further stated they do not switch R63's drainage leg bag to a full drainage bag at night (which would allow the drainage bag to be below the level of the bladder) because it is not on the care plan.

During an interview on 5/10/23 at 10:14 a.m., nursing assistant (NA)-F stated R63, "sleeps with her drainage leg bag on."

During an interview on 5/10/23 at 12:23 p.m., registered nurse (RN)-G stated residents with catheters should have orders to direct the nurses what to do with the resident's catheter, such as when to change the catheter. RN-G stated the NAs should be documenting urine output in tasks and the nurses should put in a progress note of the catheter/urine assessment. RN-G verified there were no orders in the EMR and no interventions on the medication administration record (MAR).

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2 835	Continued From page 44 During an interview on 5/10/23 at 12:55 p.m., the assistant director of nursing (ADON) stated the expectation for residents with catheters was to have specific physician orders to monitor and change the catheter that would be transcribed to the MAR for the nurses to follow and the NAs document output in tasks. The ADON further stated he would have concerns with patency of the catheter if a resident slept with a drainage leg bag strapped to their leg. The ADON confirmed this would cause the catheter to be positioned above the level of the bladder which may increase the risk for urinary tract infections. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 835		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 900		7/14/23

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2 900	Continued From page 45 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary treatment to promote healing, reduce the risk of complications, and prevent pressure ulcer development for 2 of 3 residents (R32, R72) reviewed for pressure ulcers. Findings include: R32's significant change Minimum Data Set dated 4/19/23, indicated R32 required extensive assistance of two staff for bed mobility, transfers, toilet use, and personal hygiene, was morbidly obese, incontinent of bowel, and had diagnoses of failure to thrive, congestive heart failure (CHF), and kidney failure. The MDS indicated he was at risk of pressure ulcers and had one stage 3 pressure ulcer. R32's Pressure Ulcer/Injury Care Area Assessment dated 4/7/23, indicated he had an existing pressure ulcer with a checkmark in the box next to "Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin, and identified risk factors of pressure, immobility,	2 900	Corrected	

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incontinence, antidepressant medications, kidney disease, heart disease, and limited range of motion.

R32's Braden Scale for Predicting Pressure Sore Risk identified he was a high risk for pressure ulcers.

R32's care plan updated 5/3/22, indicated he had vascular wounds on his left foot and pressure injury on his right foot and included instruction to administer treatments as ordered and monitor for effectiveness.

R32's Follow-Up Progress Notes dated 4/5/23 and 5/2/23, written by nurse practitioner and wound care nurse (NP)-A included the following recommendations:
- Left lateral foot: Clean with saline/Vashe (cleanser) only, pat dry, apply skin prep/barrier film to peri-wound, allow to dry, then ABD (a thicker padded dressing), and secure with stretch gauze bandage wrap: place compression from forefoot to below knee (short stretch wraps in figure-8 pattern) or compression stockings, then pressure offloading/redistribution boot
- Bilateral lower legs: Apply tubigrip then short stretch wraps in a figure-8 pattern from just above the toes to just below the knees, ok to apply over dressings on left foot. Change with dressing changes. Continue heel protection

R32's Follow -Up Progress Note dated 5/9/23, written by NP-A included tubigrips were recommended to assist with management of fluid in lower extremities for bilateral lower legs and were initiated on 3/15/23, however had not been in place the last several weeks on rounds. In addition, the note identified "no heel protection in place for 3 weeks with rounds".

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2 900	Continued From page 47 On 5/8/23 at 2:32 p.m., R32 was lying in his bed with his left foot on a flat pillow covered in a light tubular stockinette over a gauze dressing dated 5/5/23. R32 stated he wasn't sure what it was for, but it had been a while since it was changed. He was not wearing heel protection, nor were heel protectors visible in the room. On 5/8/23 at 5:07 p.m., licensed practical nurse (LPN)-C stated R32 had a wound on his leg but did not know what type or where exactly it was because the dressing was scheduled to be changed on the day shift. LPN-C confirmed the dressing on R32's left foot was marked 5/5/23, reviewed R32's orders, and verified he had an order for daily dressing changed starting 4/6/26. She was not aware of heel protectors. On 5/8/23 at 5:36 p.m. registered nurse (RN)-F stated R32 required daily dressing changes to his left foot, and he changed it on 5/5/23. He stated he was not at the facility over the weekend and was not sure why it was not changed on 5/6, 5/7, or earlier that morning on 5/8/23. He stated it needed to be changed daily to prevent infection. On 5/9/23 at 11:59 a.m. NP-A stated R32 had vascular wounds on the side of his left foot and left fifth toe, and a pressure ulcer on his heel. She stated she expected staff to change dressings daily if ordered daily, and if not completed, the wounds could worsen or increase risk of infection. She stated she ordered heel protection and wraps for multiple weeks, but they were never on when she arrived. She stated RN-C found them in R32's closet that morning and placed them on R32's feet. On 5/11/23 at 9:08 a.m., trained medication aide	2 900		

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(TMA)-C confirmed R32's dressing was dated 5/9/23, two days prior, and stated it was the nurse's responsibility to change dressings. She was unaware of heel protectors for R32.

On 5/11/23 at 2:44 p.m., director of nursing (DON) stated he expected wounds to be monitored, dressings to be changed per provider orders, and any refusals to be documented to ensure they did not get worse or infected.

The Wound Care procedure dated 11/23, identified staff should verify there is an order for the dressing change, review the resident's care plan for any special resident needs, and document all wound assessment data and any resident refusals.

R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA), dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted

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mobility, pressure ulcer and urinary tract infection.

R72's care plan printed 5/11/23 failed to have a turn and reposition order until 5/10/23. In addition, R72's care plan focus dated 5/2/23, indicated "the resident has pressure ulcers r/t immobility" and an intervention to "Follow facility policies/protocols for the prevention /treatment of skin breakdown".

The transitional care unit (TCU) Nursing Assistant residents care sheet, dated 5/4/23, for R72 directed staff to "Pls enforce repositioning q 2hrs".

R72's Weekly Wound Report progress notes dated, 3/22/23, 3/29/23, 4/4/23, 4/11/23, 4/18/23, 4/25/23, 5/2/23, and 5/9/23 identified, "Treatment Recommendations" which state, "Heel offloading per facility protocol".

Turning and Repositioning:

During observation on 5/8/23 at 3:52 p.m., R72 was observed laying in bed, flat on her back. A piece of paper posted to the wall at head of her bed indicated a Turning Schedule with the following:

7:00am-9:00am, facing the ceiling
9:00am-11:00am, facing the window
11:00am-1:00pm, facility the door
1:00pm-3:00pm, facing the ceiling
3:00-5:00pm, facing the window
5:00pm-7:00pm, facing the door
7:00pm-9:00pm, facing the ceiling
9:00-11:00pm, facing the window
11:00pm-1:00am, facing the door
1:00am-3:00am, facing the ceiling
3:00am-5:00am, facing the window

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During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated the importance of repositioning R72 every two hours "because of her wounds" and immobility. NA-D stated expectation of nursing assistants to document turning and repositioning R72 every two hours in the electronic medical record (EMR). NA-D unable to find out where in the EMR the documentation was supposed to be done.

During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated the expectation of nursing assistants was to reposition residents every two hours and to document it in the EMR. NA-A stated they were unable to see any documentation of turning and repositioning of F72 at all.

During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated the expectation was R72 be turned every two hours. RN-B stated R72, "is high risk for more breakdown because she can't turn by herself".

During interview with licensed practical nurse (LPN)-B on 5.10/23 at 7:33 a.m., LPN-B stated the expectation was nursing assistants are to document turning residents every two hours in the EMR. LPN-B stated R72, "should be turned because she can't do it herself."

During interview with staffing coordinator (SC)-A on 5/10/23 at 10:30 a.m., SC-A stated the expectation was the nurse manager updated the nursing assistant care sheets and nurses are responsible for making sure the residents are turned on time. SC-A stated expectation each time a resident is turned the nursing assistants are to chart in the EMR to show it was completed

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or offered. SC-A stated R72's EMR lacked any area to document turning and repositioning and that R72 should have it "so she doesn't get pressure ulcers".

During interview with RN-C on 5/10/23 at 11:53 a.m., RN-C stated he was the facility in-house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds. RN-C stated nurses on the units are responsible for establishing a turning schedule for residents who are at high risk for pressure ulcers. RN-C stated the expectation of an order in the EMR to turn and reposition R72. RN-C stated prior to 5/10/23 R72 EMR did not have an order to reposition or turn her.

Floating Heels:
During observation and interview with registered nurse (RN)-A on 5/8/23 at 7:08 p.m., R72's heels were resting on top of soiled pillowcase. RN-A stated R72's heels "should be rested off bed but they are not."

During observation on 5/9/23 at 12:33 p.m., R72 laying flat on back and not on side facing door per her posted turning schedule. Both heels were resting on top of small pillow.

