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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2U04

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00522

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245267**
2.STATE VENDOR OR MEDICAID NO.
(L2) **369742800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ANTHONY HEALTH & REHABILITATION**
(L4) **3700 FOSS ROAD NORTHEAST**
(L5) **ST ANTHONY, MN** (L6) **55421**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 07/13/21 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **140** (L18)
13.Total Certified Beds **140** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	140			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jamie Perell, Unit Supervisor 07/21/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/03/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 20, 2021

CMS Certification Number (CCN): 245267

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

Dear Administrator:

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

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

Effective June 29, 2021 the above facility is certified for:

140 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 140 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 20, 2021

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: CCN: 245267
Cycle Start Date: May 24, 2021

Dear Administrator:

On June 16, 2021, we notified you a remedy was imposed. On July 13, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 29, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 1, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 16, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 24, 2021. This does not apply to or affect any previously imposed NATCEP loss.
The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2U04

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(L4) **3700 FOSS ROAD NORTHEAST**
(L5) **ST ANTHONY, MN** (L6) **55421**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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13.Total Certified Beds **140** (L17)

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	140			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Ann Peterson, HFE NE II — 06/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 07/21/2021 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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07/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
June 16, 2021

Administrator
St Anthony Health & Rehabilitation
3700 Foss Road Northeast
St Anthony, MN 55421

RE: CCN: 245267
Cycle Start Date: May 24, 2019

Dear Administrator:

On May 24, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 20, 2021, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

On May 24, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2021.

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

This Department is also recommending 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 1, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2021, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Anthony Health & Rehabilitation is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 24, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro A 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: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 November 24, 2021 (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 DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the

conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded

by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245267	A. BUILDING _____ B. WING _____	C 05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421**

(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 5/17/21, through 5/24/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 004		6/29/21

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

Electronically Signed | 06/17/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. BUILDING _____ B. WING _____	C 05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421**

(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 004	Continued From page 1 that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility's emergency plan was reviewed and updated annually. This had the potential to affect all 86 residents who resided at the facility. Findings include: Review of the facility's Emergency Operations Plan (EOP) revealed it was last reviewed on 11/7/19.	E 004	E004 □ Develop EP Plan, Review and Update Annually 1. - The executive director, Director of Maintenance, and nursing department designee (DON, Nurse Manger) reviewed and updated the emergency preparedness plan and documented the date of the review. 2. - It is understood that all current and new residents have the potential to be affected by not reviewing and ensuring the	

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E 004	Continued From page 2 On 5/23/21, at 2:00 p.m. the administrator confirmed the EOP was last reviewed on 11/7/19, and had not been reviewed again to ensure it was effective in case of an emergency. The administrator stated this was something he needed to do this year.	E 004	emergency preparedness plan is current and effective. 3. - The executive director will add to the standing QAA Agenda the requirement to review the EP Plan on an annual basis. The executive director will set a reminder in the previous months QAA meeting of the upcoming plan to review the EP Plan and set a calendar reminder. 4. - At the next QAA meeting on 6/24/2021 the EP plan will be reviewed utilizing the QAPI process. The standing QAA agenda will be noted to include an annual review along with the stated next due date. This will be noted at each monthly QAA meeting in an ongoing manner. 5. - This deficiency will be corrected by 6/29/2021.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		6/29/21

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E 007	Continued From page 3 plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's emergency preparedness plan (EPP) failed to identify resident populations including, but not limited to: residents most at-risk during an emergency; the type of services the facility has the ability to provide in an emergency; and, continuity of operations, including delegations of authority and succession plans. This had the potential to affect all 86 residents in the facility. Findings include: Review of the facility EPP dated 11/7/19, indicated no plan was documented to address the facility's at-risk populations, delegation of authority, or the types of services the facility could provide in the event of an emergency. The EPP also lacked indication of a plan for continuity of care of the residents during an emergency.	E 007	E007 □ EP Program Patient Population 1. - The administrator, with assistance from nursing (DON, Nurse Managers), updated the emergency preparedness plan to include the required missing elements: a. Identify resident□s most at risk during an emergency; b. Type of services the facility has the ability to provide in an emergency; c. Continuity of operations, including delegations of authority and succession plans. 2. - It is understood that all current and new residents have the potential to be affected by not having all the required elements in place in the emergency preparedness plan. 3. - Utilizing QAPI process, under EP, review current patient population for at	

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E 007	Continued From page 4 During an interview on 5/23/21, at 2:00 p.m. the administrator stated in an emergency situation, all residents would be treated the same and there was no plan to address special populations.	E 007	risk residents and update EP plan as necessary. - All staff will be trained/educated on the new elements of the EP plan during scheduled education the week of 6/21/2021. 4. - At the next QAA meeting on 6/24/2021 the EP Plan will be reviewed utilizing the QAPI process. The EP Plan will be an ongoing QAA agenda item, included in the EP agenda will be a review of the current resident population. 5. - This deficiency will be corrected by 6/29/2021.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	E 032		6/29/21

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E 032	Continued From page 5 *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness plan (EPP) addressed alternative means of communication with staff and outside agencies in the event of an emergency. This had the potential to affect all 86 residents in the facility. A review of the facility EPP dated 11/7/19, indicated no alternative means of communication with staff or federal, state, tribal, regional, and local emergency management agencies in the event of telephone or cellular device failure. During an interview on 5/23/21, at 2:00p.m. the administrator stated there was one emergency telephone with a list of emergency contact phone numbers. The administrator confirmed there were no other means of communicating with staff or emergency agencies in the event of telephone service failure.	E 032	E032 □ Primary/Alternate Means for Communication 1. - The executive director updated the emergency preparedness plan to include primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies, such as a message board, or system, like payroll that all staff logs onto, initiation of calling tree. Facility purchased a satellite phone to be used in the event of an emergency. 2. - It is understood that all current and new residents have the potential to be affected by not having all the required elements in place in the emergency preparedness plan. 3. - Utilize QAPI process, under EP agenda review contact lists to ensure information is current. - All staff will be trained/educated on the new elements of the EP plan during scheduled education the week of 6/21/2021. 4. - At the next QAA meeting on 6/24/2021 the EP Plan will be reviewed utilizing the QAPI process. The EP Plan will be an ongoing QAA agenda item, included in the EP agenda will be a review of the current communication plan. 5. - This deficiency will be corrected by 6/29/2021.	

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F 000	INITIAL COMMENTS	F 000		

On 5/17/21 through 5/24/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The survey resulted in findings of immediate jeopardy (IJ), at F678, when it was determined R26 would not had received cardiopulmonary resuscitation (CPR) in accordance with their wishes due to discrepancies identified the medical record. The administrator was notified of the IJ on 5/18/21, at 1:30 p.m. The IJ was removed on 5/20/21, at 2:57 p.m., however, non-compliance remained at the lower scope and severity of D, isolated which indicated no actual harm with potential for more than minimal harm that is not IJ.

An additional IJ, at F689, was identified when it was determined the facility failed to provide supervision, as directed by the care plan, for R75 when eating. R75 began to choke and staff did not respond until alerted by a surveyor. The director of nursing (DON) was notified of the IJ on 5/21/21, at 4:12 p.m. The IJ was removed on 5/24/21, at 10:08 a.m., however non-compliance remained at the lower scope and severity level of E, pattern which indicated no actual harm with potential for more than minimal harm that is not IJ.

The above findings constituted substandard quality of care, and an extended survey was conducted on 5/20/21.

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F 000	Continued From page 7 The following complaints were found to be SUBSTANTIATED: H5267146C (MN73067), H5267139C (MN58537), H5267143C (MN72105) with a deficiency cited at F689. H5267140C (MN70034) with a deficiency cited at F686. The following complaints were found to be UNSUBSTANTIATED: H5267137C (MN56801/MN56809) H5267138C (MN57036) H5267141C (MN61332) H5267142C (MN61385) H5267144C (MN72308) H5267145C (MN68452) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
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	F 676		6/29/21

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F 676	Continued From page 8 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, (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 implement a therapy recommended walking program for 1 of 1 resident (R22) reviewed for rehabilitation. Further, the facility failed to provide assistance removing facial hair and/or provide nail care for 2 of 11	F 676	F676 □ Activities Daily Living (ADLs)/Mntn Abilities 1. R22 □ PT evaluated on 6/4, currently working with therapy, discharge date from therapy anticipated 1.5 weeks from 6/23/21, anticipated to be placed on	

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F 676	Continued From page 9 residents (R37 and R23) reviewed for activities of daily living. Findings Include: R22's diagnoses included abnormal gait and mobility, weakness, history of falls with a displaced left femur fracture, and dementia obtained from the quarterly Minimum Data Set (MDS) dated 2/25/21. The MDS also identified R22 required extensive physical assistance of two staff for bed mobility, transfers, dressing, toileting and personal hygiene. In addition, the MDS indicated R22 had severely impaired cognition, did not walk in the room or in the corridor during the assessment period. R22's care plan dated 11/16/21, identified R22 had a activities of daily living (ADL) problem related to shortness of breath, weakness, and falls. The care plan directed staff to, "Ambulate 50 feet 3 times daily..." R22's physical Therapy (PT) discharge summary dated 2/3/21, recommended R22 ambulate with contact guard assist (CGC) up to 273 feet with encouragement using a rolling walker. In addition, the assessment identified R22 was to be in a restorative nursing program to prevent a decline and maintain current level of performance. Review of the medical record revealed R22's medical record lacked documentation of R22 being on a restorative nursing program, per PT recommendation at discharge. Further, the medical record lacked evidence R22 had been assisted to walk/ambulate since being discharged from PT.	F 676	walking program with PT aide upon discharge from PT. R37 □ Updated care plan to include and address grooming needs. - Facial hair has been removed per resident□s preference 6/17/21, facial hair removal preference has been added to resident summary POC for staff reference. - Toenails have been trimmed by nurse. - Follow up with R37 and place on podiatry list if she is agreeable. R23 □ Assess R23s ADL ability to ensure ability and assistance directed on NAR report/service task and care plan is current and correct, update if needed. - Facial hair has been removed per resident□s preference 6/17/21, facial hair removal preference has been added to resident summary POC for staff reference. 2. Care plans of residents on walking maintenance programs will be reviewed and updated, if needed, with current walking program, ambulation ability, and level of staff and/or equipment support needed. - Review diabetic residents charts/care plans for podiatry services and/or that they specify a nurse is to cut the toenails. - Review resident charts/care plans to be reviewed/updated to reflect residents current grooming needs and preferences. 3. - Nursing staff will be trained/educated on grooming expectations during education scheduled for the week of 6/21/2021. - Develop and implement action rounds to be completed each shift to audit current	

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F 676	Continued From page 10 During interview on 5/17/21, at 2:03 p.m. family member (FM)-D stated two-to-three days after R22 was admitted to the facility, he had a fall and sustained a fracture. FM-D stated she thought therapy had been working with R22 to strengthen him so she would be able to care for R22 at home. FM-D stated she had brought up, during a meeting with the director of social services (DSS), the need for therapy to follow-up with R22 with ambulating and completing basic cares. FM-D stated she was told the facility was going to work with R22. On 5/19/21, at 7:16 a.m. R22 was observed seated in the wheelchair in the TV lounge. R22 stated he had not been assisted to walk during the morning. -At 8:35 a.m. R22 wheeled himself out of the dining room and down the hallway and went to his room. R22 self-transferred himself to bed. On 5/20/21, at 7:55 a.m. R22 was observed propel his wheelchair down the hallway towards the dining room. When R22 got to the dining room entrance, the environmental service director wheeled R22 to a table. -At 8:37 a.m. R22 was observed to wheel himself out of the dining room. Registered nurse (RN)-D approached R22 and asked him to wait for her as she was going assist him to his room and into bed. During interview on 5/20/21, at 2:06 p.m. registered nurse (RN)-D reviewed R22's medical record and verified R22 was not being ambulated per the PT recommendations. RN-D was previously not aware R22 was on a walking program and stated, "we should put him on a walking program."	F 676	identified deficient practices and identify emerging deficient practices. This tool will be used ongoing, past survey compliance. - Nursing staff to be trained/educated on action round tool during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. Audit bath sheets and/or nurses notes weekly to verify that toenails have been cut when needed and facial hair removed as appropriate. Audit at least once a week for 4 weeks, decrease auditing schedule based on compliance. - Observational audits of facial hair, trimmed/clean nails, general cleanliness via action rounds completed each shift daily ongoing. 5. This deficiency will be corrected by 6/29/2021.	

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During interview on 5/21/21, at 8:11 a.m. the director of nursing (DON) stated the staff was supposed to follow the care plan which included ambulating R22 per physical therapy's recommendations. During a follow-up interview at 9:46 a.m. the DON stated she reviewed R22's medical record and confirmed there was not documentation of R22 being walked per PT recommendations. The DON stated she was going to follow-up to ensure walking was added for staff moving forward.
R37's Face Sheet dated 5/20/21, indicated R37's diagnosis included type 2 diabetes mellitus without complications, generalized muscle weakness, and unspecified abnormalities of gait and mobility.

R37's quarterly Minimum Data Set (MDS) dated 3/16/21, indicated R37 was cognitively intact, utilized a wheelchair, and required two person assistance for personal hygiene. The MDS further indicated R37 had refused a shower during the assessment period.

R37's care plan dated 12/12/20, indicated R37 had a self-care deficit and required assistance with activities of daily living (ADLs). R37 needed assistance of two staff for bathing. The care plan did not identify grooming needs for R37.

R37's progress notes dated 3/26/21, indicated, R37 required extensive assistance with grooming and bathing. R37's level of care fluctuated and was dependent upon pain, weakness, and mood.

When interviewed on 5/17/21, at 2:08 p.m. R37 stated, "My toenails have not been cut for 6 months." R37's feet were unable to be observed

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at this time.

During an observation on 5/18/21, at 2:48 p.m. R37 had visible facial hair above her lip, on her chin, and up the sides of her cheeks about one-fourth to one-half inch in length.

When observed on 5/19/21, at 8:02 a.m. R37's facial hair remained unchanged. R37 stated, "Before I came here I took care of that, but I don't have any tweezers here. I always plucked them out or cut them with a scissors. I don't have a scissors here." R37 stated she would like staff assistance in managing her facial hair, but did not want it shaved. R37 stated she preferred to have it tweezed or cut with scissors. R37 stated she had asked staff to cut her toenails for three months and stated, "They make my toes hurt." R37 stated, "It makes me feel very pissed off."

When interviewed on 5/19/21, at 8:13 a.m. nursing assistant (NA)-K stated she was not aware that R37 wanted her toenails cut and experienced pain. At 8:20 a.m. NA-K verified the presence of R37's facial hair and stated, "Yeah, I see the little beard. She doesn't want it shaved." NA-K stated she needed to check with the nurse about other methods of removing facial hair such as tweezing or cutting. NA-K verified R37's toenail length and stated they, "Need a little bit of trimming." NA-K stated she needed to check with the nurse to see if R37 was diabetic. NA-K stated, "if she is not diabetic, I can trim it. It looks a little bit long." NA-K stated she also believed the facility occasionally offered podiatry services.

When interviewed on 5/19/21, at 1:33 p.m. licensed practical nurse (LPN)-A verified R37's facial hairs were, "overgrown" and stated when

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staff identified this, they were supposed to trim the facial hairs. LPN-A verified R37's toenail length which were one-eight to one-quarter of an inch long. LPN-A stated, "Yeah it should be trimmed" and verbalized whether the nurses trimmed nails when a resident was diabetic.

When interviewed on 5/19/21, at 1:55 p.m. registered nurse (RN)-A stated the facility would not provide tweezing of facial hair for residents as it was, "too time intensive." RN-A stated, "We could trim her up with the scissors." RN-A verified a nurse could trim R37's toenails as she was diabetic and stated, "Yeah, she needs to see a podiatrist."

When interviewed on 5/20/21, at 7:26 a.m. RN-A stated she believed it was, "possible" for R37 to clip her own toenails and trim her own facial hair.

When interviewed on 5/20/21, at 7:30 a.m. trained medication assistant (TMA)-A stated R37 would not be able to trim her own toenails due to "shaking from medications." TMA-A stated R37 would not be able to cut her own facial hair as, "She might accidentally cut herself, so I am thinking no."

When interviewed on 5/21/21, at 10:29 a.m. the director of nursing (DON) stated grooming is usually done on the bath day, or as requested and staff are expected to assist with this.
R23's Face Sheet dated 11/17/10, indicated R23 had a diagnoses of dementia, mild intellectual disability, and major depressive disorder.