During interview with nursing assistant (NA)-D on 5/9/23 at 12:42 p.m., NA-D stated R72 heels should be on the pillow to prevent pressure ulcers.

During interview with NA-A on 5/10/23 at 6:32 a.m., NA-A stated R72's heels "Should be on top of the pillow and not off".

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During interview with NA-B on 5/10/23 at 8:56 a.m., NA-B stated R72's heels should be on the pillow and not resting off of it.

During interview with RN-B on 5/10/23 at 7:18 a.m., RN-B stated "heels should be resting on top of the pillow and not off of it."

During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated understanding that heels can rest on top of the pillow and not off.

During interview with RN-C on 5/10/23 at 11:53 a.m., RN-C stated he was the facility in-house wound care nurse and was very familiar with R72 due to her sacral pressure ulcers and two bilateral lower extremity vascular ulcers. RN-C stated he rounds with the contracted Nurse Practitioner weekly with all of the residents that have wounds including R72. RN-C stated offloading means, "relief of pressure on particular points like feet and heels". RN-C stated heels should not touch anything and should be off the pillow and not resting on the pillow.

During interview with director of nursing (DON) on 5/11/23 at 1:31 p.m., DON stated "I wasn't aware that there was no order to turn and reposition her. There should be an order for any person who cannot turn themselves and yes there should be one for her because she cannot turn on her own. It important to protect against skin breakdown. [R72] is vulnerable for skin breakdown". In addition, DON stated recommendations by the wound care nurse from the Weekly Wound care notes is an order should be put in the EMR.
The DON stated the in house or facility wound care nurse, RN-C was responsible for putting in

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the turning and repositioning order and the offloading of heels into the EMR for R72 which was not done. Furthermore, the DON stated off-loading meant the heels must be off the bed and not touching anything. Having heels resting on top of a pillow is not acceptable and the staff need education to prevent this.

During interview with facility administrator on 5/10/23 at 1:22 p.m., administrator stated, "it is very important to turn [R72] every two hours because we don't want her to get pressure ulcer or make it get worse." The administrator stated the order to turn and reposition R72 was not in the electronic medical record (EMR) and it should have been.

Facility policy titled, Repositioning, reviewed November 2023, identified a turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. In addition, it identifies residents with a Stage I or above pressure ulcer, an every two hour (q2 hour) repositioning schedule is inadequate. Also, the position in which the resident was placed, the name and title of the individual who gave care, and the signature and title of the person recording the data are expected to documented in the resident's EMR.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents with edema, to assure they are receiving ongoing monitoring and assessment of the edema along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the

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2 900	Continued From page 54 risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meal set up was provided for 1 of 1 resident (R35) reviewed for activities of daily living (ADLs) Findings include: R35's quarterly Minimum Data Set (MDS) dated 2/17/23, indicated cognition, mood, and behavior	2 915	Corrected	7/14/23

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was not assessed, required extensive assist for most ADLs, except required set up help for eating.

R35's Medical Diagnosis form in the electronic medical record (EMR) indicated the following diagnoses: unspecified intracranial injury with loss of consciousness, unspecified dementia, mild cognitive impairment, quadriplegia unspecified (partial or complete paralysis of both the arms and legs), aphasia (loss or impairment of the power to use or comprehend words), dysphagia (difficulty swallowing), muscle weakness, and apraxia (a neurological disorder characterized by the inability to perform purposeful movements and gestures despite having the physical ability and desire to perform them).

R35's Clinical Physician Orders form dated 4/10/22, in the EMR indicated regular diet, regular as tolerated texture, regular thin consistency for R35 requests regular diet and understands he may choke.

R35's care plan revised 9/2/22, indicated R35 had an ADL self care deficit related to traumatic brain injury and could eat independently following tray set up.

R35's care plan revised 1/16/22, indicated R35 had a communication problem due to expressive aphasia, receptive aphasia, but could communicate via use of gestures, pointing, as well as nodding head yes/no, and speaking in short phrases. The interventions indicated R35 required adequate time to respond and indicated R35 required total assist with fluid intake in order to meet his daily requirements. Further, indicated R35 had behaviors and interventions included anticipating and meeting needs, including when

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visiting ask about food, radio, and pop preferences as R35 changes mind often.

R35's care plan revised 12/31/22, indicated R35 was at nutritional risk related to receiving a regular diet and interventions included to assist with eating as needed and finger foods as able.

R35's Task ADL-Eating Form under question header, Eating: Support Provided from 4/10/23 to 5/9/23, indicated R35 required no set up three times, setup help only 64 times, one person physical assist 16 times, and two person physical assist four times.

R35's Task ADL-Eating form under question header, Eating: Self Performance How resident eats and drinks, regardless of skill from 4/10/23 to 5/9/23, indicated R35 required supervision, oversight, encouragement, or cueing 14 times, limited assistance 8 times, extensive assistance 3 times, and total dependence four times.

The facilities Menu Matrix form indicated for week two, Tuesday lunch was choice of juice, chicken taco salad, cucumber slices, gentilly angel food cake, salsa, sour cream, milk, and coffee.

During observation on 5/8/23 at 1:13 p.m., R35's shirt was soaked with liquid from the neck down and his lunch was untouched in front of him.

During observation on 5/9/23 at 12:22 p.m., R35 was in bed with his breakfast tray and a bowl of uneaten oatmeal on the bedside table. A plate on the tray contained a small amount of uneaten eggs and R35 had a small piece of bacon on his green shirt. The menu ticket on the tray indicated 4 ounces of juice, choice of cereal, one egg, one slice of bacon, one slice of toast, 1/2 cup of

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2 915	Continued From page 57 assorted fruit, eight ounces of milk, six ounces of coffee. R35's cover for his plate of food was located on the bed. During observation on 5/9/23 at 12:40 p.m., an unknown staff member delivered lunch to R35's room. During interview and observation on 5/9/23 at 12:46 p.m., R35 was in bed and his meal tray was located on his bed side table. He had a bag of unopened chips, cake with strawberries, and chicken taco salad on his tray. R35 had not attempted to eat or take any bites. R35 requested more juice and instructed to activate the call light for assistance. R35 had a cup of yellow fluid with the cover on and had not attempted to eat or drink. During interview and observation on 5/09/23 at 12:55 p.m., an unknown staff came to answer light and turned off light. R35 stated his cup was empty. The staff did not offer to open chips. During interview and observation on 5/09/23 1:09 p.m., R35's bag of chips remained unopened and R35 stated "yeah" when asked if he needed help opening his chips. His food remained untouched. During observation 5/09/23 at 1:24 p.m., R35 took the cover off his juice and drank the whole cup. No other food had been touched. During interview and observation on 5/9/23 at 1:36 p.m., R35 stated "yes" when asked if he needed assistance to eat and instructed to activate the call light. R35 stated "yes" when asked if he liked chips. During observation 5/9/23 at 1:42 p.m., unknown	2 915		

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staff answered R35's call light and R35 gave unknown staff the urinal and unknown staff emptied the urinal and placed it on R35's bedside table next to his water and food tray. R35 asked for water and unknown staff took water cup and walked out of the room. The unknown staff did not offer assistance to open R35's bag of chips.

During observation 5/9/23 at 1:46 p.m., unknown staff gave R35 his fork, but did not offer to open his chips.

During interview 5/9/23 at 1:49 p.m., nursing assistant (NA)-B stated set up meant residents required more help and cueing and encouragement to eat. NA-B stated R35 required help to take covers off of cups and opening his chips, after first asking and explaining to R35 what you were going to do. NA-B further added if you let him know what you are doing with a slow friendly approach, he allows assistance.

During interview and observation on 5/9/23 at 1:54 p.m., licensed practical nurse (LPN)-A stated R35 required meal set up. R35's chips were opened following staff interview and had the bag of chips in his left hand.

During interview on 5/9/23 at 3:01 p.m., LPN-A stated having the urinal on the bedside table could contribute to lack of eating.

During interview on 5/9/23 at 2:52 p.m., registered nurse (RN)-F stated the expectation is to set everything up for R35 and the NA should ask R35 if he wanted assistance and if R35 did not want assistance, the NA should reapproach and RN-F stated it was inappropriate to place a urinal on the bedside table.