R23's admission Minimum Data Set (MDS) dated 2/20/21, indicated R23 had intact cognition. The MDS also indicated R23 required supervision with

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F 676	Continued From page 14 an assist of one staff for personal hygiene. R23's Care Area Assessment (CAA) dated 2/20/21, indicated R23 had potential for more independence with activities of daily living (ADLs) and fluctuating ADLs. R23's care plan dated 10/4/17, indicated R23 had a grooming deficit and required a limited assist of one staff. The care plan further indicated R23 refused cares. R23's Nursing Assistant Report (NAR) undated, indicated nursing assistants were to assist R23 to remove facial hair. During an observation on 5/17/21, at 1:18 p.m. R23 was observed in her room with gray, curly hair, across the length of her chin which was visible from greater than five feet away. During an observation and interview on 05/18/21, at 2:25 p.m. R23 was laying in bed with her arm over her chin. R23 stated staff assisted her get dressed in the morning, but did not shave her face. R23 moved her arm and curly, gray hair was seen across R23's chin from greater than five feet away. R23 stated it bothered her sometimes and she would like staff to help her remove it. R23 stated she had asked staff for assistance a while ago but they had not helped her. During an interview on 5/18/21, at 2:31 p.m. nursing assistant NA-E stated R23 could perform her own cares without assistance and was unaware if R23 had a razor. During an interview on 5/18/21, at 2:38 p.m.	F 676		

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F 676	Continued From page 15 licensed practical nurse (LPN)-B stated either family or the facility could provide a razor for a resident. LPN-B stated R23 was independent with cares and had not approached R23 to assist her with cares. On 5/19/21, at 8:45 a.m. R23 was observed laying in bed with less, but still visible from greater than five feet away, gray hair under her chin. R23 stated she shaved herself the evening before and felt better. R23 stated staff did not assist her. During an interview on 5/19/21, at 1:14 p.m. registered nurse (RN)-A stated if a resident required a limited assist of one for grooming, staff should assist the resident by setting up items such as razors. RN-A stated there was no clear expectation or process for female residents with facial hair. RN-A stated if staff noticed female residents with facial hair, they should have approached the resident and assisted the resident to shave. RN-A stated male residents were assessed daily for facial hair; however, shaving was not a task that was charted. RN-A stated she was not aware of R23's facial hair. Facility policy titled Activities of Daily Living revised 10/25/20, directed the facility was to provide necessary services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.	F 676		
F 677 SS=E	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	F 677		6/29/21

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F 677	Continued From page 16 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hairs were removed, oral and nail care was offered/provided, and/or assistance eating was offered/provided for 4 of 11 residents (R15, R73, R35, R64, R68), who were dependent upon staff for assistance for activities of daily living (ADLs). Findings include: R15's diagnoses included Alzheimer's disease and dementia without behavioral disturbance obtained from the annual Minimum Data Set (MDS) dated 5/21/21. In addition, the MDS indicated R15 had severely impaired cognition and no behaviors which included refusal of care. R15 required extensive assistance with personal hygiene and eating. R15's care plan dated 6/20/19, identified R15 had an ADL deficit related to history of a left hip fracture and weakness. The care plan directed R15 required assistance of one staff with which included grooming. On 5/17/21, at 12:03 p.m. R15 was observed seated in a wheelchair at a dining room table. R15 was noted to have multiple white and gray one inch long facial hairs on her upper and lower chin and both corners of the mouth. On 5/18/21, at 7:50 a.m. R15 was observed seated in a wheelchair at a dining room table and appeared dressed for the day. R15 still had the facial hairs from the previous day.	F 677	F677 □ ADL Care Provided for Dependent Residents 1. R15 □ Shave/remove facial hair if not already completed □ If resident routinely refuses, note this on the care plan and that resident rights will be honored. - Oral care verified and observed to be completed on 6/23/21 and will be verified ongoing through action rounds. R73 □ Shave/remove facial hair if not already completed □ If resident routinely refuses, note this on the care plan and that resident rights will be honored. - Cut fingernails, if not already completed and clean hands around fingernails. - If nails cannot be cut by staff, verify R37 is on the podiatry list. R15, R35 and R64 □ Review care plan and NAR tasks to verify that eating assistance is addressed, update if needed. 2. Identify all residents who require assistance with eating, review, and update, if needed NAR tasks and care plan. 3. - Staff will be trained/educated on grooming expectations during education scheduled the week of 6/21/2021. - Residents that require assistance will be brought to the dining room for supervision, residents have the right to refuse and those who choose to remain in their room will be supervised. Supervision will be conducted by nursing staff or	

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F 677	Continued From page 17 On 5/18/21, at 2:53 p.m. R15 was observed seated in a wheelchair in the TV lounge and was being assisted to an activity by the life enrichment director (LED). On 5/19/21 8:12 a.m. to 8:28 a.m. nursing assistant (NA)-F was observed to assist R15 with morning cares. NA-F applied gloves, approached R15 with a wet wash cloth, and was observed wipe R15's face down and pat it dry. NA-F then wiped R15's armpits and dried them. NA-F assisted R15 apply a blouse, socks, and pants to the knees. -At 8:25 a.m. NA-F cued R15 he was going to assist R15 to sit on the edge of bed. -At 8:26 a.m. NA-F moved a wheelchair close to R15's bed and assisted R15 to stand up, pulled R15's pants up, and guided R15 to sit in a wheelchair. NA-F never offered to remove R15's facial hairs which were visible while standing 10 feet away. -At 8:27 a.m. NA-F went to R15's bathroom, got a comb, and cued R15 he was going to comb her hair. NA-F then wheeled R15 out of the room to the TV lounge. NA-F did not offer oral care to R15. -8:31 a.m. TMA-A approached R15 and wheeled the resident into the dining room. Removal of facial hairs or oral care was not offered. On 5/19/21, at 11:10 a.m. NA-F assisted R15 transfer to a wheelchair after assisting with toileting, however, never offered to remove facial hairs or oral care. -At 11:13 a.m. NA-F wheeled R15 out of the room and to the TV lounge. During interview on 5/19/21, at 12:04 p.m.	F 677	designee with training to identify signs and symptoms of choking and ability to summon nursing staff for assistance. - Update procedure/process for meal delivery so that residents who require eating assistance do not have food in front of them until someone is available to assist - Schedule/designate staff to help in the dining room for certain meals or designated time frames. Nursing staff has been assigned to all dining rooms for all meals, schedule is found on the daily schedule that is posted at the time clock and each nursing station. Leadership staff is assigned to all dining rooms and all meals to verify nursing is present throughout the meal as assigned. - Develop and implement action rounds to be completed each shift to audit current identified deficient practices and identify emerging deficient practices. This tool will be used ongoing, past survey compliance. - Nursing staff to be trained/educated on action round tool during education scheduled the week of 6/21/2021. - All staff will be trained/educated on any dining processes changes during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. - DON, Nurse Manager, or designee	

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F 677	Continued From page 18 registered nurse (RN)-A stated she expected staff to remove/shave facial hairs if visually seen and not wait for bath days. R15 was scheduled baths on Friday's. RN-A stated residents were supposed to be offered oral cares. During interview 5/19/21, at 1:44 p.m. NA-F acknowledged he had not offered to remove R15's the facial hairs or brush her teeth. NA-F stated due to staffing concerns he was not able to complete all the cares directed by the care plan because of the workload. During interview on 5/19/21, at 2:44 p.m. the director of nursing (DON) stated she would expect residents to get facial hairs removed on bath days and as needed. The DON stated were supposed to provide all residents care including eating, personal hygiene, and grooming according to the resident care plan. R73's diagnoses included hemiplegia (paralysis of one side of the body), hemiparesis (partial weakness or the inability to move one side of the body), essential tremor, and contracture of left hand obtained from the annual Minimum Data Set (MDS) dated 4/13/21. In addition, the MDS indicated R73 had a mild cognitive impairment and no behaviors which included refusal of care. R73 required extensive assistance of with all activities of daily living including grooming. R73's care plan dated 10/20/19, identified R73 required ADL support related to weakness, impaired cognition, depression with anxiety, hemiplegia, hereditary essential tremors, and contracture of left hand. During an interview on 5/17/21, at 12:58 p.m. R73	F 677	to audit bath sheets and/or nurses notes weekly to verify that facial hair removed as appropriate, and fingernails are neatly trimmed and clean. Audit at least once a week for 4 weeks, decrease auditing schedule based on compliance. - Executive Director, DON, Nurse Manager, or designee to audit dining room 5 times per week at alternating mealtimes to verify staff are present and assisting those residents who require assistance, and that food is not set in front of those who require assistance until assistance is available. - Observational audits of facial hair, trimmed/clean nails, general cleanliness via action rounds completed each shift daily ongoing. 5. This deficiency will be corrected 6/29/2021.	

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stated , "I want to have my facial hair shaved and my fingernails trimmed. They have not cut my fingernails in weeks and felt "kinda crippled." R73 stated staff were informed about these concerns. R73 indicated due to medical conditions grooming assistance was needed by staff.

On 5/17/21, at 1:11 p.m. R73 was observed sitting up in bed and fully dressed. R73's fingernails on both hands had brown matter underneath and were overgrown by approximately 1.0 centimeter (cm). R73's fingernails were curled under on all fingers. R73 was also observed with white chin hairs measuring approximately 1 inch (in).

On 5/18/21, at 8:30 a.m. R73 was observed sitting up in bed. R73's fingernails remained overgrown with brown matter underneath. R73's facial hair remained unshaven.

On 5/19/21, at 7:40 a.m. R73 observed laying down in bed with pajamas on. R73's fingernails remained overgrown with brown matter underneath. R73's facial hair remained unshaven.

During an interview on 5/19/21, at 7:49 a.m. nursing assistant (NA)-K stated stated R73 was scheduled baths on Mondays.

During an interview on 5/19/21, at 7:58 a.m. licensed practical nurse (LPN)-A stated an entry is normally written in a resident's progress notes when a resident refused a bath. LPN-A stated the assigned nursing assistant updates the nurse and the nurse puts in the note when cares are refused. LPN-A stated R73 is not a diabetic and nursing assistant's were able to cut R73's

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fingernails.

During an interview on 5/19/21, at 8:06 a.m. LPN-A confirmed R73's fingernails had not been cut and needed to be. LPN-A described the R73's fingernails on as overgrown by 0.3 cm and dirty underneath. LPN-A also confirmed R73 had chin hairs which measured about 1.3 cm. LPN-A stated R73 chain hairs should had been shaved.

During an interview on 5/19/21, at 8:36 a.m. LPN-A stated R73 was shaved and some of R73's fingernails were trimmed. LPN-A stated R73 would be put on the podiatrist list for having her fingernails. LPN-A stated R73's fingernails were too overgrown to cut. LPN-A stated R73's fingernails should had been cut on scheduled bath day.

On 5/19/21, at 8:44 a.m. R73 was observed sitting up in bed and fully dressed. R73's first and third fingernails were trimmed. R73's facial hairs were trimmed. R73's left hand fingernails were not cut and brown matter observed under all five fingernails.

During an interview on 5/19/21, at 10:20 a.m registered nurse (RN)-A stated the expectation was fingernails were to be cleaned when trimmed. RN-A observed R73's fingernails and confirmed R73's, "fingernails had not been cleaned, including the fingernails that were cut." RN-A stated the podiatrist was to cut fingernails that the facility cannot cut themselves. RN-A confirmed R73 is not independent with trimming fingernails.

During an interview on 5/20/21, at 7:23 a.m. trained medical aide (TMA)-A stated R73 needed

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help with having their fingernails trimmed and was unable do so independently.

During an interview on 5/20/21, at 7:29 a.m. NA-L stated R73 required assistance with trimming fingernails as R73 could not do so independently. NA-L did not mention that R73 had a history of refusing cares.

Facility policy titled Activities of Daily Living revised 10/25/20, directed the facility was to provide necessary services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.

ASSISTANCE WITH EATING

R35's annual MDS dated 7/2/20, indicated R28's diagnoses included dementia and depression. R28 had severely impaired cognition and required limited assistance of one person eating.

R64's annual MDS dated 11/18/20, indicated R28's diagnoses included Alzheimer's disease and dementia. R28 had severely impaired cognition and required extensive assistance eating.

R68's admission MDS dated 1/14/21, indicated R68's diagnoses included Alzheimer's disease, dementia, and depression. R68 had severely impaired cognition and required extensive assistance eating.

On 5/19/21, at 8:35 a.m. to 9:49 a.m. during the breakfast observation, NA-F and TMA-A were observed assist residents eat in the dining room.
-At 8:35 a.m. to 8:49 a.m. R35 and R64 were

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observed seated at a table with food in front of them, however, no staff was present at that time to assist the resident's eat. R35 and R64 made no attempts to eat themselves.
-At 8:53 a.m. Eighteen minutes later, NA-F sat next to R64 to assist with eating.
-At 8:54 a.m. NA-F got up to assist a resident use that bathroom and left R64 at a table with no assistance to eating.
-At 8:56 a.m. R35 and R64 sat at a table looking at their food and waited for staff to assist them. R35 and R64 still had made no attempts to eat themselves. TMA-A approached and stated, "this is the problem with this facility right now. We have 13 people here on this floor and three need help to feed and someone needs to use the bathroom and you have to leave them. Then the food gets cold."
-At 9:00 a.m. TMA-A sat next to R35 and stated, "you see what am talking about. This man right here needs to be fed and if we had two aides, he would have them all feed. We tell them everyday and they see the struggle everyday." TMA then stated she was not done passing the morning medications and some of them would be late.
-At 9:03 a.m. R64 was observed seated at the table with food in front of her, but there was no staff except TMA-A who was assisting R35 to eat.
-At 9:27 a.m. NA-F returned to the table to assist R64.
-At 9:37 a.m. to 9:42 a.m. after TMA-A left R15's side, NA-F came over and sat next to R15 and assisted her to eat. R15 was then observed eat all but 4 small pieces of the French toast. NA-F then got up from assisting R15 and then was observed take R15's tray which still had beverages. R15 was not asked if she had enough to eat and drink.

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F 677	Continued From page 23 During interview on 5/19/21, at 1:38 p.m. NA-F stated meal times on the unit were a challenge as other residents needed to use the toilet in the middle of the meal. NA-F stated staff had to assist residents to the bathroom because they were a fall risk. NA-F stated staffing was the problem and if they had more assistance residents would be provided assistance to eat and provided food at the right temperature. During interview on 5/21/21, at 8:17 a.m. the DON stated staff were supposed to call for assistance to assist residents with eating.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a system to ensure residents cardiopulmonary resuscitation (CPR) status was accurately reflected throughout the medical record and 2 of 2 resident's (R26 and R74) whose wishes would not had been honored in the event of cardiopulmonary arrest (cessation of heart beat and breathing). This resulted in an immediate jeopardy (IJ) situation for R26 who would not had received CPR in the event of a cardiopulmonary arrest and was at risk for death. The IJ began on 5/18/21, at 1:10 p.m. when R26's Health Care Directive Summary (HCDS)	F 678	F678 □ Cardio-Pulmonary Resuscitation (CPR) 1. R26 □ Update code status throughout the medical record to match resident wishes □ completed 5/18/2021. R74 □ Update code status throughout medical record to match resident/family wishes □ completed 5/18/2021. 2. - Audit all resident charts to ensure code status is consistent throughout the medical record, update any discrepancies. □ Audit started on 5/17/2021 and has been completed. 3. - Review and update advanced	6/29/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421**

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F 678	Continued From page 24 reflected do-not-resuscitate status, which was contrary to the physicians order and R26's wishes for CPR. Facility staff verbalized they would had utilized R26's HCDS to identify her code status which put R26 at risk to not receive CPR and subsequent death. The administrator was notified of the IJ on 5/18/21, at 4:30 p.m. The IJ was removed on 5/20/21, at 2:57 p.m. but noncompliance remained at the lower scope and severity level of D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R26's Face Sheet dated 5/20/21, indicated R26's diagnoses included sepsis (bacteria in the bloodstream), stroke, chronic kidney disease, and type two diabetes. R26's comprehensive Minimum Data Set (MDS) dated 3/2/21, identified R26 had moderately impaired cognition. R26's HCDS dated 10/28/20, revealed initials were over a box which indicated, "I wish to have DNR/DNI code status." To the immediate left of the initialed box the form indicated, "I wish to have FULL CODE Status." The document was signed by R26 and a facility witness. The document lacked a physicians signature. R26's EMR had an order dated 11/26/20 at 1:38 p.m. which indicated R26 was a full-code (CPR). During an interview on 5/17/21, at 4:35 p.m. registered nurse (RN)-A verified R26's initials were over the DNR/DNI box of the HCDS and	F 678	directive/POLST policy and procedure to include direction on completing and changing a resident□s code status. - All staff will be trained/educated on POLST during education scheduled the week of 6/21/2021. This education includes the simplification of the code status verification change from the health care directives summary form to the simpler POLST form, the POSLT form, how often the POLST form is reviewed on admission, quarterly with care conference, any significant change, and upon resident/resident representative request. - If facility has admission packet, include facilities POLST, social worker, nurse, or employee trained on POLST will assist the resident with the POLST, provider will review and sign the POLST. Facility has updated the admission packet POLST and POLST information sheet, the nurse/nurse manager or designee will review and complete the POLST with the resident upon admission, the form will then be signed by the PCP. - Develop and implement a checklist tool that can utilized during admission and hospital returns and change of conditions to verify all orders and/or changes have been captured and documented and followed up on if indicated. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached.	