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2 915	Continued From page 59 A policy, Activities of Daily Living (ADLs), Supporting dated November 2022, indicated residents were provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resisted care, staff would identify the underlying cause and approach the resident in a different way or time. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' requiring staff assistance, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene and ADL needs are met consistently. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		7/14/23

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2 920	Continued From page 60 by: Based on observation, interview, and document review, the facility failed to ensure bathing assistance was provided for 1 of 1 resident (R35) reviewed for activities of daily living (ADLs) R63's quarterly Minimum Data Set (MDS), dated 2/24/23, indicated R63 had severe cognitive impairment and needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene and supervision with transfers, ambulation and eating. The MDS lacked any Care Area Assessments. R63's Medical Diagnosis sheet, dated 10/18/21, indicated R63 had several medical diagnoses including Alzheimer's disease and neuromuscular dysfunction of the bladder. R63's care plan, dated 9/3/22, indicated R63 had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease. The care plan further indicated R63 needed extensive assistance from facility staff with showering on Tuesday evenings and limited assistance from facility staff with personal hygiene. R63's nursing assistance task named ADL-Bathing was reviewed for the past 30 days and indicated R63 received a shower on 4/18 and 4/25, two times in the past 30 days. During interview and observation on 5/8/23 at 6:38 p.m., R63 stated she was not getting showers or baths regularly and "really wanted one." R63 had facial hair on her upper lip and chin approximately ¼ inch long and was wearing socks with multiple red stains on them.	2 920	Corrected	

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During observation on 5/9/23 at 12:40 p.m., R63 was wearing the same pair of teal shorts, salmon colored t-shirt, and red stained socks from 5/8/23. Facial hair was still present on R63's upper lip and chin.

During interview and observation on 5/10/23 at 7:55 a.m., R63 stated facility staff had not offered to give her a shower last night, (R63's scheduled shower day), and had not offered to shave her upper lip and chin hairs because facility staff are, "just too busy." R63 rubbed the hairs on her chin and stated, "it's just terrible, I really wish this hair was not here, but I need help to shave it." R63 was wearing the same teal shorts, salmon colored t-shirt and red stained socks from 5/8/23.

During interview on 5/10/23 at 9:56 a.m., nursing assistant (NA)-H stated the bath schedule for residents is posted at the nurse's station and in the electronic medical record (EMR). NA-H stated if a resident refused or missed their bath the NAs needed to let the nurse know. NA-H further stated facial hair should be shaved on shower day if a resident prefers to be shaved.

During interview on 5/10/23 at 12:23 p.m., registered nurse (RN)-G stated the NAs should be checking the bath schedule at the start of their shift. RN-G stated the NAs should be updating the nurses if a bath is missed for any reason, as it is "very important" for baths to get done weekly. RN-G further stated facial hair should be shaved during baths. RN-G confirmed R63's ADL-Bathing task indicated she had not had a shower since 4/25/23.

During interview on 5/10/23 at 12:55 p.m., the assistant director of nursing (ADON) stated the expectation was for residents to receive their

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2 920	Continued From page 62 baths every week. If a bath was missed the nurse should be notified and should make a note of the missed bath. A facility policy titled Activities of Daily Living (ADLs), Supporting, reviewed 11/2022, indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. If a resident refuses care or services they will be offered alternative interventions, informed of the risks and benefits of refusal and the refusal and reason for refusal will be documented. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food	2 965		7/14/23

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2 965	Continued From page 63 served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure ongoing weight loss was identified timely, comprehensively assessed, and acted upon to stabilize or reverse weight loss for 1 of 1 resident (R3) reviewed for significant weight loss. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/16/23, indicated she was severely cognitively impaired, required set-up assist for eating, and had diagnoses of malnutrition, anemia, and diabetes. The MDS indicated she did not have a swallowing disorder, weighed 102 pounds, and "No or unknown" weight loss in the past six months. R3's dental status lacked documentation. R3's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 6/22/22, lacked documentation in the "Eating" section. R3's Nutritional Status CAA dated 6/17/22, identified factors which affected R3's ability to eat and nutritional needs as: arthritis, functional range of motion, poor memory, anxiety, anemia, depression, pain, diabetes, and antipsychotic medications. R3's Dental Care CAA dated 6/22/23, indicated R3 had no natural teeth or tooth fragments.	2 965	Corrected	

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2 965	Continued From page 64	2 965		

R3's care plan revised 3/24/23, included R3 was at nutritional risk related to a severe weight loss of 13 pounds over the past three-month period, and indicated R3 needed set-up assistance with eating, had difficulty chewing related to lack of teeth, and needed food cut into bite-sized pieces. New interventions of dietician to monitor R3 at meals as needed, and dental consult as needed were added.

R3's Nutrition Data dated 3/26/23, indicated she had an admission weight of 148 pounds, had a severe weight loss of 13 pounds over the previous three months, had dental problems, and ate over 75% of her meals.

R3's Order Summary Report dated 5/11/23, included:
- Monthly weight on the first day of the month starting 9/1/22
- Nutritional supplement between meals starting 10/26/22
- Mechanical soft diet starting 4/17/23
- RD (registered dietician) evaluate and treat ordered 4/19/23

R3's Nutrition - Amount Eaten task identified she ate over 1/2 of her food during 70% of meals during the period 4/10/23, through 5/9/23.

R3's Weights and Vitals Summary dated 5/10/23, indicated the following weights (in pounds):
- 3/2/23 = 102.2
- 3/18/23 = 102.2
- 4/1/23 = 102.1
- 5/2/23 = 83 (an 18.7% loss in one month)
- 5/10/23 = 77.4 (a 24.2% loss in five weeks)

During observation and interview on 5/8/23 at 2:52 p.m. R3 was lying in bed in her room. She

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2 965	Continued From page 65	2 965		

stated she had diarrhea and could not keep food down, but liquids were usually ok. She stated she bought a bunch of Sprite, and it was all she could drink. During conversation she was noted to have no teeth.

During observation and interview on 5/8/23 at 6:53 p.m., R3 was seated at the dining room table with a plate containing meatloaf cut into pieces approximately 1.5"(inches) by 1.5", a large piece of bright green, crunchy broccoli approximately 2" by 2", and mashed potatoes with gravy. She had two beverages, one milk and the other a red juice. R3 stated she couldn't eat the food at the facility because it wasn't seasoned, it was too hard, and she had no teeth. R3 took two small bites of mashed potatoes and left the table.

During an interview on 5/9/23 at 12:32 p.m. NA-I stated she documented how much each resident ate in the NA documentation system.

During and interview on 5/10/23, at 7:22 a.m. nursing assistant (NA)-H stated the NAs weighed each resident monthly and either she or the nurse documented the weight in the computer, She stated staff could see the resident's previous weight at the top of the screen, and if there was a significant difference, she reweighed the resident and notified the nurse if there was still a concern. NA-H stated R3 was not on any special diet and eating was "hit or miss" and R3 would rather go out and have a cigarette.

During an interview on 5/10/23 at 7:50 a.m. registered nurse (RN)-G stated NAs weighed residents and reported results back to her to review and record them. She looked at the previous weight every time she entered one, and if there was a large difference, she asked staff to

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2 965	Continued From page 66	2 965		

reweigh the resident. She stated she was trained to inform the managers if a weight was still "off" so they could re-calibrate the scale, and if a resident's weight was still significantly different, she informed the provider, the kitchen, and the managers. RN-G stated she did not notice any change in R3's status. Upon review of R3's food intake documentation she stated it was not accurate. R3 always picked at her food, was "never a big eater", and usually ate 25-50% if she liked what was served. She stated she did not like the mechanical soft diet and cut the food herself. Upon review of R3's weights, she stated R3 could not afford to drop that much weight and stated she would have called the provider.

During an interview on 5/10/23, at 8:30 a.m. director of nursing (DON) stated all residents were weighed monthly, while others required them more often. The computer alerted staff when a weight was abnormal, and staff re-weighed the resident to ensure it was accurate and informed the provider if there was a concern or if a resident refused. The DON stated R3 had significant weight loss in the past and was given protein supplements. He stated she was refusing to eat and likely ate 10% of her meals, and dietary evaluated her and tried to implement interventions. He stated he did not think the percentages of food recorded as eaten by R3 were accurate, and the NAs may not have been given the correct information and education regarding assessing and recording that information. He stated the NAs in the dining room should cut up R3's food into bite sized pieces and needed additional education to ensure they were doing all they could to maintain R3's weight to keep her healthy.

During an observation on 5/10/23 at 9:35 a.m.

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2 965	Continued From page 67	2 965		

NA-F was observed clearing stacks of plates in the dining room and scraping the leftover food off. She stated she received training regarding intake documentation and remembered who sat where and how much they ate at each meal and went back later to document it for all who ate in the dining room.

During an interview on 5/10/23 at 12:19 p.m., dietary director (DD) stated she knew if a resident had a significant weight change when the computer system alerted her or the nurse manager relayed information, and she also reviewed resident weights just in case something did not get communicated. She stated she saw R3 a few weeks prior but was not notified of her significant weight loss on 5/2/23. She stated if she had known she would have requested a re-weigh at that time, and if accurate, would have gone to see her and added interventions. She stated the NAs were supposed to track intake, but R3 did not eat very much, perhaps 25-50%. She stated R3 needed set-up assistance and a mechanical soft diet because she did not have teeth. Meatloaf and other foods should have been cut up into bite-sized pieces so it could be mashed by gums. DD confirmed R3's meal ticket identified R3 needed set-up assist/assist with feeding as necessary, and all foods cut up into bite sized pieces/soft texture. She stated large pieces of food were difficult for her to eat without teeth. She stated there was a time R3 was on a mechanical soft diet, but she did not like it, so it was changed back to regular diet. R3's care plan was not accurate and needed supervision and cueing during meals.