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F 678	Continued From page 25 stated R26 was DNR/DNI and would not had performed CPR. RN-A stated nurses would look in either the paper chart or EMR. RN-A verified there was a discrepancy in R26's code status on the HCDS which indicated DNR and R26's EMR physician's order which indicated full-code. During an interview on 5/17/21, at 4:44 p.m. licensed practical nurse (LPN)-B stated he would go to the paper chart and look for the HCDS to determine a resident's code status if a resident was found unresponsive and not breathing During an interview on 5/17/21, at 5:18 p.m. LPN-C stated that she would go to the paper chart because it would be faster to look for someone's code status. LPN-C stated that she would look for the HCDS sheet if someone was found unresponsive and not breathing to determine a resident's code status. During an interview on 5/17/21, at 6:45 p.m. director of nursing (DON) stated staff were expected to follow the advance health care directive in the paper chart. The DON further stated the paper chart and the EMR should match. During an interview on 5/18/21, at 9:04 a.m. R26 indicated she wanted CPR performed by stating "yes" when asked if she wanted chest compressions completed if she was found unresponsive and not breathing. During an interview on 5/18/21, at 12:33 p.m. the DON stated R26 went to the hospital in November of 2020, and was a DNR/DNI. The DON stated upon returning to the facility R26 had a changed her code status to full-code.	F 678	4. - DON, Nurse Manager, or designee to audit charts of new admissions and hospital returns weekly to verify code status is consistent throughout medical record and is in accordance with resident wishes. 5. - This deficiency will be corrected by 6/29/2021.	

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F 678	Continued From page 26	F 678		

During an interview on 5/19/21, at 11:17 a.m. R26's nurse practitioner (NP)-F stated R26 could make her own decisions. NP-F stated R26 was full-code since arriving to the facility.

During the review of the CPR policy reviewed on 10/28/15, revealed the policy lacked direction and process staff were to follow when completing or changing a resident's advanced directive wishes.

The IJ was removed on 5/20/21, at 2:57 p.m. when the facility developed and implemented a systemic plan which was verified interview and document review: The plan included:
- The facility provided staff education regarding changes in policy related to advanced directives and honoring residents' health care wishes on 5/18/21. Nursing personnel who were not working were notified education needed to be completed prior to their next scheduled shift.
- An audit of all resident charts was completed on 5/17/21, to ensure code statuses were consistent throughout the medical record.
- R26 was interviewed by facility staff and it was verified she wished to be a full-code on 5/18/21.

R74's diagnoses included Alzheimer's disease and dementia obtained from the quarterly MDS dated 4/13/21. In addition, the MDS identified R74 had severely impaired cognition.

R74's hospital history and physical (H&P) and discharge orders dated 1/6/21, indicated R74 code status was, "Do Not Resuscitate (DNR)/Do Not Intubate (DNR)."

R74's medical record lacked a copy of the Health Center Health Care Directive Summary (HCDS)

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F 678	Continued From page 27	F 678		

which was supposed to be completed upon admission to identify a resident code status wishes.

R74's electronic medical record (EMR) on 5/18/21, revealed R74's ordered code status was full-code with a date of 5/17/21. R74's medical record lacked documentation from the physician and the resident/representative on the change.

During interview on 5/17/21, at 6:46 p.m. the LPN-A reviewed R74's chart and verified R74's chart did not have a paper copy of the facility HCDS. LPN-A stated he was not certain what happened to R74's facility HCDS as R74 transferred from another unit at the facility. LPN-A stated in case of an emergency, the nurses were supposed to review advanced directive wishes in the paper chart because it was the most current, but R74 did not have one. LPN-A stated he would review the advanced directive in the EMR.

During interview on 5/18/21, at 2:03 p.m. RN-A confirmed R74 was a, "no code" per discussion with R74's wife in a care conference. RN-A reviewed R74's medical record including the hospital discharge discharge orders and history and physical. RN-A verified R74 was a DNI/DNR. RN-A reviewed the EMR and verified R74 status was listed as full-code which was updated on 5/17/21.

During interview on 5/18/21, at 3:03 p.m. family member (FM)-C stated, R74 was DNR/DNI.

During an interview on 5/18/21, at 3:57 p.m. the director of nursing (DON) stated she was made aware of the issue regarding R74's code status. The DON stated the expectation was if a

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F 678	Continued From page 28 resident's code status was changed staff were supposed to have obtain a physician order in addition to a conversation with the resident or their representative. The DON stated since the concern was brought forward the facility R74's code status was changed back to DNI/DNR on 5/18/21.	F 678		
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 ensure individualized activities were provided for 1 of 4 residents (R79) reviewed for activities. Findings include: R79's Face Sheet printed 5/21/21, indicated R79's diagnosis included Alzheimer's disease and dementia. R79's admission Minimum Data Set (MDS) dated 4/30/21, indicated R79 had a severe cognitive impairment. R79's MDS further indicated it was "very important" to be engaged in activities while	F 679	F679 □ Activities Meet Interest/Needs Each Resident 1. R79 - R79 discharged May 27, 2021. - R79 discharged May 27, 2021. 2. □ Audit current activity assessments and care plans on all sub-acute residents, beginning with those with a dementia diagnosis, update care plans, NAR tasks, sub-acute engagement records as needed. 3. - Review and update activities assessments with quarterly and annual assessments, ensure that the individual and group activities provided match interests/preferences of the sub-acute	6/29/21

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F 679	Continued From page 29 in the facility. R79's care plan dated 4/23/21, indicated her leisure interests included watching TV, reading the newspaper, reminiscing, and listening to music. R79 was at risk for reduced socialization and needed assistance in pursuing some activities of interest. Staff would invite, encourage, escort, and assist R79 to engage in hallway/room to room activities and provide R79 the option to go to garden court activities. R79's activity assessment dated 4/23/21, indicated R79 was able to identify leisure activities which she was interested in. R79's current activities were self-directed or done with others/planned by others. R79's interests included reading the newspaper and certain magazines, old fashioned music, playing the piano, sewing, handwork, being outside, gardening, watching news and drama movies, reminiscing about music, family, her church, knitting, live music, and dogs. R79's progress noted dated 4/23/21, indicated, "Staff will assist with TV and TV/music channel selection. Staff will offer her weekly in-room roaming activities." When observed on 5/17/21, at 6:29 p.m. R79 self-propelled throughout the unit in her wheelchair. R69 entered another resident's room and stated, "well that won't do me any good." R79 then exited the room and continued to wander towards the nurses' station. At 6:34 p.m. puzzles, colored pencils, and activity books were observed near the television in the commons area of the unit, however, were not offered to R79.	F 679	residents. - Review and update, if needed, Activity Program policy. - Activity department and nursing staff will be trained/educated on activity expectations during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. - Activities director, or designee to audit sub-acute engagement records 3 times a week to verify activities are being offered and documented per resident assessment, for at least 4 weeks. Decrease auditing schedule based on compliance. -Activity director or designee will observe activities 3 times a week for at least 4 weeks to ensure they are personalized and match the individual needs of the residents as stated in the activity care plan and documented on the engagement record. 5. - This deficiency will be corrected by 6/29/2021.	

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F 679	Continued From page 30	F 679		

On 5/18/21, at 7:52 a.m. R79 sat on the edge of her bed, with her head down and in her hands. There was no television, radio, or stimulation occurring.

On 5/18/21, at 2:22 p.m. R79 sat in her wheelchair near a bedside table and played with a banana peel in her hands. R79 also talked to her roommate.

On 5/19/21, at 9:05 a.m. R79 sat in her room and was eating breakfast. There was no television, radio, or other stimulation occurring.

On 5/20/21, at 7:23 a.m. R79 was in bed sleeping. At 9:11 a.m. R79 self-propelled around the unit and into the kitchen. Registered nurse (RN)-E assisted R79 to sit at the table and eat breakfast. From 10:37 a.m. to 11:00 a.m. R79 sat sleeping in her wheelchair in front of the nurse's station. Staff were active around the nurse's station and did not attempt to engage R79. At 11:05 a.m. the activities director (AD) approached R79 and offered a magazine and R79 declined. At 11:10 a.m. R79 self-propelled around the unit in her wheelchair, stopped in the middle of the hallway, put her head down, and held her head in her hands. At 11:15 a.m. R79 wheeled herself to the nurse's station and stated, "I feel really spacy" at which time registered nurse (RN)-G acknowledged R79 and offered her a glass of orange juice which she accepted.

On 5/21/21, at 10:16 a.m. R79 sat in her room in her wheelchair facing the bed with her head down. There was no television, radio, or other stimulation occurring.

When interviewed on 5/20/21, at 11:44 a.m.

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F 679	Continued From page 31	F 679		

activities director (AD) stated all current activities, "are basically 1:1." AD stated there is one activities staff that works on the weekends, and activity staff go through the subacute unit daily and offered resident's leisure supplies. AD stated she was unable to provide and answer why R79 had no activity documentation for several dates.

When interviewed on 5/21/21, at 9:04 a.m. family member (FM)-E stated, "I am not sure what she is involved in activity wise, she is in therapy." FM-E stated he did not know if books or magazines were appropriate for R79 at this time and stated, "She doesn't read anymore, she might look at pictures." FM-E stated he felt R79 would enjoy participating in music and singing groups.

When interviewed on 5/21/21, at 10:35 a.m. the director of nursing (DON) stated she believed activities were offered daily and she would expect the activities staff to be aware of what resident's are interested in and engage with them.

Review of R79's April 2021 Sub-Acute Engagement Record indicated the following:
- No activities were documented on 28 of 30 dates.
- Documented as refused twice.
- Documented as "positive" for puzzles on one occurrence.
- Documented as "positive" for reminiscence on one occurrence.

Review of R79's May Sub-Acute Engagement Record indicated the following:
- No activities were documented on 14 of 30 dates.
- Documented as refused on 13 dates.

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F 679	Continued From page 32 - Documented as "positive" for refreshments on two occurrences. - Documented as "positive" for trivia on one occurrence. - Documented as "positive" for active games on one occurrence. Facility policy titled Activity Program revised 12/4/20, indicated "Activities are scheduled daily, and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs." The policy further indicated evening, weekend, and holiday programs are scheduled and may be conducted, supervised, or coordinated by staff.	F 679		
F 686 SS=E	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 timely repositioning for 3 of 7 residents (R68, R62, R75)	F 686	F686 □ Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. R68 □ Complete skin assessment	6/29/21

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F 686	Continued From page 33 reviewed for pressure ulcers. In addition, failed to implement interventions, comprehensively assess, and monitor pressure ulcers to promote healing and prevent complications for 1 of 7 residents (R43) reviewed for pressure ulcers. Findings include: R68's diagnoses included Alzheimer's disease and dementia with behavioral disturbances obtained from the significant Minimum Data Set (MDS) dated 4/12/21. The MDS identified R68 had severely impaired cognition, required extensive physical assistance of two staff with bed mobility, toileting, and transfers. The MDS identified R68 was at risk for pressure ulcers, had two unstageable pressure ulcers. R68's care plan dated 1/7/21, identified R68 had pressure ulcers to the right heel and coccyx. The care plan directed staff to turn and reposition R68 every two hours and as needed. During review of R68's wound assessments, it was revealed a assessment dated 5/12/21, indicated the pressure ulcer wound on R68's coccyx had been healed. On 5/19/21, during continuous observation, the following was observed: - At 8:40 a.m. R68 remained in the dining room after being brought to the dining room for breakfast by NA-F. -At 10:16 family member (FM)-B wheeled R68 out of the dining into her room. FM-B brought R68 back to the dining room at 10:18 a.m. -At 10:25 a.m. trained medication aide (TMA)-A approached R68 and administered eye drops to both of her eyes. R68 was not offered	F 686	and Braden to develop an individualized turning and repositioning schedule. - Update care plan, NAR service task with turning and repositioning schedule. R62 □Develop individualized turning and repositioning schedule based on skin assessment and Braden. - Update care plan, NAR service task with turning and repositioning schedule. R75 □ Provider to assess skin concerns and determine if referral to wound care is appropriate. - OT to reassess w/c positioning and make recommendations. - Update care plan, NAR service task with any plan of care changes. R43 □Provider to assess and determine if referral to wound care appropriate. - Treatment order is entered into the TAR. - Wound is being tracked in wound tracking. - Update care plan with interventions for pressure ulcer treatment and reduction, specific to resident. - Update NAR tasks as needed. 2. - Review/audit all residents turning and repositioning schedule, update/change as indicated based on skin assessment, Braden, mobility level, care assistance, resident preference, resident/family interview, etc. - Identify all residents that have active wounds and ensure they are being tracked/followed and have treatment orders in place as applicable, including pressure relief. 3. □ Nursing staff will be trained/educated to reinforce the	

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F 686	Continued From page 34 repositioning. -At 10:43 a.m. R68 remained in the dining doing an activity with FM-B. -At 10:49 a.m. NA-F came into the dining room and briefly looked at R68 as she sat on the wheelchair. R68 was still doing an activity with FM-B. Repositioning was not offered. -At 10:53 a.m. FM-B left the unit. -At 11:17 a.m. two hours and 37 minutes later, the surveyor intervened and NA-F confirmed R68 was supposed to be repositioned every two hours. NA-F stated R68 required assistance of two staff and he needed assistance to get R68 in the bed. NA-F stated he needed assistance from TMA-A who was on break and would ask her. During interview on 5/19/21, at 11:19 a.m. TMA-A stated, "am right here he just needed to ask me. The residents deserve for us to care and follow the plans of care. If there was two aides we would not have this problems." -At 11:32 a.m. after two hours and 52 minutes R68 was transferred to bed. When R68 was turned over, redness was observed on her buttocks and coccyx. During interview on 5/19/21, at 12:13 p.m. registered nurse (RN)-A stated R68 was on a every two hour schedule for repositioning. RN-A stated R68 was at high risk for pressure ulcers and had recently healed a pressure wound on her coccyx three weeks prior. During interview on 5/19/21, at 2:44 p.m. the director of nursing stated staff was supposed to provide all residents care including turning/repositioning according to the resident care plan.	F 686	importance of documentation of refusals of service/care during education scheduled the week of 6/21/2021. - Develop process for enhanced communication between identification of new wounds and the appropriate timely notifications. - Review and update, if needed policy and procedure on facility pressure ulcer/pressure injury prevention and management policy. - Working on wound care agreement with AHI wound care. - Nursing staff will be trained/educated on any policy/process changes during education scheduled the week of 6/21/2021. - Nursing staff will be trained/educated on turning and repositioning practices during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. - DON, Nurse manager, or designee to audit turning and repositioning 5 days a week at different times for at least 4 weeks. Decrease auditing schedule based on compliance - DON, Nurse Manager, or designee to audit nursing notes, 24-hour report daily for new wounds or other skin issues that require follow up. - DON, Nurse Manager, or designee to	

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F 686	Continued From page 35 R62's Face Sheet dated 5/20/21, indicated R62 had diagnoses of Alzheimer's and dementia. R62's comprehensive Minimum Data Set (MDS) dated 3/29/21, indicated R62's cognition was unable to be assessed due to being rarely/never being understood. The MDS further indicated R62 required a total assist of two staff for transferring and extensive assist of one staff for bed mobility. In addition the MDS indicated R62 was at risk for developing pressure ulcers and identified R62 had two pressure ulcers staged at a stage two (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed without slough (soft moist dead tissue). May present as an intact or open/ruptured fluid filled blister. R62's Care Area Assessment (CAA) completed 4/9/21, indicated R62 required regular scheduled repositioning, and was confined to a bed or chair all or most of the time. R62's care plan indicated R62 had alteration in skin integrity related to ulcers on right and left buttocks. In addition R62's care plan indicated that staff were to assist with positioning needs. However, R62's care plan lacked evidence of frequency that R62 was to be offered or repositioned. R62's nursing assistant care sheets printed 5/20/21, indicated R62 had wounds to right and left buttocks but did not identify how frequent R62 needed to be repositioned. The Braden Scale for predicting pressure sore risk completed on 4/5/21, and 4/12/21, indicated that R62 was at a high risk for developing	F 686	audit weekly wound tracking weekly to ensure compliance for a minimum of 8 weeks. Decrease auditing schedule based on compliance. 5. - This deficiency will be corrected 6/29/2021.	

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pressure ulcers.

A Tissue Tolerance in bed assessment dated 3/29/21, indicated R62 was to be placed on a two hour repositioning schedule. Furthermore, R62's Tissue Tolerance in chair assessment dated 3/29/21, indicated R62 was to be on a two hour sitting schedule.

During an observation on 5/19/21, at 7:31 a.m. nursing assistant (NA)-J came out of R62's room with R62 in her wheelchair and dressed for the day. NA-J assisted R62 to a table in the dining room near the television.
-7:41 a.m. registered nurse (RN)-A approached R62 and stated "good morning"
-7:44 a.m. NA-J approached R62 and adjusted a blanket on her lap.
-7:59 a.m. licensed practical nurse (LPN)-D approached R62 in the dining room, stated, "good morning" and gave R62 medications.
-8:19 a.m. NA-J approached R62 and assisted R62 with sanitizing her hands. R62 continued to be in the dining room in her wheelchair facing the television.
-8:33 a.m. multiple staff began passing breakfast trays to the residents in the dining room. R62 continued to sit at the table facing the television and appeared to be sleeping.
-8:51 a.m. NA-J approached R62 with a breakfast tray, sits down next to R62 and provided assistance eating.
-9:12 a.m. NA-J got up from R62's table and walked down the hallway and left R62 at the table facing the television.
-9:14 a.m. staff removed R62's breakfast tray from in front of her.
-9:27 a.m. NA-J walked by R62 who is still seated in her wheelchair in the dining room facing the

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television. R62 appeared to be sleeping.
-9:39 a.m. NA-J walked through dining room with cart full of empty breakfast room trays. R62 continued to sit in the dining room. A staff member asked R62 if she would like to play bingo.
-9:48 a.m. NA-J brought another resident to the dining room, meanwhile R62 continued to sit in her wheelchair at a table facing the television.
-10:00 a.m. R62 continued to sit in her wheelchair in the dining room facing the television when surveyor intervened.
-10:04 a.m. RN-A verified with LPN-A that NA-J and LPN-D went on break and asked LPN-A to lay R62 down in bed.