DD stated staff told her two weeks ago R3 knew staff were concerned about her weight and she threatened not to eat if she could not go out to

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2 965	Continued From page 68 smoke when she wanted, but this was not documented. She stated staff had the responsibility to care for the residents, exhaust all options, and identify changes. She stated R3 had a significant weight loss and improved identification would help staff intervene and slow or eliminate weight loss progression. A dietary/nutrition policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for monitoring weight loss. Nursing staff could be educated as necessary to the importance of monitoring weight loss. The DON or designee, could audit any/all resident's weights located in have interventions in place. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a urinary drainage bag was kept off the floor to prevent	21375	Corrected.	7/14/23

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contamination for 1 of 2 residents (R14). In addition, the facility failed to ensure a contaminated urinal was properly stored to prevent contamination for 1 of 1 residents (R35). In addition, the facility failed to adhere to proper infection control practices during routine blood glucose monitoring. This had the potential to affect 16 residents residing in the facility who received finger stick blood glucose monitoring.

Findings include:
During observation on 5/10/23 at 12:18 p.m., trained medication aide (TMA)-B entered R28's room and proceeded to use a lancet and a glucometer to check the residents finger stick blood glucose levels. The glucometer was not cleaned, was placed back into a carrying tray, and TMA-B left the room.

During observation on 5/10/23 at 12:23 p.m., TMA-B entered the room of R27. Without cleaning the glucometer per manufacturers recommendations, TMA-B proceeded to use the glucometer to measure R27's finger stick blood glucose levels.

During an interview on 5/10/23 at 12:24 p.m., TMA-B stated that she uses the glucometer with every resident and the facility standard was to sanitize the glucometer after every two residents.

During an interview on 5/10/23 at 12:28 p.m., registered nurse (RN)-C stated glucometers are to be cleaned after every use before they are used on another resident to prevent the spread of bloodborne pathogens.

The glucometer used was the Assure Prism Multi Blood Glucose Monitoring System. The quality assurance/quality control reference manual dated

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2/16 indicated "The meter should be cleaned and disinfected after use on each patient. The Assure Prism multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed ...The disinfection procedure is needed to prevent the transmission of blood-borne pathogens."

A facility policy titled "Blood Sampling - Capillary (Finger Sticks)" dated 2/2023 indicated staff should "always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses."
R35's quarterly Minimum Data Set (MDS) dated 2/17/23, indicated cognition, mood, and behavior was not assessed, required extensive assist for most ADLs, was occasionally incontinent of bladder and frequently incontinent of bowel.

R35's Medical Diagnosis form in the electronic medical record (EMR) indicated the following diagnoses: unspecified intracranial injury with loss of consciousness, unspecified dementia, quadriplegia unspecified (partial or complete paralysis of both the arms and legs), muscle weakness, and apraxia (a neurological disorder characterized by the inability to perform purposeful movements and gestures despite having the physical ability and desire to perform them).

R35's care plan revised 1/16/22, indicated an intervention to offer to toilet and or use the urinal every two hours.

During observation on 5/8/23 at 1:13 p.m., R35's lunch was untouched in front of him with a dirty urinal on the table next to his lunch tray.

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During observation on 5/9/23 at 1:42 p.m., an unidentified staff came in to R35's room to answer the call light. R35 gave the staff person the urinal and the staff person emptied the urinal and at 1:43 p.m., the staff person put the urinal on the bedside table next to R35's water and food tray.

During interview on 5/9/23 at 1:54 p.m., licensed practical nurse (LPN)-A stated the bedside table was for food and the urinal should not have been placed on the bedside table.

During interview on 5/9/23 at 2:52 p.m., registered nurse (RN)-F stated it was not appropriate to set the urinal on the bedside table next to R35's food and water.
R14's quarterly Minimum Data Set (MDS), dated 4/6/23, indicated R14 was admitted to the facility on 12/29/22 with an indwelling catheter in place and needed extensive assistance with dressing, personal hygiene, and toilet use. The MDS lacked an assessment of R14's cognition and Care Area Assessment.

R14's Medical Diagnosis sheet, dated 12/29/22, indicated R14 had several medical diagnoses to include urinary tract infection, above the knee amputation and chronic kidney disease.

R14's entire electronic medical record (EMR) was reviewed to include the care plan, physician orders, medication and treatments record, progress notes, and tasks and lacked evidence of R14's catheter to include orders for changing the catheter, catheter cares, and urine output monitoring.

R14's hospital discharge orders, dated 2/7/23,

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21375	Continued From page 72 indicated R14 had a diagnosis of severe sepsis while hospitalized from 2/1/23 - 2/7/23. R14's physician note, dated 2/13/23, indicated R14 had recurrent urinary tract infections. During observation and interview on 5/11/23 at 1:27 p.m., R14 was sitting on his bed with an indwelling catheter in place and a drainage bag on the floor covered in a urine-soaked pillowcase. R14 stated his catheter bag started leaking yesterday, on 5/10/23, and the facility staff placed the drainage bag in a pillowcase. Two unnamed staff members walked into R14's room, looked at the drainage bag on the floor and immediately walked out. During observation at 1:33 p.m., an unnamed staff member walked into R14's room, placed a towel over the urine-soaked pillowcase and picked up the drainage bag without wearing gloves. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;	21390		7/14/23

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21390	Continued From page 73 B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 9 of 134 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of 93.8% and had the potential to affect all 75 residents in the facility. Findings include: The Centers for Medicare and Medicaid (CMS) QSO-23-02-ALL, dated 10/26/22, identified the revised guidance for staff vaccination	21390	Corrected	

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21390	Continued From page 74	21390		

requirements. The QSO memo outlined the requirement for full staff vaccination had been enforced since February 2022, and listed a section labeled, "Vaccination Enforcement," which outlined, "CMS expects all providers' and suppliers' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by the CDC [Centers for Disease Control]. Facility staff vaccination rates under 100% constitute noncompliance under the rule."

During document review and interview on 5/10/23 at 2:30 p.m., The administrator provided the COVID-19 Staff Vaccinations Status for Providers Form. The form indicated, 116 employees were completely vaccinated, 9 employees had granted exemptions and 9 were partially vaccinated. There was no additional information presented demonstrating why the 9 partially vaccinated employees were not completely vaccinated.

During an interview on 5/11/23 at 1:07 p.m, the director of nursing (DON) reviewed the COVID-19 Staff Vaccinations Status for Providers Form completed by the administrator and stated the facility did not have further documentation regarding why the 9 partially vaccinated employees and stated he did not know why they were not fully vaccinated.

The facility's Coronavirus Disease (COVID-19)- Vaccination of Staff, dated 11/2021, indicated all staff are required to be fully vaccinated for COVID-19 in accordance with 483.80(i). Policy indicated "Fully vaccinated" means it has been two weeks or longer since the individual completed a primary vaccination series for COVID-19, Policy also indicated staff who are

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21390	Continued From page 75 fully vaccinated must provide documentation of vaccination. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit COVID-19 vaccine compliance for vaccinations and mitigation of COVID-19 for non-vaccinated employees. The DON or designee could report findings of the audits to the quality assurance committee for follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		7/14/23

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21426	Continued From page 76	21426		
	This MN Requirement is not met as evidenced by: Base on interview and document review, the facility failed to complete screening for active tuberculosis (TB) for 4 of 5 employees (NA-P, NA-L, TMA-D, and RN-H) and 3 of 5 residents (R27, R23, R32) and failed to ensure 1 of 5 employees (AA-A) and 4 of 5 residents (R27, R1, R30, R32) received the required two-step tuberculin skin test (TST). The facility also failed to complete a TB risk assessment and develop policies and procedures for the handling of persons with active TB disease and initial and ongoing TB-related training and education for all health care workers. This had the potential to affect all 75 residents residing in the facility, staff and visitors.		Corrected.	
	Findings include:			
	During the survey entrance conference on 5/8/23 at 12:32 p.m. a copy of the facility's TB risk assessment, and the infection control plan with policies and procedures for TB was requested.			
	Nursing assistant (NA)-P's hire date was 3/27/23. NA-P's employee file lacked evidence of symptom screening for active TB.			
	NA-L's hire date was 1/26/23. NA-L's employee filed lacked evidence of symptom screening for active TB			
	Trained medication aid (TMA)-D's hire date was 3/23/23. TMA-D's employee file lacked evidence of symptom screening for active TB.			
	Registered nurse (RN)-H's hire date was 4/6/23.			

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RN-H's employee file lacked evidence of symptom screening for active TB

Activity aide (AA)-A's hire date was 2/8/23. AA-A's employee file identified a first step TST was administered on 2/8/23, however, the record lacked documentation a second TST was completed.

R27 was admitted to the facility on 3/31/23. R27's medical record lacked evidence of a symptom screening for active TB. The record identified R27 was administered a first step TST on 4/6/27 and the second step TST was administered on 4/20/23, however, the results of the test were pending and had not been read.

R1 was admitted to the facility on 4/7/23. R1's medical record identified symptom screening and first step TST were completed/administered on 4/7/23, however results of the TST were pending and had not been read. The record lacked evidence a second TST was completed.

R30 was admitted to the facility on 4/8/23. R30's medical record identified symptom screening was completed on 4/9/23 and the first step TST was administered on 4/8/23, however results of the TST were pending and had not been read. The record lacked evidence a second TST was completed.

R23 was admitted to the facility on 3/13/23. R13's medical record lacked evidence of symptom screening for active TB.

R32 was admitted to the facility on 3/14/23. R32's medical record lacked current symptom screening of active TB. The record identified a

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21426	Continued From page 78 first step TST was administered on 3/16/23, however lacked evidence a second TST had been completed. The facility TB risk assessment and policies and procedures for the facility TB plan including the handling of persons with active TB disease and initial and ongoing TB-related training and education for all health care workers was requested but not provided. During interview on 5/12/23 at 10:32 a.m., the director of nursing (DON) stated he did not have a TB risk assessment for the facility, nor the required policies. All staff should be screened for TB symptoms upon hire and all residents should be screened for TB symptoms upon admission, however he was not certain of the TST requirements. DON verified residents and staff should have been screened and tested as required to prevent the potential transmission of the disease. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the aquisition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21426		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.	21550		7/14/23

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21550	Continued From page 79 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supply and administration of ordered medication for 1 of 1 resident (R25) reviewed for pharmacy services. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/28/23, indicated intact cognition and did not reject care. R25's Medical Diagnosis form from the electronic health record (EHR), indicated the following diagnosis: other constipation. R25's Clinical Physician Orders form indicated an order dated 4/27/23, for Preparation H ointment. Please insert per intra-rectal with applicator for intra-rectal use. Use as directed on packaging. Nurse manager call pharmacy regarding sending this as it is OTC (over the counter). Use applicator and call pharmacy if you question how to administer two times a day for hemorrhoids. R25's Clinical Physician Orders form indicated an order for an appointment on 6/15/23, for anorectal (both the anus and rectum) surgery for hemorrhoids. R25's medication administration record (MAR) and treatment administration record (TAR) dated	21550	Corrected.	

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April 2023, indicated the medication was ordered to be administered "7A to 11" and "HS 19." In the a.m. slot 4/27/23, a number 2 was designated indicating on the chart code the drug was refused. On the HS slot 4/27/23, there was no documentation of the medication given. There were two check marks on the a.m. slot 4/28/23 and 4/30/23, indicating the medication was given, and four time slots (4/28/23 HS 19, 4/29/23 7A-11 and HS 19, and 4/30/23 HS 19) with the number 9 designated indicating "Other/see progress notes." The progress notes were reviewed, but did not identify the reason for "9" designated in the administration time slots.

R25's MAR and TAR dated May 2023, indicated the medication was ordered to be administered "7A-11" and "HS 19". There was a check mark in the 7A-11 slot on 5/1/23, 5/5/23, 5/6/23, 5/7/23, and a check mark in the HS 19 slot on 5/6/23, and 5/7/23, and 5/10/23 indicating the medication was given. A number 9 was designated in the 7A-11 slot on 5/2/23, 5/3/23, 5/4/23, 5/9/23, 5/10/23, and in the HS 19 slot on 5/1/23, 5/2/23, 5/3/23, 5/4/23, 5/5/23, 5/8/23, and 5/9/23 with the number 9 indicating "Other/see progress notes." The progress notes were reviewed, but did not identify the reason for "9" designated in the administration time slots.

During interview on 5/8/23 at 6:05 p.m., R25 stated he had a bleeding hemorrhoid the facility was aware of and R25 requested the Preparation H applicator internal medication 5/5/23, and had not received the medication.

During interview on 5/8/23 at 3:15 p.m., R25 stated the medication did not come on 5/5/23, and was told the medication would arrive 5/6/23. On 5/8/23, R25 received witch hazel pads. R25

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21550	Continued From page 81 stated he spoke with registered nurse (RN)-C who informed him the medication was stolen and instead of receiving the internal applicator, received tucks. During interview on 5/10/23 at 10:35 a.m., licensed practical nurse (LPN)-D stated she thought RN-C followed up on the Preparation H internal applicator ointment and added R25 did not get it most of the time because R25 wanted to administer the medication himself. During interview on 5/10/23 at 11:12 a.m., RN-C stated the pharmacy could not provide the internal applicator Preparation H and stated the medication had been ordered prior to the weekend and added sometimes the pharmacy don't deliver timely and stated only the witch hazel came and the medication was re-ordered. RN-C stated he would follow up again. During interview on 5/10/23 at 11:19 a.m., LPN-D verified the Preparation H ointment intra-rectal medication was not on the medication cart and contacted the pharmacy. LPN-D stated the pharmacy instructed her the medication was not covered by insurance and she requested the cost of the medication for either the facility or the resident to pay for the medication. During interview on 5/10/23 at 1:14 p.m., pharmacist-O stated the Preparation H intra-rectal medication was first ordered 5/10/23, they sent the medication 5/10/23, and billed the facility. Pharmacist-O stated they initially received the order 4/26/23 and on 4/27/23, sent a non covered form and were waiting to hear from the facility. Pharmacist-O stated they don't send medications until they hear back from the facility and they never heard back from the facility.	21550		

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During interview on 5/10/23 at 2:25 p.m., RN-F stated they utilized Thrifty White Pharmacy and if a medication was not received, the nurse on the shift collaborated with the trained medication aide (TMA) to determine why the medication was not delivered and contacts the pharmacy. RN-F stated he expected the medication to be available by the next pharmacy run after the medication was ordered. RN-F explained if the staff contacted the pharmacy at 8:00 p.m., the medication would be available the next day and if the staff contacted the pharmacy at 8:00 a.m., he expected the medication to be available the same day. RN-F stated if a medication is not covered, the cost information is provided to the administrator and the administrator signs a form and the pharmacy delivers the medication. RN-F stated the purpose of the medication was to help relieve itching and eliminate bleeding. RN-F stated signing medications off as administered on the MAR when they are not available was not acceptable. RN-F added it has been difficult to receive medication orders from the pharmacy in between their monthly standard deliveries.

A policy, Administering Medications reviewed November 2022, indicated medications were administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI (quality assurance and performance improvement) committee to inform process changes and or the need for additional staff training.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could

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21550	Continued From page 83 review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the aquisition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain resident rooms in a clean and sanitary condition for 4 of 4 resident rooms (RM 210, RM 213, RM 226, RM 227) and 1 of 3 kitchenette common use areas. This had the potential to affect 27 residents residing on the locked dementia unit. Findings include: During interview on 5/11/23 at 9:40 a.m., housekeeper (HK)-A indicated he had been with the facility for two to three weeks. He stated R62 only wanted her room cleaned two to three times	21695	Corrected	7/14/23

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per week, but the other resident rooms were cleaned every day.

During interview on 5/11/23 at 1:36 p.m., family member (FM)-A stated R426's (room 210) was dirty and she had spoken to the director of nursing about her concerns.

On 5/12/23 at 12:31 p.m., the floor of room 210 was observed to have a clear, tan discoloration approximately four inches wide, around the edges of all of the walls with a buildup of dust and dirt concentrated in the corners of the room and behind the door. At 12:33 p.m. t,he floor of room 213 and the adjoining bathroom were noted to have a tan discoloration approximately four inches wide, around the edges of the walls, with a build up of dust and dirt concentrated in the corners of the room, behind the door, and under the nightstand.

During observation and interview on 5/12/23 at 12:24 p.m., room 210 was reviewed with the maintenance director (MAIN). He stated it looked like the floor of the room had glue from the mopboards which had collected dust and debris and needed to be cleaned.

During observation on 5/12/23 at 12:39 p.m., the floors of room 227 and 226 had similar buildup noted around the edges of the room with dust and debris collected along the perimeter of the room approximately four inches wide and concentrated in the corners and behind the door.