Upon surveyor inquiry, two-hours and 33 minutes had passed until staff was asked by RN-A to reposition R62.

During an interview on 5/19/21, at 10:00 a.m. registered nurse (RN)-A stated R62 had wounds on her right hip and a wound on the coccyx area. RN-A further indicated that R62 should have been offloaded at least every two hours.

During an interview on 5/19/21, at 10:10 a.m. LPN-A stated the aide caring for R62 was on break at this time, and repositioning residents timely is difficult due to staffing concerns.

During an interview on 5/19/21, at 10:16 a.m. RN-A stated even if R62 did not want to go to bed for repositioning, repositioning should have occurred while R62 was up in her wheelchair.

During an interview on 5/19/21, at 10:30 a.m. NA-J stated that R62 was to be repositioned every two hours. NA-J further stated R62 was last

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repositioned between 8:00 a.m. and 8:30 a.m. when R62 got up from bed.
R75's Face Sheet dated 5/20/21, indicated R75 had cerebral infarct (stroke), Alzheimer's disease, muscle disuse atrophy (a wasting away of a body part), and abnormalities of gait and mobility, and hemiplegia affecting left side (paralysis of one side of the body).

R75's annual Minimum Data Set (MDS) dated 4/16/21, indicated R75 had BIMS score of 7 which indicated severe cognitive impairment.

R75's Care Area Assessment (CAA) dated 4/29/21, indicated R75 required extensive assistance with bed mobility, and personal hygiene. R75's CAA indicated R75 was totally dependant upon staff for transfer between surfaces and toileting. R75's CAA further indicated R75 was at risk for pressures ulcer related to urinary incontinence, bowel incontinence, and extensive assistance by staff to assist R75 in bed mobility.

R75's physician's note dated 4/20/21, indicated R75 acquired a skin ulcer of left lateral malleolus with measurement of 4 centimeters (cm) x 3 cm. The physician's note further indicated R75 skin ulcer wound bed was granulated. Physician order indicated R75's heels to be off load while in bed. No staging was indicated in the physician's note.

R75's physician order dated 5/21, indicated heels to be offloaded with a pillow and monitor for skin breakdown.

R75's care plan dated 5/20/21, indicated R75 had a history of alteration in skin integrity related to cerebral vascular accident (CVA) and a history of

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unstageable left heel ulcer. R75 care plan indicated R75 was unable to self-transfer and had a limitation to independently to turn in bed. R75 care plan further indicated staff were to offload heels on pillow daily to reduce risk for further skin breakdown. In addition, R75's care plan indicated staff were to assist with positioning needs.

R75's nursing assistant report sheets printed 5/20/21, indicated R75 was to have their heals offloaded at all times and repositioned every two hours.

During observations on 5/19/21, a 7:26 a.m., 7:46 a.m. and 7:51 a.m. R75 was lying in bed with a pillow under his knees. R75's heels were touching the mattress. At 7:51 a.m. Registered nurse (RN)-C verified the observation of R75. RN-C performed a skin assessment and found R75 buttocks and gluteal cleft were deep purple/red in color with boggy indentation.

During a continuous observation on 5/20/21:
- 8:00 a.m. to 8:49 a.m. R75 was in bed. The head of R75's bed was at a 50-degree angle. R75 had one pillow under his legs. R75's heels were touching the bed.
- 8:50 a.m. to 8:57 a.m. nursing assistant (NA)-A served a breakfast tray to R75 and left the room. R75's heels remained on the bed.
- 9:04 a.m. NA-A entered R75 room and lowered the head of the bed. NA-A encouraged R75 to take bites of oatmeal then NA-A left R75's room. R75 was not offered repositioning at this time.
- 9:05 a.m. to 9:21 a.m. R75 was observed in bed no position change, R75 has eaten some scrambled eggs on right side of plate, and currently eating toast. R75 has one pillow under legs with heels observed touching bed.

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- 9:22 a.m. to 9:39 a.m. RN-A entered R75's room and rotated his plate. RN-A encouraged R75 to eat. R75 was not offered to be repositioned.
- 9:40 a.m. NA-B entered R75's room and removed his clothing protector. NA-B then took R75's meal tray and exited the room. NA-B did not offer to reposition R75.
- 9:46 a.m. to 10:05 a.m. R75 remained in the same position with their heels touching the bed.
-10:06 a.m. NA-A and NA-B were observed to enter R75's room and provided incontinence care. R75 was positioned on left side for roughly two minutes. R75's heels were touching the mattress and noted to be red in color roughly two inches in diameter. R75 buttocks revealed left side buttocks deep red, gluteal cleft is purple. NA-A stated R75 does not like to be on his side and why she does not reposition R75 off his back. R75 was asked by NA-A if he would like to be repositioned to his side, R75 stated "yes." NA-A and NA-B repositioned R75 to his right side and placed a pillow behind R75 back for support. NA-A positioned R75's pillows down under R75 knees and heels are touching mattress. NA-A was informed R75 heels were touching the mattress and are not floating, NA-A grabbed a second pillow and placed under legs of R75 which elevated heels off of the mattress.

During an interview on 5/19/21, at 7:51 a.m. NA-M stated it was hard to get all the residents on the floor taken care of because most of the time it was one-to-two nursing assistants needing to get all the residents up and cared for throughout the day. NA-M stated many times residents cannot get repositioned every two hours due to heavy a workload. NA-M stated R75 was last repositioned on previous shift when providing

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F 686	Continued From page 41 incontinent cares. During an interview with RN-C on 5/19/21, at 7:53 a.m. RN-C verified R75's entire buttocks and gluteal cleft were deep purple in color, a roughly two inch in diameter dark redness to right and left heel. RN-C further stated that occupational therapy has assessed the R75 and made corrections to the wheelchair. RN-C stated R75 was not put into in a wheelchair because he slides out and the staff changed. RN-C stated R75 mattress was a low air loss mattress to a concave mattress so R75 does not fall out of bed. RN-C stated R75 needed to be repositioned every two hours due to a risk for pressure ulcers. During an interview with RN-C 5/20/21, at 10:21 a.m. RN-C R75's heels needed to be floating off mattress and the pillow needs to be placed lengthwise under the calves to completely elevate the heels to avoid a pressure ulcer from occurring. During an interview on 5/20/21, at 10:30 a.m. RN-A stated her expectation was for NAs' to reposition R75 every two hours and his heels were to be floated. During an interview on 5/20/21, at 1:07 p.m. the director of nursing (DON) stated she expected R75 was provided cares and treatments per his care plan and nursing assistant care sheet. The DON stated the NA and nurse scheduled to provide cares for R75 were responsible. R43's Face Sheet dated 12/13/19, indicated R43 had diagnoses of peripheral vascular disease, diabetes, kidney disease, and dementia.	F 686		

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R43's quarterly Minimum Data Set (MDS) dated 4/1/21, indicated R43 had a Brief Interview for Mental Status (BIMS) of 12 which indicated a moderate cognitive deficit. The MDS indicated R43 required extensive assistance with bed mobility, transfers, and toileting.

R43's care plan dated 12/13/19, indicated R43 was at risk for impaired skin integrity. Interventions indicated weekly skin checks on bath day.

R43's Physician Orders dated 5/21, indicated a weekly body audit was to be completed every Thursday beginning 5/20/20. The orders also indicated a Braden Scale was to be completed every month.

R43's Braden Scale dated 3/4/21, indicated, although R43 was an extensive assist with bed mobility and transfers, R43 moved in his bed and chair independently, and had no risk for pressure sores.

R43's Clinical Notes Report dated 4/16/19, at 2:36 p.m. indicated R43 had a small opening on the back of his right thigh, lower gluteal area The opening measured 0.2 centimeters (cm.) by 0.2 cm. The report indicated the wound was cleansed, a foam dressing was applied, and the provider was notified. The report also indicated the wound would be monitored.

R43's provider progress note dated 4/16/21, at 2:43 p.m. indicated registered nurse (RN)-C notified nurse practitioner (NP)-C of the new pressure ulcer on R43's right thigh/lower gluteal. The provider progress note also indicated R43 complained of discomfort when sitting for too

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long.

R43's provider progress note dated 4/16/21, at 2:52 p.m. indicated a verbal order was given to licensed practice nurse (LPN)-B to continue with cleansing and foam dressings daily. The provider progress note further directed staff to monitor and notify the provider of any significant changes.

During an observation on 5/20/21, at 9:43 a.m. RN-C and nursing assistant (NA)-B wheeled R43 to his bathroom and assisted him to stand in order to change the wound dressing. RN-C removed a foam padded dressing from below R43's right gluteal cleft. The foam of the dressing had been pushed out of the dressing and bunched into two foam balls on the edge of the dressing. The middle of the dressing was flat and stained black on both sides. The dressing did not have staff initials or a date. An open pressure injury approximately the size of a nickel with partial-thickness loss of skin and a moist pink wound bed was observed below R43's right gluteal cleft. R43 became irritable and was lowered into his wheelchair and refused further assessment. RN-C did not measure or assess R43's pressure ulcer at that time.

During an interview on 5/18/21, at 2:58 p.m. LPN-B stated the nurse should notify the family and provider if a new pressure ulcer was identified. Although LPN-B received a verbal order for treatment of R43's wound, LPN-B stated he was unaware of a pressure wound below R43's right gluteal cleft.

During an interview on 5/20/19, at 9:26 a.m. RN-C stated he cleansed R43's right upper thigh/gluteal wound and applied a foam dressing

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,per standing order. RN-C also stated he notified the provider by phone on 4/16/21. RN-C confirmed he had not assessed R43's pressure ulcer since 4/16/21, because R43 refused further assessments and/or treatments. RN-C stated there is no record indicating R43 had refused assessment of the wound or a task on the treatment assessment record (TAR) indicating staff should provide wound care to R43's right upper thigh/gluteal.

During an interview on 5/20/21, at 10:22 a.m. wound nurse RN-E stated she would be notified of new pressure ulcers during the daily Interdisciplinary Team (IDT) meeting. RN-E stated she was not informed of a new pressure ulcer or physician's orders to provide wound care on R43's right upper thigh/gluteal.

During an interview on 5/19/21, at 1:14 p.m. RN-A stated the physician's verbal order should have been entered into R43's electronic medical record and documented daily as a task on the TAR. RN-A confirmed there was no task for the treatment of a right upper thigh/gluteal pressure ulcer on R43's TAR.

During an interview on 5/20/21, 12:00 p.m. the DON stated the physician's order should have been entered as a task and documented on the TAR. The DON stated if a resident refused treatment, the nurse should document that in the TAR and/or enter a progress note. The DON further stated the wound nurse was notified of new wounds during the daily IDT meeting and would add the resident to her weekly rounding list for assessment and treatment.

Review of R43's medical record indicated no

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F 686	Continued From page 45 treatment orders, wound care, and/or subsequent assessments were completed for R43's new pressure ulcer after it was identified on 4/16/21. R43's medical record lacked indication of R43's refusal to allow the nursing staff to assess or treat the pressure ulcer pressure ulcer. Facility Pressure Ulcer/Pressure Injury Prevention and Management policy dated 10/24/19, directed interventions for prevention and promotion of healing a pressure wound included documenting interventions in the weekly summary charting and communicating interventions to all relevant staff. The policy also indicated a nurse should complete a weekly, full body skin assessment that included measuring the wound, initiating a weekly wound monitoring sheet and implementing the physician's initial orders. The policy further indicated weekly monitoring of the pressure wound's progress toward healing, treatments, dressing changes and the effectiveness of interventions.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		6/29/21

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F 688	Continued From page 46 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow through on a therapy recommended splinting of left hand for 1 of 2 residents (R75) reviewed limited range of motion. Findings Include: R75's Face Sheet dated 5/20/21, indicated R75's diagnoses included cerebral infarct (stroke), Alzheimer's disease, contracture of left hand, and hemiplegia (paralysis of one side of the body). R75's annual Minimum Data Set (MDS) dated 4/16/21, indicated R75 had a severe cognitive impairment and functional limitation related to the hemiplegia affecting the left side of R75 body. R75's Physician Order Sheet dated 5/20/21, directed R75 was to wear a left had splint at night and remove in the morning. R75's care plan dated 5/20/21, indicated R75 had was to wear a left-hand splint in morning and off in the evening. R75's May 2021, Treatment Administration Record (TAR) indicated R75's left hand splint was to be on in the morning and off in the evening. The TAR lacked indication R75 refused to wear his left hand splint.	F 688	F688 □ Increase/Prevent Decrease in ROM/Mobility 1. R75 □ Treatment order clarified - on in AM and off at HS - Updated care plan, orders, NAR care tasks with clarified order □ if resident routinely refuses this will be noted on the care plan and resident□s rights will be honored. 2. - Audit resident charts to determine other residents that have splint/brace orders. Ensure orders are clear and reflected on the ETAR, care plan, and NAR care tasks. 3. □ Review and update, if needed, facility policy titled Use of assistive devices. - Nursing staff will be trained/educated on any policy changes during education scheduled for the week of 6/21/2021. - Develop and implement action rounds to be completed each shift to audit current identified deficient practices and identify emerging deficient practices. This tool will be used ongoing, past survey compliance. - Nursing staff to be trained/educated on action round tool during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the	

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F 688	Continued From page 47 During an observation on 5/18/21, at 8:55 a.m. R75 was observed lying in bed and a left hand brace was not on. During an observation on 5/20/21, at 8:50 a.m. NA-A served R75 his breakfast tray in his room. R75's left hand splint was not on. During an observation on 5/21/21, at 8:59 a.m. R75 was observed seated in his wheelchair in the dining room eating his breakfast R75's. A left hand splint was not on R75. During an interview 5/20/21, at 10:21 a.m. RN-C verified R75 left hand brace was not on. RN-C stated he thought the TAR indicated the left hand splint was to be worn at night. RN-C verified the TAR indicated left hand splint is to be on in the morning. During an interview on 5/20/21, at 1:07 p.m. the director of nursing (DON) stated her expectation was R75 was provided cares and treatments per his care plan and nursing assistant care sheet. The DON stated the nurse manager is responsible to ensure orders, care plans and care sheets for R75 are up to date and staff provided the cares as directed. The DON stated R75 had two orders which directed staff had two different sets of instructions on when splint for left hand should be worn. The DON further stated her expectation was RN-A should had clarified and updated the splint order with R75's physician and updated care plan to reflect the correct order. Facility's policy Use of Assistive Devices dated 10/14/18, indicated the purpose of the policy was to directed staff to provide a reliable process for proper and consistent use of assistive devices for	F 688	QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. DON, Nurse Manager, or designee to audit use of splints/braces per orders daily for 4 weeks. Decrease auditing schedule based on compliance. 5. This deficiency will be corrected by 6/29/2021.	

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F 688	Continued From page 48 residents who required devices to maintain or improve function and/or dignity. Facility's policy further directed staff to provide assistance to residents who need it. The facility's policy further indicated nursing assistants will be trained on assistive device and resident's nurse will monitor for continued use.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided during meals for 1 of 3 residents (R75) identified to be at risk for choking. This resulted in an immediate jeopardy (IJ) situation for R75, who was eating unsupervised in the facility dining room and staff was not aware the resident began to choke. Further, the facility failed to implement interventions as directed by the care plan or ensure a resident wore appropriate footwear to prevent a fall for 2 of 3 residents (R1, R22) reviewed for falls. This resulted in actual harm for R1 when only one staff person assisted R1 with incontinence cares, she rolled out of bed and on the floor, and suffered three rib fractures and a dislocated finger. The IJ began on 5/21/21, at 8:57 a.m. when it	F 689	F689 □ Free of Accident Hazards/Supervision/Devices 1. R75 □ Education provided to nurse caring for R75, regarding the need to supervise and monitor his meals on the evening of 5/21/2021. - Education provided to all licensed nursing personnel scheduled to provide cares for R75 on the need to supervise and monitor R75s intake on 5/21/2021 R1 - Employee NA-I was suspended pending the outcome of the investigation into the fall; NA-I was permitted to return to work after completion of education related to abuse and neglect, care plans, and resident plan of care, and assessment of competency of cares for residents. Physician notified of fall on	6/29/21

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F 689	Continued From page 49 was identified R75 ate unsupervised in the facility dining room on. R75 began choking and turned a bluish/purple color. Staff did not recognize R75 had began choking and surveyor intervention was required to prompt staff to assist R75. R75 suffered a choking episode which put R75 at risk for death. On 5/21/21, at 4:12 p.m. the administrator, director of nursing (DON), and regional staff were notified of the IJ for R75. The IJ was removed on 5/24/21, at 10:08 a.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: CHOKING R75's Face Sheet dated 5/20/21, indicated R75 had a cerebral infarct (stroke), dysphasia (difficulty swallowing foods or liquids), Alzheimer's disease, aphasia (loss of ability to understand or express speech), and hemiplegia (paralysis of one side of the body) affecting left side. R75's annual Minimum Data Set (MDS) indicated R75 had a BIMS score of 7 which indicated a severe cognitive impairment, and required extensive assistance for eating with one person physical assistance to provide weight bearing support. R75's Care Area Assessment (CAA) indicated R75 required extensive assistance with bed mobility and eating. R75's care plan dated 5/20/21, indicated R75 had difficulty swallowing related to the CVA with hemiparesis, dysphasia, and history of choking.	F 689	5/20/2021 and orders obtained to monitor implemented. R1 seen by attending provider on 5/21/2021, orders implemented. R22- Review and update care plan and NAR plan of care by end of week of 6/21/2021, to include that resident is offered and encouraged to wear non-skid footwear when awake If resident routinely refuses, note this on the care plan and that resident rights will be honored. 2. -Audit completed to identify all residents at risk of choking completed 5/21/2021 by dietician and reviewed with speech therapy. - Residents at risk for choking who prefer to eat in their room were evaluated by speech therapy on 5/24/2021. - Audit all resident care plans to verify level of assistance is accurate and congruent with what is on the NAR plan of care. - Audit all resident care plans and NAR plans of care to ensure that if non-skid footwear is indicated that it is offered and encouraged while resident is awake. Ensure that it is noted on the resident care plan if they refuse the intervention routinely. 3. -Policy and procedure titled The supervision of Residents at risk for choking and policy and procedure titled foods brought in by family/visitors were reviewed and updated 5/21/2021. -Nursing staff were assigned as a dining room monitor for each dining room and each shift daily and verified on 5/24/2021. - Nursing staff educated on updates to	

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F 689	Continued From page 50 R75's Speech Therapy Evaluation and Plan of Treatment dated 4/28/21, indicated R75 had dysphasia of the oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). The speech language pathologist (SLP) indicated recommendations of close supervision during oral intake, seated in an upright position for meals, mechanical soft solids, and nectar thick liquids for safety. R75's Nutritional Assessment dated 5/20/21, indicated R75 had a history of choking episodes and was downgraded to mechanical soft diet textures and seemed to tolerate mechanically altered textures. The Nutritional Assessment further indicated R75's current diet orders were a dysphasia level 3 mechanically advanced diet with nectar thick liquids. Nutrition interventions and recommendations included to monitor intake of food and fluids. R75's Nutritional Assessment lacked recommendations for supervision during meals. R75's nursing assistant report sheet dated 5/21/21, indicated R75 required supervision at meals and needed to be up in wheelchair at meal. R75's physician order dated 5/20/21, indicated R75 was ordered to have assistance with all feeding and monitoring of intake related to diagnosis of choking during meals. R75's physician order indicated a level 3 dysphasia diet, with nectar thick liquids. On 5/18/21, at 9:55 a.m. R75 was observed lying in bed when the dietician brought in R75's breakfast tray and placed it on the over the bed table. At the time R75's bed was at a 30-degree	F 689	policy and procedures supervision of resident at risk for choking and foods brought in by family/visitors education began 5/21/2021. - Nursing staff to be trained/educated on following the plan of care /care plans during education scheduled the week of 6/21/2021. - Develop and implement action rounds to be completed each shift to audit current identified deficient practices and identify emerging deficient practices. This tool will be used ongoing, past survey compliance. - Nursing staff to be trained/educated on action round tool during education scheduled the week of 6/21/2021. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. - Executive director, DON, or designee to audit dining room during meals 3 times a day for 2 weeks to ensure nursing staff is present. Decrease audit schedule based on compliance. - DON, Nurse Manager, or designee to audit footwear of residents identified via care plan audit daily for 2 weeks. Decrease audit schedule based on compliance. - DON, nurse manager, or designee to audit care delivery to ensure care plan/plan of care is being followed	

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F 689	Continued From page 51 angle. The dietician set up R75's meal tray which contained scrambled eggs, toast, oatmeal, and drinks, shut the R75's room door, and left R75 alone and unsupervised. Staff did not check on R75 while eating his meal. On 5/20/21, 8:50 a.m. to 9:01 a.m. during continuous observations, nursing assistant (NA)-A brought a breakfast tray into R75's room which contained two bowls of oatmeal and orange juice. NA-A uncovered cups,and left the room with R75 unsupervised. R75 was observed coughing while eating his breakfast. -At 9:04 a.m. NA-A returned to R75's room and was overheard giving R75 verbal cues to take a bite of the oatmeal. NA-A assisted R75 take two bites of the oatmeal and then lowered the head of bed to approximately 30-to-40 degree angle. -At 9:05 a.m. NA-A exited R75's room and left the nursing unit. No staff were observed in the hallway to supervise R75. -At 9:40 a.m. NA-B went into R75's room and removed R75's clothing protector and meal tray and exited the room. During interview on 5/19/21, at 8:44 a.m. trained medication aide (TMA)-A stated due to staffing there was a delay in breakfast which was supposed to be served at 8:00 a.m. TMA-A further stated residents were supposed to be assisted with morning cares and be at the dining room an hour ago, however, due to staffing this had not happened. TMA-A further stated the facility management was aware of concerns and staff had expressed the need to have two nursing assistants (NA) in the unit's Garden Court. During an interview, on 5/20/21, at 10:30 a.m. RN-A stated her expectation was for nursing	F 689	regarding level of staff assist 3 times a week for 4 weeks. Decrease audit schedule based on compliance. 5. - This deficiency will be corrected by 6/29/2021.	

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assistants to provide supervision during meals. RN-A stated R75 was "to be up in his wheelchair during meals." RN-A stated "supervised means supervised or watching the resident during meals." RN-A stated she expected nursing assistants to be supervising residents during mealtimes and nursing assistants probably should not take breaks or leave the floor without another staff member covering the residents.

During an interview on 5/20/21, at 1:07 p.m. the director of nursing (DON) stated her expectation was R75 needed to be supervised during meals. The DON stated supervision was watching residents until the meal was done. The DON further stated if a nurse or aide left the floor a replacement needed to be found to provide supervision.

On 5/21/21, at 8:57 a.m. during an observation, R75 was sitting in a wheelchair in the dining room. R75 was seated at a table alone and was positioned with his back to the other six other residents who were all eating. Licensed practical nurse (LPN)-A was seated at a nurses' station, which was located across the from the dining room, and approximately 27 feet away. No staff were located in the dining room at this time. LPN-A had his back turned to the residents and was working on a computer.

-At 8:59 a.m. R75 was eating in the dining area and dropped a fork on his plate. R75's plate was observed to have scrambled eggs, cut up French toast covered with a red strawberry topping. R75's face turned a deep blue/purple color. R75 was unable to cough, speak, or spit. LPN-A, remained at the nurses' station with his back turned and did not recognize R75 was choking. At

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this time, the surveyor alerted LPN-A who then immediately approached R75, shook R75's right shoulder, and asked if the resident was okay. R75 did not respond verbally and gestured with his right hand to his throat. LPN-A then used his right fist and pressed into R75 lower sternum/upper abdomen area and compressed R75 chest in roughly two inches twice. R75 immediately started to cough and spit. R75 continued to cough and spit out a light brownish/red colored piece of food roughly ¾ inches in diameter.

During an interview on 5/21/21, at 9:06 a.m. LPN-A stated he was documenting at the computer in the nurse's station on another resident's chart when R75 began choking. LPN-A stated R75 choked on French toast and he performed Heimlich maneuver because R75 was choking. LPN-A confirmed R75 needed be supervised during meals. LPN-A confirmed no one was supervising the residents in the dining room and stated he was unsure why.

During an interview on 5/21/21, at 9:20 a.m. the registered dietitian (RD) stated R75 was served French toast, scrambled eggs, and a strawberry topping for breakfast when R75 had an incident of choking. The registered dietitian further stated R75 was given dietary directions, or orders, from either the physician or SLP.

During an interview on 5/21/21, at 9:50 a.m. the SLP stated R75 had a significant history of dysphasia and was admitted with a modified soft textured diet and level 3 dysphasia advanced diet. SLP stated she wanted to ensure R75 was doing well and tolerating his diet with no episodes of choking because he was not getting up in his

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wheelchair. SLP stated that it was important for people with dysphasia to sit up in a chair or bed at a 90-degree angle. SLP stated residents with dysphasia have a higher chance of choking. SLP stated she was informed by the dietitian R75 turned blue and choked on French toast. SLP stated the kitchen used Texas toast which was a thick piece of bread and had a hard crust on the edges and made it a risk for a resident with dysphasia. SLP stated French toast was too firm for R75's diet, he should have no tough meats, meat should be able to cut with a fork not a knife. SLP defined supervision as a staff person in the dining room with eyes on the residents. SLP stated a nurse at the nurse's station with their back to residents was not considered supervision. SLP stated she completed an in-service on 5/13/21, with kitchen staff on modified diets.

During interview on 5/21/21, at 10:07 a.m. NA-D stated, "we are not able to provide supervision with meals because sometimes we have to leave the residents in the dining room to go to a room to help the residents and sometimes the nurse is busy and we are not able to do it and this is for both downstairs and upstairs."

During interview on 5/21/21, at 10:27 a.m. NA-M stated, "staffing is horrible" and sometimes she was in rooms to get residents ready while other residents were served food and would eat. NA-M stated staff was unable to be in the dining room due to getting residents ready for the day.

During an interview on 5/21/21, at 12:44 PM the medical director stated, "I am not aware of any choking incident." The medical director stated his expectation for supervision was, "I do not think my expectation is that they don't need to have

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eyes on the patient every second." The medical director further stated, "One of the problems with COVID is there less people in the dining room. Someone is available to monitor, but not hands on every second." The medical director stated with six people in the dining room someone should have been responsible to monitor the situation and if the surveyor had not come and he did not know how long it would have taken someone to respond. The medical director stated there was always a risk for someone to choke and thought someone needed to be available nearby to hear and respond, but not visibly. The medical director stated if the speech therapist recommended someone be with a resident, then the order was not followed. The medical director also stated if the patient was already purple, they should had been monitored a little bit more closely.

During an interview with DON on 5/21/21, at 2:28 p.m. The DON stated all the residents in the dining area were supposed to be supervised and would expect someone to be in the dining area to watch the residents. The DON also stated if the nurse was at the nurses' station and positioned at a certain angle, she would consider it supervision, but if the residents were not in eyesight from the nurses' station then it would not had been considered supervision.

During an interview on 5/21/21, at 2:40 p.m. nurse practitioner (NP)-C stated she was informed of the incident of R75 choking. NP-C stated R75 had a history of dysphasia after his CVA and a history of aspiration pneumonia, but was unsure of when it last occurred. NP-C stated R75 was treated with inhalers after a respiratory illness which was possibly related to aspiration in

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January 2020. NP-C stated she expected R75 is to be monitored in the dining room with staff in dining room or at nurses' station facing residents.

Facility policy Activities of Daily Living dated 3/11/15, revised on 10/25/20, directed staff to provide necessary services for residents who were unable to carry out activities of daily living.

The IJ which began on 5/21/21, was removed on 5/24/21, 10:08 a.m when the facility developed and implemented a systemic plan which was verified by observation, interview, and document review: The plan included:
- Education on the need to supervise residents identified at risk for choking was provided to nursing personnel on 5/21/21. Nursing personnel who were not working were notified education needed to be completed prior to their next scheduled shift.
- An audit was completed on 5/21/21, which identified residents who were at risk for choking.
- The Supervision of Residents At Risk for Choking and Foods Brought in by Family/Visitors policy and procedure for was reviewed and revised on 5/21/21.
- Residents at risk for choking who prefer to eat in their room were evaluated by speech therapy on 5/24/21.
- Nursing staff were assigned as a dining room monitor for each dining room and each shift daily and verified on 5/24/21.

FALLS
R1's Face Sheet printed 5/21/21, indicated R1's diagnosis included congestive heart failure, generalized muscle weakness, and macular degeneration.

R1's admission Minimum Data Set (MDS) dated

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5/14/21, indicated R1 was cognitively intact and required two staff physical assistance for bed mobility, transfers, and toilet use. R1 was frequently incontinent of urine and bowel and the MDS indicated no fall history.

R1's care plan dated 5/12/21, directed R1 required assistance of two staff for bed mobility, and toileting. The care plan further indicated R1 was at risk for falls due to impaired mobility.

R1's activities of daily living (ADL) Care Area Assessment (CAA) dated 5/20/21, indicated R1 required extensive assistance for bed mobility and transfers, and had impaired mobility and balance.

R1's nursing assistant task sheet dated 5/20/21, indicated R1 required assistance of two staff for ADL's.

R1's progress notes dated 5/20/21, at 11:41 p.m. indicated at 8:50 p.m. nursing assistant (NA)-I reported R1 had fallen out of bed. R1 was lying on the floor on her right side. R1's right hand was tucked under her body and was bleeding. NA-I's statement was, "I turned [R1] to her left side, giving peri care, then she said 'I am having a BM', then I feel the heaviness of her body going over to the ground, I try to pull her back but I couldn't." R1's bed was at waist height. R1 was assisted off the floor with Hoyer and two staff assist. R1 obtained a skin tear to the back of right-hand measuring 10 cm [centimeters] by 7 cm, and a skin tear to the right elbow measuring 10 cm by 3 cm, both secured and dressing applied. R1 was able to wiggle fingers and complained of [C/O] burning sensation to skin tear. Range of motion (ROM) was intact to extremities, neurological

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examination was normal for R1. R1 C/O difficulty breathing to right side (while holding right rib area)." Staff applied oxygen and contacted the on-call provider who stated to provide comfort cares, apply ice to ribs, if needed, and monitor until R1 was seen tomorrow by in house provider.

R1's progress notes dated 5/21/21, at 6:00 a.m. indicated R1 complained of right sided pain and stated, "It's hard to breathe on my right side."

R1's progress notes dated 5/21/21, at 1:39 p.m. indicated R1 was an assist of two staff with a Hoyer lift. R1 complained of pain on right hip and legs due to fall. R1's doctor ordered a x-rays of R1's right rib, hand, and wrist. The progress note further indicated R1 was able to move both of her arms and expressed some pain; R1 was able to move both legs without pain. Multiple bruises were noted on R1's abdomen and left thigh. R1 also had one bruise to her right inner thigh.

R1's Post Fall Evaluation dated 5/21/21, indicated R1 did not have a history of falls and nursing interventions included assistance of two staff.

R1's x-ray results dated 5/21/21, indicated she suffered fractures of the third, fourth, fifth, and sixth ribs and also had a partial dislocation of her fifth finger at metacarpophalangeal joint (where the hand bone meets the finger bones).

When interviewed on 5/21/21, at 12:10 p.m. family member (FM)-F stated on 5/20/21, R1 had a fall out of bed when a staff was providing incontinence care. FM-F stated there was only one staff-person who assisted R1 and there was supposed to be two. FM-F stated R1 received an x-ray of her hand and was notified on 5/19/21,

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R1's bed was elevated at the time of the fall. FM-F stated, "The one gal was changing her and rolled her over and she fell right out of bed." FM-F also stated R1 had sustained a skin tear to her hand.

When interviewed on 5/21/21, at 12:28 p.m. R1 stated, "They were taking care of me and only one person tried to change me. It is ridiculous." R1 was observed to have a skin tear about the size of a quarter on the back of her elbow with bruising which extended down the forearm towards the wrist. R1 had a dressing midway down forearm wrapped with gauze and tape with visible blood on the dressing. R1 had an ace wrap on her arm with gauze below with the wrap holding visible dried blood. All fingers on R1's right hand were bruised with dark blue, dark red, and dark purple coloration, up to the knuckles before the nail. R1 was able to move all fingers upon command. R1 verified she required the assistance of two staff for incontinence care and positioning needs. R1 stated, "It's two always." R1 stated she felt 10/10 pain immediately after the fall and stated, "it felt like I was being tortured."

When interviewed on 5/21/21, at 12:56 p.m. registered nurse (RN)-E verified R1's fall occurred and the plan of care was not followed and stated, "NA-I was doing cares for her and there was only one aid and she rolled out of bed, she is actually assist of two for transfers and ADL's."

When interviewed on 5/21/21, at 1:36 p.m. NA-I confirmed she provided incontinence care for R1 5/20/21, and stated, "I know I shouldn't have done her myself, but the floor was very busy, call lights were going off." NA-I stated she removed R1's

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brief, turned R1 on her side when R1 began having a bowel movement. NA-H stated she had her left hand on R1's hip when cleaning R1 with her right hand. NA-I stated she felt R1's weight stating to shift, and, "The next thing I know she was on the floor." NA-I stated R1's bed was elevated slightly above her hip height and about three-to-four feet above the ground. NA-I verified R1 required two staff for incontinence care and stated, "When I looked there was no one to help me." NA-I stated after the fall, R1 complained of pain on her right side and her right hand where she sustained a skin tear.