During a tour of the facility on 5/12/23 at 12:45 p.m., the housekeeping/laundry supervisor (HLS) stated housekeeping staff provided deep cleaning of resident rooms Monday through Friday. They washed the bed, walls, tray tables, dusted and

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THE TERRACE AT CRYSTAL LLC	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 85 swept and mopped the floor. Each room was cleaned once per week and as needed. Staff provided a deeper cleaning when a resident was discharged. HLS observed the floors in room 210, 213, 226 and 227 and stated the floors were dirty around the edges and under items and needed to be cleaned. During observation on 5/10/23 at 12:45 p.m., the second floor dining room counter top sink area with the upper and lower cabinets contained three drawers stained with a dripping sticky dry red matter. The handles on the drawers were sticky. The first drawer contained individual sized plastic containers of peanut butter, jelly, packets of Italian fat free dressing, ketchup, mustard, syrup, sugar packets and butter. The drawer had a couple quarter sized area covered with a sticky amber fluid on the bottom right side of the drawer. There were visible stains of sticky matter on several packets. The cabinet above and next to the refrigerator was noted with debris which contained disposable plastic lids and plastic bags and on the upper shelf there was a tray containing small paper packets of salt and pepper. During interview on 5/10/23 at 12:50 p.m., nursing assistant (NA)-N stated the kitchen was responsible for the refrigerator and counter and added she never used the drawers or handles any of the items for the resident because that was the kitchen staff's job. During interview and observation on 5/12/23 at 11:36 a.m., the cabinet drawers on the second floor kitchenette next to the refrigerator had red liquid dripping down the front and pooled on the top of the drawers was a red and brown liquid substance. There were packaged ketchup, apple sauce, sugar packets, butter, and jelly in the top	21695		

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21695	Continued From page 86	21695		

drawer and the front of the drawers and handles were sticky to the touch. Janitor-B stated he was not responsible for cleaning the kitchenette and did not know who was responsible.

During interview and observation on 5/12/23 at 1:05 p.m., the second floor cabinet had a small amount of pink dried substance and there was brown debris on the corner of the cabinet. The HLS verified the dirty cabinet and stated it was the housekeeper's responsibility to clean and expected the area to be cleaned.

A policy, Cleaning and Disinfection of Environmental Surfaces reviewed February 2023, indicated environmental surfaces are cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) bloodborne pathogens standard. The policy defined non-critical items as those that came in contact with skin but not mucous membranes and non-critical environmental surfaces included bed rails, some food utensils, bedside tables, furniture, and floors. Housekeeping surfaces for example floors, and tabletops were cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environment surfaces are disinfected or cleaned on a regular basis (e.g., daily, three times per week) and when surfaces were visibly soiled. Walls, blinds, and window curtains in resident areas are cleaned when surfaces were visibly contaminated or soiled. Horizontal surfaces are wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an EPA (Environmental Protection Agency)-registered hospital disinfectant or detergent.

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21695	Continued From page 87 A policy, Cleaning and Disinfecting Residents' Rooms, reviewed February 2023, indicated housekeeping surfaces for example floors and tabletops are cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Walls, blinds, and window curtains in resident areas are cleaned when surfaces are visibly contaminated or soiled. Horizontal surfaces example bedside tables, overbed tables, and chairs are cleaned daily with a cloth moistened with disinfectant solution. SUGGESTED METHOD OF CORRECTION: The administrator, housekeeping supervisor, or designee could ensure a housekeeping program was developed to ensure ongoing maintenance and preventative houekeeping schedule was completed for the facility and grounds on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure maintenance and ongoing housekeeping is adequately completed within the facilty and the grounds. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a	21805		7/14/23

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21805	Continued From page 88	21805		

health care facility.

This MN Requirement is not met as evidenced by:
Based on observation and interview, the facility failed to treat 1 of 4 residents with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life.

Corrected

Findings include:

R11's quarterly Minimum Data Set (MDS) assessment dated 8/31/2022 indicated they had severe cognitive impairments and needed extensive staff assistance with eating.

During an observation on 5/9/23 at 1:11 p.m., R11 was observed eating lunch in the dining room with supervision of an unknown nursing assistant (NA). Several residents had previously vacated the dining area and empty plates were left on the tables. Cook-A entered the dining area and shouted: "Who cleans up after these feeders?" to the unknown NA.

During an interview on 5/9/23 at 1:22 p.m., Cook-A stated that the term the staff use for residents who require assist with eating was "feeders". Cook-A further stated that she uses that term most of the time for these residents, "just like everyone else does."

During an interview on 5/9/23 at 1:57 p.m., registered nurse (RN)-C stated that staff should refer to those that need assistance with eating as such, and that he was unsure if referring to them as "feeders" was professional.

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21805	Continued From page 89 During an interview on 5/11/23 at 2:12 p.m., the director of nursing (DON) stated that his expectation is that staff would refer to these residents as "needing assistance" as respectfully as possible, and that using the term "feeder" for these residents was undignified and not the facility expectation. A facility policy dated November 2022 indicated staff were to "speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not	21810		7/14/23

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21810	Continued From page 90 reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R72). Findings include: R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs. R72's Care Area Assessment (CAA) dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection. R72's care plan with date of initiation 5/2/23, indicated staff were to keep the call light in reach of R72.	21810	Corrected	

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21810	Continued From page 91 During observation on 5/8/23 at 12:54 p.m., and 4:00 p.m., the call light was on the floor at the head of the bed out of reach of R72. During observation on 5/8/23 at 5:06 p.m., call light was on the floor at the head of the bed out of reach of R72. When asked if she would like to have the call light to ask for help if she needed it, she said, "yes". During observation and interview on 5/8/23 at 7:08 p.m., registered nurse (RN)-A stated R72's call light was again not in reach and verified it was on the floor. "I picked it up from the ground when I came in today and forgot to put the call light next to her this shift". RN-A moved the call light to rest on R72's right side of body. When asked if R72 could access or press the call light on her right side RN-A stated "no" and moved it to the left side of R72's body. During observation on 5/10/23 at 6:17 a.m., the call light was on a floor mat located on the right side of R72's bed, not in reach. During interview with RN-B at 5/10/23 at 7:18 a.m., RN-B stated the call light "should be in reach even if she doesn't use it". During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated R72's call light, "needs to be in reach of her left hand". During interview with nursing assistant (NA)-A on 5/10/23 at 8:56 a.m., stated R72's call light, "should be in reach on her left side because the right side does not work".	21810		

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21810	Continued From page 92 During interview with the director of nursing on 5/11/23 at 1:31 p.m., DON stated expectation staff "should place the call light in reach of the resident every time the staff leaves the room. [R72} does not have the capacity to reach for a call light if it is on the floor or her right side because her right side is not working. The call light should be in reach on her left side where she can press it." The facility policy Answering the Call Light, reviewed November 2022, identified, "the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff	21880		7/14/23

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21880	Continued From page 93 and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident	21880	Corrected	

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Continued From page 94

needs by ensuring the call light was accessible for 1 of 1 resident (R72).

Findings include:

R72's Significant Change Minimum Data Set (MDS) dated 4/29/23, identified an inability to assess cognition, extensive assistance of two plus persons for bed mobility, transfers, dressing, toilet use and personal hygiene. In addition, R72 diagnoses included hemiplegia (paralysis) affecting right dominant side due to a stroke, aphasia (inability to understand or use language due to brain damage), chronic pain syndrome, blood cancer, retention of urine (inability to empty bladder) and an indwelling catheter, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), Pressure ulcer to sacral (region at the bottom of the spine) region, and non-pressure chronic ulcers to both lower legs.

R72's Care Area Assessment (CAA) dated 5/2/23, identified R72 with expressive and receptive communication impairment and physical limitations resulting in need of assistance with any assistance of daily living, restricted mobility, pressure ulcer and urinary tract infection.

R72's care plan with date of initiation 5/2/23, indicated staff were to keep the call light in reach of R72.

During observation on 5/8/23 at 12:54 p.m., and 4:00 p.m., the call light was on the floor at the head of the bed out of reach of R72.

During observation on 5/8/23 at 5:06 p.m., call light was on the floor at the head of the bed out of reach of R72. When asked if she would like to

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21880	Continued From page 95	21880		

have the call light to ask for help if she needed it, she said, "yes".

During observation and interview on 5/8/23 at 7:08 p.m., registered nurse (RN)-A stated R72's call light was again not in reach and verified it was on the floor. "I picked it up from the ground when I came in today and forgot to put the call light next to her this shift". RN-A moved the call light to rest on R72's right side of body. When asked if R72 could access or press the call light on her right side RN-A stated "no" and moved it to the left side of R72's body.

During observation on 5/10/23 at 6:17 a.m., the call light was on a floor mat located on the right side of R72's bed, not in reach.

During interview with RN-B at 5/10/23 at 7:18 a.m., RN-B stated the call light "should be in reach even if she doesn't use it".

During interview with licensed practical nurse (LPN)-B on 5/10/23 at 7:33 a.m., LPN-B stated R72's call light, "needs to be in reach of her left hand".

During interview with nursing assistant (NA)-A on 5/10/23 at 8:56 a.m., stated R72's call light, "should be in reach on her left side because the right side does not work".