When interviewed on 5/21/21, at 2:25 p.m. the director of nursing (DON) stated she expected staff to follow the plan of care, and NA-I would receive retraining.

When interviewed on 5/24/21, at 8:03 a.m. R1 laid in bed and stated her arm, "hurts horribly" and, "I am so sore, I have some ribs, I can tell that they are broken." R1 recounted her fall and further stated, "I've never had something so terrifying in my life."

When interviewed on 5/25/21, at 8:15 a.m. nurse practitioner (NP)-A verified R1's fall and stated her injuries were consistent with a fall from bed. NP-A verified R1's required level of assistance and stated, "I would expect that they would have two people."

Facility policy titled Comprehensive Care Plans, revised 10/28/20, directed qualified staff were responsible for carrying out interventions specified in the care plan and would be notified of their roles and responsibilities for carrying out the interventions initially and when changed were

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made.

R22's diagnoses included abnormal gait and mobility, weakness, history of falls with a displaced intertrochanteric fracture left femur, closed fracture with routine healing and dementia obtained from the quarterly MDS dated 2/25/21. The MDS also identified R22 had severely impaired cognition, required extensive physical assistance two staff for bed mobility, transfers, and did not walk in the room or in the corridor during the assessment period.
The MDS identified for balance R22 was not steady during transitions, and walking, and moving on and off the toilet. In addition, the MDS indicated R22 had a fall in the last two to six months with a fracture.

R22's care plan effective 11/16/20, identified R22 had the potential for falls related to dementia and history of falls. Interventions included: staff to anticipate R22's needs and promote safety.

During interview on 5/17/21, at 2:20 p.m. family member (FM)-D stated R22 had no recent falls, however, two to three days after R22 was admitted at the facility, R22 had a fall and sustained a fracture. FM-D stated during a companion visit she had noticed R22 was wearing regular non-skid shoes. FM-D stated R22's non-skid shoes were missing from his room. During the interview, R22 was observed laying in bed on his back and was wearing long black with gray soles socks.

On 5/17/21, at 12:11 p.m. nursing assistant (NA)-C was observed wheeling R22 into the dining room. R22 was observed not wearing appropriate footwear.

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F 689	Continued From page 62 On 5/19/21, at 7:16 a.m. R22 was observed seated in a wheelchair in the TV lounge. R22 stated he was not assisted to walk that morning. R22 was not wearing no shoes or other non-skid footwear. -At 8:35 a.m. R22 wheeled himself out of the dining room, down the hallway, and went back to his room. R22 self-transferred himself to bed. R22 was not wearing shoes or non-skid footwear to prevent a fall. On 5/20/21, at 7:55 a.m. R22 was observed propel his wheelchair down the hallway towards the dining room and when he got to the dining room entrance, the environmental service director wheeled R22 to the table. During the observation R22 was not wearing shoes or non-skid footwear. -At 8:37 a.m. R22 was wheeled himself out of the dining room. At this time registered nurse (RN)-D approached R22 and asked him to wait for her as she was going assist him to his room and into bed as she did not want R22 to fall. -At 8:43 a.m. RN-D assisted R22 to his room and cued R22 to set the wheelchair next to bed. R22 stood up and was not wearing shoes or non-skid footwear as he pivoted and sat in his bed. During the transfer R22 was observed to be unsteady, but was able to stabilize himself without RN-D's assistance. R22 was not offered shoes or other non-skid footwear prior to the transfer to reduce the risk of a fall. -At 8:44 a.m. RN-D stated, "He should wear gripper socks because he is a high fall risk. I have never seen him with shoes" R22 then stated he used to have shoes, but they were missing. RN-D stated R22 would self-transfer if staff were not present to assist him. RN-D stated R22 also self-transferred himself on-and-off the toilet.	F 689		

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F 689	Continued From page 63 RN-D offered resident non-skid footwear and this time. R22 accepted the non-skid footwear. During interview on 5/21/21, at 8:11 a.m. the director of nursing stated staff should ask R22 if he would allow them to put on gripper socks.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		6/29/21

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F 725	Continued From page 64 Based on observation, interview and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance they needed. This had the potential to affect 65 of 65 residents who resided in the 2 South, 2 North, and the memory care unit. Findings include: Refer to F676: The facility failed to provide assistance removing facial hair and/or provide nail care for 2 of 11 residents (R37 and R23) reviewed for activities of daily living. Refer to F677: The facility failed to ensure facial hairs were removed, oral and nail care was offered/provided, and/or assistance eating was offered/provided for 4 of 11 residents (R15, R35, R64, R73), who were dependent upon staff for assistance, reviewed for activities of daily living (ADLs). Refer to F686: The facility failed to provide timely repositioning for 3 of 7 residents (R68, R62, R75) reviewed for pressure ulcers. Refer to F689: The facility failed to ensure adequate supervision was provided during meals for 1 of 3 residents (R75) identified to be at risk for choking. Further, the facility failed to implement interventions as directed by the care plan to prevent a fall for 2 of 3 residents (R1, R22) reviewed for falls. Resident/family interviews: During interview on 5/17/21, at 1:19 p.m. R73 stated, "It takes staff along time. All three shifts are bad. It can take up to an hour for staff to assist with cares."	F 725	F725 □ Sufficient Nursing Staff 1. Executive Director and DON have reviewed staffing patterns and resident acuity and will continue to do so on an ongoing basis. Staffing patterns are based on ratios applied to the census. Staffing patterns are reviewed daily by the DON and staffing coordinator, as well as at daily stand-up. 2. It is understood that all current and new residents have the potential to be affected by insufficient staffing. 3. -DON will schedule an ongoing weekly meeting with the staffing coordinator to review weekly openings, look ahead at scheduling, and problem solve staffing issues though communicating open shifts to staff, reviewing any interviews scheduled for nursing department needs, reviewing block schedule openings to be aware of those hire needs. -Actively hiring employees. - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it has been determined substantial compliance has been reached. 4. Executive director, DON, or designee to audit call light times daily for at least 4 weeks. Decrease audit schedule based on compliance. 5. This deficiency will be corrected by 6/29/2021.	

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During interview on 5/17/21, at 1:56 p.m. family member (FM)-D and R22, FM-D stated staffing was a concern on the unit because when R22 put the call light on the staff did not respond to it and R22 would get up and pee on the floor. A large yellow stain was observed on the floor to the right side of the bed. R22 stated at night, because the staff did not come to assist him, he would pee on the floor. R22's room at the time was noted with a strong smell of urine. R22 further stated he had been incontinent of urine because the staff did not come.

During interview on 5/17/21, at 3:09 p.m. R24 stated he had to wait up to one and one-half hours on the weekend for staff to assist him to the bathroom. R24 further stated, "Sometimes I need to get to the bathroom because I have diarrhea, and sometimes I cannot wait that long."

During interview on 5/17/21, at 3:44 p.m. R338 stated when she had asked for assistance to the toilet, staff would make her feel hurried, when either on the toilet or when getting out of bed. R338 further stated when she put the call light on, it was not answered promptly and that she had urine and stool incontinence, "it makes me feel terrible."

During interview on 5/17/21, at 4:31 p.m. R10 stated, "Lately I have to wait hours before someone comes to put me to bed and my bottom starts hurting. It varies and depends on how many are working."

During interview on 5/17/21, at 4:45 p.m. family member (FM)-F stated due to staffing concerns R75 did not receive timely care with being

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changed when incontinent or being assisted out of the bed to his chair.

During interview on 5/17/21, at 6:19 p.m. R67 stated, "I press the call button they come in a half-hour, I can't get pain medication or other medication quickly when needed."

Staff interviews:
During interview on 5/19/21, at 8:44 a.m. trained medication aide (TMA)-A stated due to staffing there was a delay in breakfast which was supposed to be served at 8:00 a.m. TMA-A further stated residents were supposed to be assisted with morning cares and be at the dining room an hour ago, however, due to staffing this had not happened. TMA-A further stated the facility management was aware of concerns and staff had expressed the need to have two NA's (nursing assistants) in the unit Garden Court. During the observation there was no management staff at the unit assisting with the mealtime.

On 5/19/21, at 9:00 a.m. TMA-A approached R35 to assist with eating and she sat next to R35 then she stated, "you see what am talking about. This man right here needs to be fed and if we had two aides, we would have them all fed. We tell them every day and they see the struggle every day." TMA-A then stated she was not done passing the morning medications and some of them would be late.

During an interview on 5/19/21, at 10:10 a.m. LPN-A stated the aide caring for R62 was on break at the time, and repositioning residents timely was difficult due to staffing concerns.

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On 5/19/21, at 2:18 p.m. TMA-A stated she was surprised the unit was staffed with two NA's for the evening shift. TMA-A stated this was what was supposed to happen, but the facility did not pay attention to the residents acuity, cares, and behaviors in the memory care unit.

During an interview on 5/20/21, at 6:57 a.m. LPN-A stated usually two nurses and two aides provide cares for both hallways on the 2 South unit. LPN-A further indicated that the lack of staff had caused repositioning to be missed and that a third aide floating between the two hallways on two South and a third aide floating between the two hallways on 2 North would be helpful. LPN-A stated over half the residents in rooms 213 through 225 required two staff for assistance.

During an interview on 5/20/21, at 7:35 a.m. LPN-A stated on the memory care unit the nurse is required to get two residents up in the morning and the aide was to get all the other residents up. LPN-A further stated residents on the memory care unit can have behaviors at times and made it a challenge to get everything completed when it's just one nurse and one aide. LPN-A also stated sometimes there was an aide that floated between the Transitional Care Unit (TCU) and the memory care unit, but most of the time there was not an aide that floated between the two units.

During interview on 5/20/21, at 7:41 p.m. housekeeping (HK)-A stated, "I came to help to watch dining room until they are back. They are short staffed." HK-A stated she was not a trained nursing assistant and had been asked by registered nurse (RN)-D to watch the residents in the dining room as both nursing staff were in the rooms assisting residents to get ready for the

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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
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day.

During an interview on 5/20/21, at 8:38 a.m. LPN-A stated on the weekends there was not as much help to assist with meal passes like there is on the week days. LPN-A then stated it was difficult to pass meals, pass medications, and perform cares for the residents.

During an interview on 5/20/21, at 9:22 a.m. NA-M approached surveyor and pointed out three residents in the dining room with their breakfast plates in front of them and stated all three residents needed assistance with eating their breakfast but both nursing assistants were still working on getting residents up that morning.

During interview on 5/20/21, at 2:09 p.m. anonymous staff stated, "we used to have one float aide who went between Sub Acute [TCU] and Garden Court [memory care unit] units but it's been months now and we have been working with one aide and the nurse. Staffing is a problem for sure here because you just don't know when the behaviors start and we have to be out there constantly because we have to supervise because if you don't we have had problems with resident to resident altercations."

During interview on 5/21/21, at 10:07 a.m. NA-D stated there were serious staffing problems and that staff had been working short. NA-D also stated the aides were not able to reposition residents, ambulate them or do the cares in a timely manner. NA-D stated facility management was aware of staff concerns and had been told it was from the cooperate office to decrease staffing. NA-D further stated, "we are not able to provide supervision with meals because

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sometimes we have to leave the residents in the dining room to go to a room to help the residents and sometimes the nurse is busy and we are not able to do it and this is for both downstairs and upstairs."

During interview on 5/21/21, at 10:27 a.m. NA-M stated, "staffing is horrible. It's very hard on us even here we don't have help to feed these residents. Sometimes we must be in the rooms getting residents ready and some residents are up already, and they would serve them food and they would be eating. We can't be in the dining room and getting people up. We are not able to do this as I told you. They know and they tell us corporate does not want us to have another aide even to float.

During interview on 5/20/21, at 1:19 p.m. the staffing coordinator (SC) stated during business hours Monday through Friday he did all the staffing, however, on the weekend, evening or off hours the supervisor handled staffing. SC stated, at times, he was able to assist when out of the facility. The staffing coordinator stated when there was staffing concerns, he was able to assist with meals, turning, repositioning and showers and the staff were aware to ask as he was a NA. The SC stated he was trying to hire staff however since COVID hit it had been a challenge to hire staff. The SC stated staff had brought staffing concerns to him and when staff quit from the facility the reason was not staffing but was due to pay. The SC stated staffing patterns were determined by the DON who got the information from the nurse managers on the resident acuity on the floors. The SC stated the facility did not use supplemental pool nursing for staffing to fill the open shifts, but this was something he had

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thought of because he was not able to cover shifts. The SC stated pool would have to be authorized by the facility administrator and corporate. The SC stated he had worked the floor when the facility was short to assist with cares. The SC stated prior to COVID the facility turnover rate was relatively low, however, after COVID came, they noticed a huge turnover. When asked if he was aware specifically the staffing challenges in the Garden Court unit, the SC stated, "I can't say I have been able to see. The float is usually what we use, and I have put a request for the aides to pick up if we don't have staff picking up." When asked who was supposed to come to the unit to assist in the unit during the morning shift or any other shifts such as evening or the weekend, the SC stated the nurses and the aides had been offered to call him if they needed any help. The SC stated one person from the management team was scheduled to come and help with meals, and he was not sure why there had not been assistance with meals in the Garden Court unit during the survey time 5/17/21, through 5/20/21. In addition, the SC stated he was not aware there had not been a float NA going between the Subacute and the Garden Court units during the survey. The SC stated usually during the morning and evening shifts the two units were supposed to have an NA floating between to assist with cares. He reviewed the schedule for the week and verified there was no float scheduled for the entire week then stated no staff had picked the shifts up. The SC reviewed random schedules in the last month and acknowledged at times when a licensed nurse had called in a TMA had been pulled to fill the position.

During an interview with the director of nursing

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(DON) and the facility administrator on 5/21/21, at 8:25 a.m. the administrator stated the facility had recently changed the staffing model, "we have to stay in business while caring for people." The administrator stated the new staffing model required staff to do more work, was more efficiency and the facility was looking at the Per Resident Day (PRD's- refers to costs/revenues calculation of how much you spend or make for each resident). The DON stated the facility was able to shift its resources and was able to meet staff needs and keep residents safe. The administrator stated there was residents at the facility who they were trying to adjust to their needs and the facility was looking at the acuity level of the residents. The DON acknowledged at times the facility was not staffed accordingly because the staff did not pick up the available shifts. The administrator stated a life enrichment staff for the memory care unit had been hired and this person would assist with activities in the unit. The administrator stated the staff knew what they need to do, and not do, and the facility had fired a number of staff as a result. The administrator stated using supplemental pool staff, "was a tricky thing to work with," there was no clearance to use pool by corporate office and there was concerns the pool staff would come to consult instead of working. The administrator stated there was three new people that were going to start and that there was not lot of empty shifts. The administrator also stated management had for four weeks straight been working with the corporate regional staff and had discussed about hiring plan, market, competitors, hiring bonuses and retention bonuses. The administrator stated he thought staffing was improving with currently what the facility was trying to do which included getting more staff being hired. The DON stated, "I think

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family and residents are hearing certain things from staff, our priority is the resident. We are constantly trying to adjust and provide staffing for them. We talk about staffing when we know someone had called in sick." The administrator stated, "We flexed hours down. That's what we have been having to do. We were staffing for 100 to 110, in January because of loss of census due to Covid, we went down to 85. Beginning of February 2021, after we re-assessed that we were suffering a loss, we addressed census the week of 2/11/21 and made a model change, a new pattern, which we tried out for a little bit, saw we needed more help, listened to the staff and added a certain amount of hours. We looked at what resident cares were, acuity and took it back to the table and adjusted a little bit, and had a conversation last week, and we will re-look at the acuity again." The DON acknowledged there was staffing challenges at the facility at the time and the facility was doing a referral bonus, sign on bonus for both nurses and NA's. The DON also stated one of the management staff team members was supposed to assist in the morning at the memory care unit however was not sure why this assistance was not available consistently during the survey dates.

The facility Nursing Services and Sufficient staff reviewed 10/22/20, directed, "It is the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure residents safety and attain or maintain the highest practicable physical, mental and psychological well-being of each resident..." The policy also indicated the facility will supply services by sufficient numbers of each of the personnel types on a 24 hour basis at all times to provide nursing care to all residents in accordance with the

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F 725	Continued From page 73 resident care plan. In addition, the policy indicated providing care included but was not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 725		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely referrals to in-house and/or outside optometry and audiology providers to obtain vision and hearing services for 1 of 1 resident (R37) reviewed for vision and hearing. R37's Face Sheet printed 5/20/21, indicated R37's diagnosis included, type 2 diabetes, generalized muscle weakness, and abnormalities of gait and mobility. R37's Face Sheet also indicated R37 had Medicare part A, Medicare part B, and a managed care plan with United Healthcare. R37's quarterly Minimum Data Set (MDS) dated 3/16/21, indicated R37 was cognitively intact, utilized a hearing aid or other hearing appliance. R37's care plan dated 12/19/20, indicated R37 was very hard of hearing (HOH) and utilized a whiteboard in her room for communication. R37 was able to hear best in her left ear and utilized a pocket talker.	F 745	F745 □ Provision of Medically Related Social Service 1. R37 □ Medical record updated to reflect current payor status. - Resident has been scheduled for next in-house audiology and vision visits, after communicating the co-pay and obtaining approval from the resident. 2. Audit all resident records to verify correct payor is listed. -Interview all residents to ensure that they are receiving audiology and vision services per their preference, correct any discrepancies found. 3. Add to an admission and hospital return checklist to verify/confirm payor source. -Review preferences for audiology, vision, and podiatry at admission, each care conference, and as need arises - This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the	6/29/21

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F 745	Continued From page 74 R37's progress notes dated 3/16/21, indicated R37, "does enjoy reading but states that she cannot do that at this time due to her needing a new prescription for her glasses. Resident is HOH and staff use a pocket talker or write her notes for better communication as she tends to yell when talking because she can't hear." R37's nursing assessment dated 4/2/21, indicated R37 had moderate difficulty with hearing and did not utilize a hearing device. R37's vision was adequate and did not utilize corrective lenses. R37's provider note dated 4/28/21, indicated R37 was very hard of hearing and previously had hearing aids. The note also identified R37 would like new hearing aids, but was awaiting medical assistance (MA). R37 had financial problems and was unable to pay for transportation. R37's medical assistance (MA) was pending and would be able to resume appointments once available. When interviewed on 5/17/21, at 2:14 p.m. R37 stated she was supposed to get a vision check in December, but but was not offered assistance to make an appointment. When observed on 5/18/21, at 2:41 p.m. R37 told the marketing director and stated her hearing aid was broken. R37 further explained to the marketing director her sister had sent her a pair of hearing aides, but hearing aids did not work and needed to be reprogrammed. The marketing director stated he would inform RN-A of the concern. When interviewed on 5/19/21, at 8:06 a.m. R37	F 745	QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. -Nursing, business, social worker, and admissions staff will be trained on ancillary service verification during education scheduled week of 6/21/2021. 4. Business office, Medical Records, Social Worker, or designee to audit charts of all new admissions and hospital returns weekly for at least 4 weeks to verify payor status is correct and congruent throughout the medical record. 5. This deficiency will be corrected by 6/29/2021.	

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stated she was unable to see out of her glasses and her hearing aids did not work. R37 stated she had not seen audiology since she was admitted to the facility in December.

When interviewed on 5/19/21, at 8:32 a.m. licensed practical nurse (LPN)-A stated the optometrist visited the facility one-to-two times monthly, but was unsure if R37 had been seen. LPN-A verified R37 was hard of hearing and did not have aids. LPN-A was unaware if R37 had requested an appointment with audiology.

When interviewed on 5/19/21, at 8:53 a.m. registered nurse (RN)-A stated Health Drive provided in-house services for eyes and ears. RN-A stated during COVID on-site services were unavailable, however, the facility had recently had two post-COVID audiology visits. RN-A stated audiology did not see R37. RN-A stated she believed R37 did not have a payer source for services and was awaiting MA. RN-A stated R37 would not privately pay and stated, "Until I can come up with a payer source we cannot provide [services] in-house if the resident is MA pending. RN-A stated she had attempted to send R37 out for services, but R37 refused to pay for transportation. RN-A stated social worker (SW)-A and the business office assistant handled insurance concerns and transportation.

When interviewed on 5/19/21, at 9:27 a.m. SW-A the business office assistant was working on MA for R37. SW-A verified the facility offered in-house services for podiatry, audiology, dental, optometry through Health Drive. SW-A stated the medical records assistant made resident appointments. SW-A stated R37 was MA pending and did not have coverage. SW-A stated R37

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declined to pay for transportation and outside services.

When interviewed on 5/19/21, at 9:31 a.m. SW-A stated R37, "Obviously has hearing issues, she has a hearing aid, but she doesn't like it." SW-A was not aware of vision concerns for R37.

When interviewed on 5/19/21, at 12:48 p.m. the business office assistant stated R37 was not MA pending as she had to spend downs assets prior to applying for MA. The business office assistant verified R37 had a managed care insurance plan through United Healthcare as of 2/1/21. The business office assistant confirmed staff never verified R37's insurance coverage for in-house or outside audiology or vision services. The business office assistance stated, "This is the first time someone is coming to me to ask me about this." The business office assistant stated R37 had a managed care plan and the medical records assistant scheduled appointments and transportation and should reach out to R37's managed care plan to verify coverage.

When interviewed on 5/19/21, at 1:12 p.m. the medical records assistant stated she was not aware that R37 had insurance coverage through United Healthcare and R37 was listed as private pay. The medical records assistant stated she did not believe United Healthcare covered transportation, but she had not inquired for R37. The medical records assistant stated she believed the in-house provider Health Drive required Medicaid for services, but would verify this with medical records staff. She further stated she had not inquired if United Healthcare would cover outside services for R37. She stated R37 previously refused to pay for transportation. The

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medical records assistant stated R37 may qualify for low-cost transportation services such as Metro Mobility due to her medical conditions, however, she had not applied for these services for R37.

When interviewed on 5/19/21, at 1:18 p.m. SW-A stated she was not aware that R37 had insurance through United Healthcare. SW-A stated she had not investigated completing a Metro Mobility application for R37.

When interviewed on 5/19/21, at 1:43 p.m. the sales and marketing director stated she was aware that R37 wanted to see the optometrist and audiologist and verbalized, "She has to be able to cover it for private pay." She was not aware that R37 had United Healthcare insurance coverage.

On 5/19/21, at 1:45 p.m. medical records assistant stated she received information from medical records and the in-house provider Health Drive would cover services for R37 under her United Healthcare insurance with a co-pay.

When interviewed on 5/21/21, at 10:29 a.m. the director of nursing (DON) stated she would expect if someone needed an appointment that they would be scheduled it. DON further stated, "I would have to follow-up on that and see what was missed.".

Facility policy titled Hearing and Vision Services revised 4/10/21, directed the facility will assist the resident in making appointments and arranging transportation to and from the office of a practitioner specializing in the treatment of vision / hearing impairments or provision of vision /hearing devices. The policy indicated social

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F 745	Continued From page 78 services was responsible to assist resident's in accessing resources, making appointments, and arranging for transportation.	F 745		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		6/29/21

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F 758	Continued From page 79 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure side effect monitoring was completed when prescribed psychotropic and/or anticoagulant medication for 1 of 5 residents (R68) reviewed for unnecessary medication use. Findings include: R68's diagnoses included Alzheimer's disease and dementia with behavioral disturbances obtained from the significant Minimum Data Set (MDS) dated 4/12/21. In addition, the MDS identified R68 had severely impaired cognition. R68 received antipsychotic, anxiety ,and antidepressants on a routine basis during the assessment period. R68's physician orders dated 5/20/21, revealed R68 was ordered: Seroquel (antipsychotic medication) 25 mg tablet one time daily Review of R68's medical record revealed:	F 758	F758 □ Free from Unnec Psychotropic Meds/PRN Use 1. R68 □ Side effect for antipsychotic medication monitoring added to EMAR/ETAR. -AIMs assessment completed. -Notify provider of side effects the resident is exhibiting, by end of week of 6/21/2021, if have not done so already. 2. Audit all resident charts that are on psychotropic medication to verify they have side effect monitoring in place, correct any discrepancies. -Audit all resident charts that are on an antipsychotic to verify they have a current AIMs assessment in place. 3. Develop and implement an order checklist for psychotropic medications to prompt side effect monitoring for all psychotropics and AIMs for antipsychotics. -Clinical staff to be trained/educated on process change during education	

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F 758	Continued From page 80 -An assessment titled Abnormal Involuntary Movement Scale (AIMS) was completed on 1/7/21, indicated R68 was not currently on an antipsychotic and the score was 0. -The physician orders indicated R68 was started on Seroquel on 2/10/21, however, the medical record lacked documentation of a subsequent AIMS assessment being completed to monitor for side effects of this medication. -The most recent monthly consultant pharmacist medication regimen reviews were completed on 4/7/21 and 5/7/21, however, it was not identified an AIMS assessment was not conducted. On 5/18/21, at 7:50 a.m. to 10:03 a.m. R68 was observed seated on a Broda wheelchair (specialized wheelchair) at the dining room drinking and then was served breakfast. During the observation R68 was observed to continuously stick out her tongue and had noted tremors when picking up a spoon or glass. R68 and was noted to have difficulty getting food to her mouth without spilling on her lap. On 5/19/21, at 8:35 a.m. to 9:37 a.m. R68 was observed up in a wheelchair at the dining room table and was observed sticking her tongue outward continuously and with hand tremors. During interview on 5/19/21, at 12:18 p.m. registered nurse (RN)-A stated the AIMS assessment for resident who received antipsychotic medications was supposed to be completed quarterly and when a significant change assessment was done after the admission assessment. RN-A reviewed R68's medical record and verified an AIMS assessment had not been completed on R68 since the start of Seroquel. RN-A stated she was going to have it	F 758	scheduled for the week of 6/21/2021. -Confirm with consultant pharmacist that psychotropics and all the required elements are in place during drug regimen reviews. -This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. DON, Nurse Manager, or designee to audit new psychotropic medication orders or order changes 5 days a week for at least 4 weeks. Decrease audit schedule based on compliance. 5. This deficiency will be corrected by 6/29/2021.	

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F 758	Continued From page 81 completed. On 5/19/21, at 3:40 p.m. the director of nursing provided an AIMS assessment completed 1/7/21, and verified the assessment identified R68 was not on any antipsychotropic medication and the score was 0. The DON stated she was going to follow-up on the concern. During interview on 5/19/21, at 2:44 p.m. the DON stated she would expect an AIMS to be completed for all residents on antipsychotic medications. The DON stated all residents were supposed to have a care plan for antipsychotic medication. During interview on 5/20/21, at 2:22 p.m. the facility consultant pharmacist (CP) stated the facility staff was supposed to complete an AIMS when a resident was started on new antipsychotic medications or when the medication was increased. The CP verified he did not have a current AIMS since R68 was started Seroquel. The facility Antipsychotic Medication Use reviewed 10/25/20, directed staff to monitor residents on antipsychotic medications for general cardiovascular, metabolic and neurologic adverse consequences which included tardive dyskinesia and Parkinsonism.	F 758		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of	F 773		6/29/21

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F 773	Continued From page 82 practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to update the physician of a laboratory result for 1 of 1 resident (R22) reviewed for a urinary tract infection. Findings include: R22's diagnoses included dementia, anxiety, abnormal gait and mobility, and weakness obtained from the quarterly Minimum Data Set (MDS) dated 2/25/21. In addition, the MDS identified R22 had severely impaired cognition and was frequently incontinent of urine. Review of interdisciplinary progress notes revealed: -5/11/21, at 5:27 a.m. R22 seemed restless and continued to shout out various commands/curse words intermittently throughout the shift. R22 voided spontaneously and had no abdominal discomfort. R22's post void residual was noted to be 55 (amount of urine that remains in the bladder after urinating). Will continue to monitor. -5/11/21, at 6:32 a.m. R22's urine specimen was collected and sent to the laboratory. A urine analysis/urine culture (UA/UC) results were pending. Review of the physician orders dated 5/12/21,	F 773	F773 □ Lab Srvcs Physician Order/Notify of Results 1. R22 □ Culture results obtained 5/20/2021 and resident started on new antibiotic, antibiotic completed after 5 days, and symptoms have cleared. 2. Audit all clients currently on antibiotics and verify that provider follow up was completed 48-72 hours after initiation of antibiotic. 3. Develop and implement a tracking tool that prompts follow up with the provider 48-72 hours after the initiation of antibiotics, to include culture results. -If needed, add a prompt to the EMAR/ETAR of the resident prescribed antibiotics to cue the nurse to follow up with the provider. -This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. -Nursing staff will be trained on notifying provider of 48-72 hours after initiation of antibiotics during education week of 6/21/2021.	

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F 773	Continued From page 83 revealed registered nurse (RN)-A had received the following order: "1. Keflex [antibiotic] 500 [milligrams] mg by mouth [PO] twice daily [BID] x 3 days 2. call NP [nurse practitioner] when the culture results are done." Further review of interdisciplinary progress notes revealed: -5/13/21, at 5:50 a.m. R22 was noted to be incontinent three times. No signs of urinary retention noted at the time. Will continue to monitor -5/15/21, at 5:15 a.m. R22 was screaming/yelling out. R22 was removing his incontinent pads frequently during the night with no apparent reasons. R22 was urinating either in bed, or on the floor, and was re-approached numerous times. R22 was not re-directable. In addition, R22 was often heard swearing loudly and cursing all night. R22 denied pain or discomfort when approached. Writer indicated this behavior had been observed during the days and nights per staff report and the nurse practitioner was to be updated on resident increased paranoia. Will continue to monitor. The medical record lacked documentation staff followed up with R22 who experienced urinary tract symptoms after the antibiotic course ended on 5/14/21. In addition, the medical record lacked documentation the nurse practitioner was updated with the results of the urine culture which was nine days since the specimen was sent to the lab and six days since R22 completed the antibiotic. During interview on 5/17/21, at 2:13 p.m. R22's family member, (FM)-D stated R22 was recently treated for a urinary tract infection. FM-D was not	F 773	4. Infection preventionist or designee to audit orders daily for new antibiotic orders to ensure follow up is scheduled and completed for at least 4 weeks. Decrease audit schedule based on compliance. 5. This deficiency will be corrected by 6/29/2021.	

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F 773	Continued From page 84	F 773		

sure if the infection had resolved as R22 still complained about trouble with urination. R22 stated he was still experiencing trouble when urinating and he had reported to the nurse.

During interview on 5/20/21, at 8:47 a.m. RN-D stated R22 was one of the few residents on the unit who was able to communicate their needs. R22 reported to RN-D he still experienced pain while urinating. R22 also stated it felt as if though he was constipated when urinating.

On 5/20/21, at 9:20 a.m. RN-D reviewed R22's medical record and verified an antibiotic was started for R22 on 5/12/21, and ended on 5/14/21. RN-D stated the UA/UC order was obtained on 5/11/21, by RN-A. RN-D confirmed the urine culture result was not faxed to the facility. RN-D reviewed the medical record and verified there was no documentation the facility called the lab to follow-up on the urine culture results.

R22's urine culture results obtained and printed 5/20/21, indicated Enterococcus faecalis (type of bacteria that grows in the intestinal tract) grew. The urine culture result did not indicate if the bacteria was susceptible to Keflex.

On 5/20/21, at 9:36 a.m. RN-D called the nurse practitioners office and was informed the nurse practitioner had not received the urine culture results. RN-D stated R22 still experienced, "Dysuria" (pain with urination) and was asked to fax the results to the office.

During interview on 5/20/21, at 9:38 a.m. RN-D stated there was no regularly scheduled nurse to follow-up on things like this urine culture on the

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F 773	Continued From page 85 nursing unit. RN-D stated the unit was staffed with a trained medication aide (TMA)'s who did not follow nursing tasks and duties such was following-up with labs and calling the nurse practitioner. On 5/20/21, at 2:09 p.m. RN-D stated R22 was started on Levofloxin 500 mg daily for five days. During interview on 5/21/21, at 8:13 a.m. the director of nursing stated she would expect the nurses to have followed up on the urine culture to make sure R22 got treatment timely. On 5/21/21, at 3:00 p.m. the policy for following up on physician orders was requested but was not provided.	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/29/21

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F 812	Continued From page 86 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean dishwear and cutting boards were stored seperately from soiled items to prevent cross contaimination. This had the potential to affect all 86 who resided at the facility and ate food from the kitchen. Findings include: On 5/17/21, at 12:00 p.m. a metal drying rack with multiple light rust spots was observed in the dirty dish room, near the dishwashing unit. Clean plate covers were observed to be sitting on the rack and approximately three feet away from the dishwasher. When interviewed, DSD verified the metal drying rack was used to dry clean plate covers and was in the dirty dish area. On 5/19/21, at 11:25 a.m. clean pots and cutting boards were observed to be stored in the dirty pots and pans pre-wash sink area, with less than four feet between the clean and dirty items. A dirty linen bucket containing soiled towels was positioned directly below where the clean cutting boards were hung. When interviewed, DSD stated she was not aware clean and dirty areas needed to be separated and the cutting boards were always stored that way. The DSD stated, "Well, then then rules must have changed since you were last here." On 5/20/21, at 12:00 p.m. clean items remained in dishwashing area. Soiled sheet pans observed in the sink.	F 812	F812 □ Food Procurement, Store/Prepare/Serve-Sanitary 1. Clean areas and dirty areas have been separated and designated in the kitchen. 2. It is understood that all current and new residents have the potential to be impacted by not having and maintaining sufficient separation between clean and dirty areas/items. 3. Dietary staff will be trained/educated on the storage and placement of clean and dirty items within the kitchen during the education scheduled for the week of 6/21/2021. -This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. Dietary manager or designee to audit the kitchen area 3 times a week for at least 4 weeks to ensure sufficient separation is maintained between clean and dirty areas/items. Decrease audit schedule based on compliance. 5. This deficiency will be corrected by 6/29/2021.	