During interview with the director of nursing on 5/11/23 at 1:31 p.m., DON stated expectation staff "should place the call light in reach of the resident every time the staff leaves the room. [R72} does not have the capacity to reach for a call light if it is on the floor or her right side because her right side is not working. The call light should be in reach on her left side where she

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21880	Continued From page 96 can press it." The facility policy Answering the Call Light, reviewed November 2022, identified, "the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor." SUGGESTED METHOD OF CORRECTION: The administrator, social services, DON, or designee could review and develop a plan to ensure residents concerns and grievances are being received, tracked and followed up on promptly. The facility could update policies and procedures, educate residents and staff on these changes, and audit periodically. The results of these audits could be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21880		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.	21942		7/14/23

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21942	Continued From page 97 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council during the past calendar year. This had the potential to affect all 75 residents (and their families) who reside at the facility. Findings include: During an interview on 5/11/23 at 1:14 p.m., the administrator stated the facility did not have a family counsel but that he called every family, every month, to offer a family counsel. The administrator was unable to produce any documentation supporting this. During an interview on 5/11/23 at 2:50 p.m., family member (FM)-B, whose family member was admitted to the facility on 3/15/23, stated he had never heard of family counsel and had not been asked to participate in it. During an interview on 5/12/23 at 9:30 a.m., FM-C, whose family member was admitted to the facility on 10/18/21, stated she had never heard of family counsel and had not been asked to participate in it. A policy on family counsel was requested but not received. SUGGESTED METHOD OF CORRECTION: The facility's social worker could contact resident family members via any method, to invite to participate in a family council meeting. The frequency of the family council meetings could be determined by the family council. Documentation of all meetings and attempts should be maintained. If the first attempt does not yield	21942	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	C **05/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21942	Continued From page 98 results, the facility could make another attempt later in the same year. The administrator or designee could monitor the attempts to organize a family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	**3245 VERA CRUZ AVENUE NORTH** **CRYSTAL, MN 55422**

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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 05/09/2023. At the time of this survey, The Terrace At Crystal 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

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	K 000		

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.

The Terrace at Crystal is a 3-story building with a full basement that was constructed in 1971 and was determined to be of Type II (111) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 85 beds and had a

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K 000	Continued From page 2 census of 75 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/09/2023 at 01:32 PM, it was revealed by observation that there was storage of carts, filing cabinets, and other things in the egress corridor in the basement. 2. On 05/09/2023 at 04:23 PM, it was revealed by observation that there was a table blocking the north exit door out of the dining area on the first floor. An interview with the Assistant Maintenance Director verified these deficient findings at the	K 211		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/09/2023**

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K 211	Continued From page 3 time of discovery.	K 211		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.1.3.2, and 7.2.1.5.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/09/2023 at 01:45 PM, it was revealed by observation that the center stairwell door in the basement did not self-latch when the self-closing device was released, the surveyor attempted to close the door five times. 2. On 05/09/2023 at 02:03 PM, it was revealed by observation that the sprinkler pipe at the bottom of the north stairwell was sealed with expanding foam, and when the surveyor asked the Assistant Maintenance Director he stated that he did not know what the foam was and did not have documentation of what the foam was.	K 225		

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K 225	Continued From page 4 3. On 05/09/2023 at 02:03 PM, it was revealed by observation that the north stairwell door in the basement did not self-latch when the self-closing device was released, the surveyor attempted to close the door three times. 4. On 05/09/2023 at 04:09 PM, it was revealed by observation that the door on the second floor to the south stairwell the door handle gets stuck in the down position causing the door to not latch. 5. On 05/09/2023 at 04:40 PM, it was revealed by observation that the center stairwell door on the first floor has a small hole in it above the door handle. 6. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the keypad to unlock the egress door into the north stairwell was 71" above the finished floor. 7. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the keypad to unlock the egress door into the center stairwell was 79" above the finished floor. 8. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the keypad to unlock the egress door into the south stairwell was 71" above the finished floor. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 225		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		

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K 291	Continued From page 5 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.3.1, and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the emergency lighting in the facility had been tested. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		

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K 321	Continued From page 6	K 321		

protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.
19.3.2.1, 19.3.5.9

Area Automatic Sprinkler
Separation N/A
a. Boiler and Fuel-Fired Heater Rooms
b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 64 gallons)
e. Trash Collection Rooms
(exceeding 64 gallons)
f. Combustible Storage Rooms/Spaces
(over 50 square feet)
g. Laboratories (if classified as Severe
Hazard - see K322)
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, 19.3.2.1.5, 8.4.3.5, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility.

Findings include:

1. On 05/09/2023 at 01:49 PM, it was revealed by observation that the door to room B14 had a cart blocking the door causing the door to not self-close. Room B14 had boxes of paper and carts stored in it.

2. On 05/09/2023 at 02:01 PM, it was revealed by observation that the maintenance shop door did not have a self-closing device installed on it.

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K 321	Continued From page 7 3. On 05/09/2023 at 02:05 PM, it was revealed by observation that the laundry room door in the basement was held open with a rubber wedge causing the door to not self-close. 4. On 05/09/2023 at 02:05 PM, it was revealed by observation that the surveyor could see into the laundry room from the corridor through a broken ceiling tiles and a vent in the wall. 5. On 05/09/2023 at 04:51 PM, it was revealed by observation that the resident room 120 had been turned into a storage room and there was not a self-closing device installed on the door. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 321		
K 324 SS=E	Cooking Facilities 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	K 324		

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K 324	Continued From page 8 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 inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have a patterened impact on the residents within the facility. Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that their kitchen hood system had been inspected. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		

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K 345	Continued From page 9 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect, test, and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1, 14.3.4, 14.4.5, 14.4.5.3, 14.4.5.3.2, and 14.4.5.3.3 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide up-to-date documentation showing that they have completed an annual fire alarm system test. 2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have completed sensitivity testing of the smoke detectors in the facility. 3. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide	K 345		

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K 345	Continued From page 10 documentation showing that they have completed a semi-annual visual inspection of the fire alarm system. 4. On 05/09/2023 at 10:10 AM, it was revealed by observation that there was paint covering part of the horn strobe located on the second floor near the nurse's station. 5. On 05/09/2023 at 16:21 PM, it was revealed by observation that there was paint covering part of the horn strobe located near room 103. An interview with the Maintenance Director and the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 345		
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 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		

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K 353	Continued From page 11	K 353		

This REQUIREMENT is not met as evidenced by:
Based on a review of available documentation and staff interview, the facility failed to inspect, test, and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, 9.7.5, and 9.7.8, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.2.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.2.2, and 5.4.1.4.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.4.1.1.1. These deficient findings could have a widespread impact on the residents within the facility.

Findings include:

1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that facility could not provide documentation showing that they have had their annual fire sprinkler system inspection completed.

2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide any quarterly fire sprinkler inspection reports.

3. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that there were wires attached to the sprinkler pipe above the ceiling in the corridor near room 313.

4. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that there were wires attached to the sprinkler pipes above

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THE TERRACE AT CRYSTAL LLC	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(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
K 353	Continued From page 12 the ceiling in the corridor near room 200. 5. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the air duct was propped up with blocks on the sprinkler pipes above the ceiling in the corridor near room 200. 6. On 05/09/2023 at 10:16 AM, it was revealed by observation that there were wires attached to the sprinkler pipe above the ceiling near the nurse's station on the first floor. 7. On 05/09/2023 at 10:23 AM, it was revealed by observation that there were wires attached to the sprinkler pipe above the ceiling in the corridor near room 101. 8. On 05/09/2023 at 01:41 PM, it was revealed by observation that there was paint on the sprinklers located in the kitchen storage in the basement. 9. On 05/09/2023 at 01:51 PM, it was revealed by observation that there was a piece of plastic on a sprinkler located in room B27 physical therapy. 10. On 05/09/2023 at 01:51 PM, it was revealed by observation that there were missing ceiling tiles and it was 16" to the hard deck above in room B27 physical therapy. 11. On 05/09/2023 at 02:40 PM, it was revealed by observation that there were spare sprinklers in the sprinkler box without a spot and were laying on their sides. 12. On 05/09/2023 at 04:04 PM, it was revealed by observation that there were missing ceiling tiles and it was more than 12" to the hard deck	K 353		

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K 353	Continued From page 13 above in the soiled utility room on the second floor. 13. On 05/09/2023 at 04:32 PM, it was revealed by observation that there were signs of oxidation and corrosion on the sprinklers in the kitchen near the dishwashing area. 14. On 05/09/2023 at 04:44 PM, it was revealed by observation that there were missing ceiling tiles and it was 19" to the hard deck above in utility closet 1J on the first floor. An interview with the Maintenance Director and the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1, 7.2.1.2, 7.3.1.1.1, and 7.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 355		

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K 355	Continued From page 14 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the fire extinguisher annual inspection report that the facility provided was out of date (03/30/2022), and the tags on the fire extinguishers were also out of date (3/2022). 2. On 05/09/2023 at 04:47 PM, it was revealed by observation there were wheelchairs blocking the fire extinguisher on the first floor near room 116. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 355		
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 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	K 363		

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K 363	Continued From page 15 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 19.3.6.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/09/2023 at 04:25 PM, it was revealed by observation that there was a small hole in the door to the kitchen from the dining room. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 363		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		

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K 372	Continued From page 16	K 372		

Construction
2012 EXISTING
Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.
19.3.7.3, 8.6.7.1(1)
Describe any mechanical smoke control system in REMARKS.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility.

Findings include:

1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that there was a gap between the cement and drywall in the smoke barrier above the smoke barrier doors near room 313.

2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that expandable foam was used to seal the smoke barrier wall above the ceiling near room 313, and the Assistant Maintenance Director did not have any information on what the expandable foam was listed to be used for.

3. On 05/09/2023 at 10:07 AM, it was revealed by

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K 372	Continued From page 17 observation that there was a hole in the smoke barrier caused by wires and the sealant between the cement and the drywall was falling off above the ceiling near room 200. 4. On 05/09/2023 at 10:16 AM, it was revealed by observation that the smoke barrier was not sealed where the cement meets the drywall above the ceiling near the nurses station on the first floor. 5. On 05/09/2023 at 10:24 AM, it was revealed by observation that there was a hole in the smoke barrier near room 101. 6. On 05/09/2023 at 10:39 AM, it was revealed by observation that the smoke barrier near the maintenance shop was fire-stopped using expanding foam and the Assistant Maintenance Director did not have information on what the expanding foam was listed to be used for. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 372		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and	K 374		

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K 374	Continued From page 18 are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the smoke barrier doors in the basement near the maintenance room would not fully close because they would stop on the door coordinator. 2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that both sets of smoke barrier doors located on the second floor were locked with a maglock requiring a keypad to unlock. 3. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the smoke barrier doors on the second floor near room 213 were obstructed by a cart causing the doors to not fully close. 4. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the smoke barrier doors in the basement near the maintenance room would not fully close because they would stop on the door coordinator.	K 374		

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K 374	Continued From page 19 5. On 05/09/2023 at 04:20 PM, it was revealed by observation that the smoke barrier doors near room 101 would not fully close because they would stop on the door coordinator. 6. On 05/09/2023 at 04:38 PM, it was revealed by observation that the smoke barrier doors in the basement near the administrator's office on the first floor would not fully close because they would stop on the door coordinator. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 374		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clearance in front of electrical equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, and NFPA 70 (2011 edition), National Electrical	K 511		

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K 511	Continued From page 20 Code, section 110.26. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation there was storage blocking the electrical panels in the basement electrical room. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient finding could have a widespread impact on the residents within the facility.	K 521		

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K 521	Continued From page 21 Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have had their fire dampers inspected within the last four years. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 521		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. These deficient findings could have a widespread impact on the residents within the facility.	K 711		

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K 711	Continued From page 22 Findings include: 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed in a review of available documentation that the facility's fire safety plan did not include an emergency phone call to the fire department. 2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed in a review of available documentation that the facility's fire safety plan did not include the transmission of alarms to the fire department. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 711		
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 per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. These deficient findings	K 712		

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K 712	Continued From page 23 could have a widespread impact on the residents within the facility. Findings include: 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed in a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during the first shift during the fourth quarter of 2022. 2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed in a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during the second shift during the fourth quarter of 2022. An interview with the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 712		
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741		

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K 741	Continued From page 24 that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to maintain outside smoking areas per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/09/2023 at 11:24 AM, it was revealed by observation that there was a large amount of discarded cigarettes on the ground in the employee smoking area and the noncombustible ashtray in that area was full. 2. On 05/09/2023 at 04:15 PM, it was revealed by observation that there was a large amount of discarded cigarettes on the ground out front of the building. An interview with the Assistant Maintenance	K 741		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	**3245 VERA CRUZ AVENUE NORTH** **CRYSTAL, MN 55422**

(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
K 741	Continued From page 25 Director verified these deficient findings at the time of discovery.	K 741		
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 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 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed in a review of available documentation that the facility could not provide an updated fire door inspection report the last	K 761		

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K 761	Continued From page 26 report that was completed on 01/26/2022. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 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 provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility was unable to provide an NFPA 99 Risk Assessment. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 901		

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K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), Life Safety Code, sections 314.25 and 406.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/09/2023 at 01:31 PM, it was revealed observation that there is an electrical outlet in the conference room in the basement that was hanging out of the wall. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 912		
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	K 914		

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K 914	Continued From page 28 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. 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 05/09/2023 at 01:31 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that they have tested electrical receptacles located in patient care rooms. An interview with the Assistant Maintenance	K 914		

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K 914	Continued From page 29 Director verified this deficient finding at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		

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K 918	Continued From page 30 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the generator annunciator had trouble lights that were illuminated, and when the surveyor asked the Assistant Maintenance Director he stated, "I have no clue what the lights mean". Maintenance staff then informed the surveyor that they have had a temporary generator onsite for four years because their generator has a bad motor. Later while talking with Bill Abderhalden the State Fire Safety Supervisor of Health Care and Correctional Facilities he stated that the temporary generator had been onsite roughly for one year. The annunciator that has the trouble lights illuminated was not connected to the temporary generator, so there was no annunciator for the temporary generator located in a 24-hour monitored location. 2. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that there was not an emergency stop button located on the	K 918		

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K 918	Continued From page 31 outside of the generator. 3. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation of weekly generator inspections completed before March of 2023. 4. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide any documentation of monthly generator testing and maintenance. 5. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. 6. On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fuel quality test had been performed within the last year. An interview with the Maintenance Director and the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		

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K 920	Continued From page 32 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1, 10.2.4, and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/09/2023 at 10:31 AM, it was revealed by observation that there was an extension cord near the front doors that went above the ceiling and appeared to be powering the motor for the	K 920		

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K 920	Continued From page 33 automatic door. 2. On 05/09/2023 at 01:41 PM, it was revealed by observation that there was a refrigerator plugged into an extension cord in the kitchen storage room in the basement. 3. On 05/09/2023 at 01:43 PM, it was revealed by observation that there were two power strips plugged into one power strip in the billing office (B1). 4. On 05/09/2023 at 04:35 PM, it was revealed by observation that there was a Hoyer lift battery charger plugged into a power strip in the nurse's station office. An interview with the Maintenance Director and the Assistant Maintenance Director verified these deficient findings at the time of discovery.	K 920		
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 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	K 926		

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K 926	Continued From page 34 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 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the staff in the facility have been trained on the risks associated with their handling and use. An interview with the Maintenance Director and the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 926		
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen transfilling rooms per NFPA 99 (2012 edition), Health Care Facilities	K 927		

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K 927	Continued From page 35 Code, section 11.5.2.3.1 (1). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/09/2023 between 09:15 AM and 05:15 PM, it was revealed by observation that the door to the oxygen transfill room on the third floor would not automatically latch when tested three times. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 927		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 28, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On April 26, 2023, we informed you of imposed enforcement remedies.

On August 3, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K0225 -- S/S: F -- NFPA 101 -- Stairways And Smokeproof Enclosures Bld: 01
K0321 -- S/S: E -- NFPA 101 -- Hazardous Areas - Enclosure Bld: 01
K0324 -- S/S: E -- NFPA 101 -- Cooking Facilities Bld: 01
K0345 -- S/S: F -- NFPA 101 -- Fire Alarm System - Testing And Maintenance Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 01
K0355 -- S/S: F -- NFPA 101 -- Portable Fire Extinguishers Bld: 01
K0372 -- S/S: F -- NFPA 101 -- Subdivision Of Building Spaces - Smoke Barrie Bld: 01
K0374 -- S/S: F -- NFPA 101 -- Subdivision Of Building Spaces - Smoke Barrie Bld: 01
K0521 -- S/S: F -- NFPA 101 -- Hvac Bld: 01
K0741 -- S/S: E -- NFPA 101 -- Smoking Regulations Bld: 01
K0761 -- S/S: F -- NFPA 101 -- Maintenance, Inspection & Testing - Doors Bld: 01
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 01
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 01
K0918 -- S/S: F -- NFPA 101 -- Electrical Systems - Essential Electric Syste Bld: 01
K0926 -- S/S: F -- NFPA 101 -- Gas Equipment - Qualifications And Training Bld: 01

As a result of the revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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.

As we notified you in our letter of April 26, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions

(42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2023 (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 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.

APPEAL RIGHTS

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

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On April 26, 2023, we informed you of imposed enforcement remedies.

On October 16, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is 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:

K0324 -- S/S: E -- NFPA 101 -- Cooking Facilities Bld: 01
K0521 -- S/S: F -- NFPA 101 -- Hvac Bld: 01
K0918 -- S/S: F -- NFPA 101 -- Electrical Systems - Essential Electric Syste Bld: 01

As a result of the revisit findings:

• Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2023.

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.

As we notified you in our letter of April 26, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us