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F 812	Continued From page 87 Facility policy titled Cleaning and Sanitization of Dining and Food Service Areas, dated 8/21/20, Directed, "The culinary services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		6/29/21

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F 880	Continued From page 88 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure hand hygiene	F 880	F880 □ Infection Prevention and Control 1. R68 and R15 □ Education provided	

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F 880	Continued From page 89 and gloving was completed during cares for 2 of 2 residents (R68, R15) reviewed for infection control. In addition, the facility failed to perform hand hygiene and wear appropriate personal protective equipment (PPE) after direct contact with residents and high touch environmental surfaces in quarantined resident's rooms during meal delivery. This had the potential to affect 3 of 26 residents (R342, R341, R55) who resided on the transitional care unit reviewed for dining. Findings include: R68's significant change Minimum Data Set (MDS) dated 4/12/21, indicated R68's diagnoses included dementia and severely impaired cognition. R68 required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. R68 always incontinent of bowel and bladder. R15's annual MDS dated 5/12/21, indicated R15's diagnoses included heart failure and Alzheimer's disease. R15 required extensive assistance with bed mobility, transfers, dressing, and toilet use. R15 was always incontinent of bladder and frequently incontinent of bowel. On 5/19/21, at 7:55 a.m. to 8:05 a.m. nursing assistant (NA)-F was observed getting R68 ready for the day. During the observation NA-F was observed to wipe R68's face with a wet wash cloth then patted dry R68's face. NA-F wiped R68 armpits and proceeded to provide with pericare. NA-F provided frontal perineal care and turned R68 towards a wall. NA-F wiped R68's buttocks which had visible stool. NA-F tossed the soiled linen and towel in the trash bag, removed his gloves, and re-applied another pair of gloves	F 880	and documented to employee NA-F to reinforce appropriate and expected hand hygiene practices during cares. R342, R341, and R55 □ Education provided and documented to employee NA-H to reinforce appropriate and expected hand hygiene practices and PPE use related to transmission-based precautions. 2. -All staff will be competency tested on hand hygiene practices during the education scheduled the week of 6/21/2021 -All staff will be competency tested on donning and doffing of PPE during education scheduled the week of 6/21/2021. 3. Root cause analysis will be completed to identify the problems that lead to the deficient practices related to hand hygiene and PPE use, interventions or corrective action plan will be developed and implemented to prevent recurrence. -Hand hygiene policies and procedures will be reviewed and updated, if needed, to ensure they meet CDC and CMS requirements. -PPE donning and doffing during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care, and standard care will be reviewed and updated, if needed. -Source control mask policy and procedure will be developed and implemented. -Policy and procedure for proper use of gowns will be developed and implemented.	

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F 880	Continued From page 90 without washing his hands. NA-F then applied R68's clothing, applied a clean incontinence pad and fastened it. NA-F then went to a drawer and grabbed a pair of socks. NA-F returned to the bedside and applied them on R68. NA-F then removed gloves and left R68's room without washing his hands. NA-F returned to R68's room shortly after with the mechanical lift. On 5/19/21 8:12 a.m. to 8:28 a.m. nursing assistant (NA)-F was observed assist R15 with morning cares. During the observation, after NA-F applied gloves, he approached R15 with a wet wash cloth and wiped R15's face and armpits then patted them dry and then assisted R15 to get dressed. -At 8:18 a.m. NA-F cued R15 he was going to provide pericare. NA-F then was observed provide pericare in the front, turned R15 to the side, and wiped R15's buttocks. NA-F wiped stool then removed a wet pad. NA-F tossed the incontinent pad in the trash. NA-F, without removing his gloves and washing hands, reached for a clean pad and applied it on R15. NA-F touched R15's clothing and body. At this time, the surveyor intervened and asked NA-F to remove his gloves. NA-F went to the bathroom and washed his hands. During interview on 5/19/21, at 1:38 p.m. NA-F stated he was supposed to change gloves after doing pericares and wash his hands before applying another pair of gloves. NA-F acknowledged he had not completed proper gloving and hand hygiene during care observations. NA-F stated, "I know what to do but I forgot. The work is just too much here." During interview on 5/21/21, at 8:15 a.m. the	F 880	-Transmission-based precautions and standard precautions policies and procedure will be reviewed and updated if needed. -All staff will be educated on infection control prevention and control practices, including standard precautions, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. -Residents and resident representatives will receive education on facility□s infection control program as it relates to them and to the degree possible consistent with the resident□s capacity. -This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. DON, Infection Preventionist, or designee to audit hand hygiene practices every shift, every day for one week. Audit frequency may be decreased based on compliance. -DON, Infection Preventionist, or designee to audit donning and doffing of PPE with transmission-based precautions, on all shifts, 4 times a week for one week, then twice weekly for one week once compliance is met. -DON, Infection Preventionist or designee to audit source control masking of staff, visitors and residents 4 times a week for one week, then twice weekly for one week once compliance is met. -DON, Infection Preventionist, or designee	

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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
F 880	Continued From page 91 director of nursing stated she would expect all the staff at the facility to follow proper hand hygiene and glove use when providing cares. The facility Hand Hygiene policy reviewed 10/21/2020, directed staff to perform hand hygiene during this occasions: a. Whenever hands are visibly contaminated or soiled. b. Before and after contact with residents. c. After contact with contaminated environmental surfaces adjacent to the resident. d. Before assisting residents with eating or handling food. e. After toileting or assisting residents with toileting, handling of urinals, bedpans, catheters, soiled linens, towels, wash cloths. j. Before performing a resident care ADL procedure and after removal of gloves is worn. k. When caring for isolation residents before and after donning gloves. R342' admission MDS dated 5/11/21, indicated R342's diagnoses included dementia and diabetes mellitus. R341's admission MDS dated 5/12/21, indicated R341's diagnoses included renal insufficiency and diabetes mellitus. R55's admission MDS dated 4/3/21, indicated R55's diagnoses included respiratory failure. On 5/18/21, at 8:47 a.m. NA-H delivered a meal tray to R342's room. NA-H then exited the room and returned to the meal cart. NA-H obtained another meal tray and entered R341's room who was on quarantine. NA-H did not wear a gown or gloves. NA-H adjusted R342's bedside table and	F 880	to conduct real time audits on all aerosolized generating procedures to ensure PPE use. -DON, Infection Preventionist, or designee to conduct real time audits on proper gown use to ensure PPE use. 5. This deficiency will be corrected by 6/29/2021.	

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	245267	A. BUILDING _____ B. WING _____	C 05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HEALTH & REHABILITATION	**3700 FOSS ROAD NORTHEAST ST ANTHONY, MN 55421**

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F 880	Continued From page 92	F 880		

pulled R342's wheelchair backwards. NA-H then placed a towel around R342's neck and removed the plate cover. NA-H stirred R341's oatmeal and exited the room without performing hand hygiene. NA-H returned to meal cart and obtained another tray. NA-H then delivered a tray to R55's room who was not on quarantine. NA-H exited R55's room without performing hand hygiene and returned to meal cart. NA-H obtained an additional meal tray and delivered it to R343's room who was on quarantine. NA-H did not wear a gown or gloves. NA-H adjusted a Kleenex box on R343's bedside table and placed the meal on the table. NA-H adjusted the head of R343's bed and placed a towel around R343's neck. NA-H then removed R343's plate cover and exited the room without performing hand hygiene. NA-H went back to the meal cart and obtained another tray. NA-H delivered the tray to R344's room who was on quarantine. NA-H moved R344's remote control which was on a bedside table. NA-H then set R344's meal tray down and put on gloves. NA-H picked up R344's cell phone, glasses, urinal, and water mug from off of the floor. NA-H then moved R344's wheelchair and adjusted the bedside table. NA-H removed one glove and threw it in the trash. NA-H then grabbed a bag of soiled linen with their gloved hand and exited R344's room. NA-H pushed the meal cart with her ungloved hand to the kitchen. NA-H then entered the soiled utility room and left the bag of soiled linen in the room. NA-H performed hand hygiene at this time.

When interviewed on 5/18/21, at 9:00 a.m. NA-H verified she had not sanitized when passing meal trays during the observation on 5/18/21.

When interviewed on 5/18/21, at 9:10 a.m. NA-G

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F 880	Continued From page 93 verified she did not sanitize her hands between resident's rooms during meal service, including those on contact precautions and stated, "I'm sorry, I forgot. I was just trying to get everyone food." NA-G further stated she was educated on infection control, hand sanitization, and handwashing. When interviewed on 5/20/21, at 8:06 a.m. the infection preventionist, registered nurse (RN)-H verified hand sanitization should be completed when moving from resident-to-resident during meals. RN-H stated staff should, "gel in, gel out." RN-H verified there are multiple residents on quarantine who resided on the transitional care unit (TCU). RN-H stated it was important to sanitize after contact with quarantined residents and their environment ,"to make sure we did not have another COVID outbreak." When interviewed on 5/21/21, at 10:27 a.m. the director of nursing (DON) stated staff, "Should always sanitize between rooms." Facility policy titled Transmission Based Precautions, revised 10/29/20, identified infections agents are spread by direct or indirect contact with the patient or patient's environment and directed staff to wash hands with soap and water before leaving the room when working with a resident on transmission based precautions.	F 880		
F 921 SS=F	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.	F 921		6/29/21

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F 921	Continued From page 94 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the primary steam oven was maintained in a safe and functional manner. Further, the facility failed to ensure a sanitary kitchen environment for food preparation and distribution. This had the potential to affect all 86 residents who resided at the facility. Findings include: Equipment During the initial kitchen tour on 5/17/21, at 12:00 p.m. multiple towels were observed on the floor beneath the steamer oven. The towels appeared visibly moist with a light yellow color. When interviewed, the dietary services director (DSD) stated the steamer oven was "chronically leaking" and verbalized towels needed to be changed out twice daily. When interviewed on 5/19/21, at 11:20 a.m. DSD stated the steamer should be receiving general maintenance including to delime the machine. DSD stated the water softening system did not run into the kitchen, causing the steamer to not "work properly." DSD stated the steamer not working properly, "it's a safety hazard." When interviewed on 5/21/21, at 8:21 a.m. the maintenance director (MD) verified he was aware of a previous steamer leak and stated the machine was serviced by a contracted vendor on 3/25/21, as the unit, "was not working." MD stated the unit was delimed/descaled and, "there was a heavy accumulation." MD stated after the March	F 921	F921 □ Safe/Functional/Sanitary/Comfortable Environ 1. Complete repairs/clean steamer oven. -Clean/remove dust from areas above clean pots and pans and above food preparation areas. 2. It is understood that all current and new residents have the potential to be affected by failure to maintain cleanliness of food preparation areas and proper maintenance of food service equipment. 3. The routine daily cleaning list will be updated to include cleaning/dusting of ceiling tiles, walls, lights, and power cords to cleaning checklist. -Dietary staff will be trained/educated on the additional cleaning responsibilities during education scheduled the week of 6/21/2021. -This and all deficiencies and the resulting POC will be brought to QAA on 6/24/2021. - Audit findings will be reviewed at the QAA meeting on 6/24/2021 and in the monthly QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. Dietary manager or designee to audit cleanliness of kitchen daily for at least 4 weeks. Decrease audit schedule based on compliance. Maintenance director to be notified immediately of any observed food service equipment malfunction. 5. This deficiency will be corrected by 6/29/2021.	

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F 921	Continued From page 95	F 921		

repair the unit was functioning and he was not aware of the current leak and stated, "I thought everything was okay." MD stated he was not aware kitchen staff were using towels to absorb fluid and this was a safety concern. MD stated, "If you have a towel that is holding water, that is an issue for me, standing water is an issue, there should not be standing water." DSD stated he did not do anything as far as regular maintenance on the unit.

When interviewed on 5/21/21, at 11:56 a.m. the administrator verified he was aware of the steamer leaked and stated it was previously serviced and, "required some significant cleaning." The administrator further stated the unit was "put on the radar" for possible capital replacement.

Facility invoice from Commercial Kitchen Services, indicated a service date of 3/24/21, indicated, "please go through steamer unit overflows and floods kitchen at night..." Arrived on site and went over equipment. Found steam relief valve full on scale and will require replacement. Steam inlet valves are not opening all the way. Turned unit off and found rain valve also not draining. Ordered parts next day are per customer request.

Facility invoice from Commercial Kitchen Services, indicated a service date of 3/25/21, indicated "returned and replaced solenoid valves and relief valves. Reassembled unit. Found boiler packed full of scale, cleaned unit manually. Will provide an estimate for further repairs needed. Unit should have boiler replaced."

Facility policy titled Requesting Equipment

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F 921	Continued From page 96 Repair, revised 3/31/20, indicated "equipment must be maintained in proper working aid." Cleanliness On 5/19/21, at 11:26 a.m. a heavy accumulation of dust was observed caked on the ceiling tiles and the wall directly above the storage area for clean pot and cutting boards. When interviewed, DSD verified the finding and stated it looked like dust. On 5/19/21, at 11:30 a.m. a heavy accumulation of dust was observed on the ceiling vent, ceiling light, ceiling tiles, and descending power cords from the ceiling directly above the food preparation area. The DSD verified the finding and stated, "Look at all that dust there." On 5/20/21, at 11:56 a.m. a heavy accumulation of dust was again observed on the ceiling vent, ceiling light, ceiling tiles, and descending power cords from the ceiling directly above the food prep area. Open containers of mashed potatoes and pureed vegetables were sitting on the counter directly below. When interviewed, C-B verified the finding and stated, "Looks like dust." C-B further stated, "I can wipe that off. I will get a stool and take care of it." On 5/20/21, at 12:00 p.m. a heavy accumulation of dust remained on ceiling tiles and the wall directly above the storage area for clean pots and cutting boards. Clean items remained in dishwashing area. Soiled sheet pans observed in the sink. When interviewed on 5/21/21, at 8:21 a.m. Maintenance Director (MD) stated cleanliness	F 921		

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F 921	Continued From page 97 should be taken care of by kitchen staff. MD stated he recently cleaned some ceiling tiles which were dirty. The maintenance director stated cleaning was done upon request. Review of the kitchen Daily Cleaning List undated, lacked indication of vents, lights, ceiling tiles, and power cords. Facility document titled Lunch Cook Position A Daily Cleaning List lacked direction for staff to clean above food preparation areas. Facility policy titled Cleaning and Sanitization of Dining and Food Service Areas, dated 8/21/20, directed, "The culinary services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule."	F 921		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 19, 2021. At the time of this survey, St. Anthony Health & Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/21/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Anthony Health and Rehabilitation is a 2-story building without a basement that was built in 1967 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic 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 shares a common wall with an assisted living facility that has a 2-hour fire rating.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 140 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting 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 document review and staff interview, the facility failed to maintain emergency lighting in accordance with NFPA 101 2012 edition, Life Safety Code, section 19.2.9.1 and 7.9.3.1.1. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of 9:00-1:00 pm on 5/19/2021, it was revealed that the emergency light units were not tested for the months of September and October. This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 291	1. The Director of Maintenance or designee will ensure that emergency light unit testing is completed on a monthly basis. 2. Emergency light unit testing has been added to the Maintenance Connection software as a task to notify the Maintenance department staff that monthly testing is needed on an ongoing basis. 3. Maintenance staff will be trained/educated on any policy changes by 6/29/21. This deficiency and POC will be brought to the QAA meeting on 6/24/21. Audit findings will be reviewed at the QAA meeting on 6/24/21 and QAA meetings thereafter until it is determined that substantial compliance has been reached. 4. The Director of Maintenance,	6/29/21

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K 291	Continued From page 3	K 291	Executive Director, or designee, are responsible for making sure monthly tests are completed and logged. 5. This deficiency will be corrected by 6/29/2021.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 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 document review and staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 101 2012, Life Safety Code, Section 9.6.1.5, and NFPA 72 2010 edition, National Fire Alarm and Signaling Code, section 14.3.1 and 14.6.2.1. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of 9:00 AM and 1:00 PM on 5/19/2021, it was revealed that the facility did not have a current copy of the last annual testing of the fire alarm system. This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 345	1. Annual fire testing of the fire alarm system was in compliance at the time of the fire marshal inspection; however, a copy of the inspection report was not able to be located. A copy of the annual testing of the fire alarm system inspection report was sent to Roy Kingsley on May 21, 2021. All testing records for the fire alarm system will be maintained in the Director of Maintenance□s office. 2. Annual fire testing of the fire alarm system is in the Maintenance Connection software to notify the Maintenance department staff that this testing is needed on an ongoing annual basis. 3. Maintenance staff will be	6/29/21

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K 345	Continued From page 4	K 345	trained/educated on completion of annual fire testing of the fire alarm system. This deficiency and POC will be brought to the QAA meeting on 6/24/21. The facility was in compliance. 4. The Director of Maintenance, Executive Director, or designee are responsible for making sure that fire testing of the fire alarm system is completed on an annual basis. 5. This deficiency will be corrected by 6/29/2021.	
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 This REQUIREMENT is not met as evidenced by:	K 353		6/29/21

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K 353	Continued From page 5 Based on document review and staff interview, the facility failed to maintain the automatic fire sprinkler system in accordance with NFPA 101 2012 edition, Life Safety Code, section 9.7.5 and 9.7.7, and NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of (9:00-1:00 pm) on 5/19/2021, it was revealed that the facility did not provide a record of quarterly fire sprinkler system inspection being completed. This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 353	1. Quarterly fire sprinkler system inspection was in compliance at the time of the fire marshal inspection; however, a copy of the inspection report was not able to be located. A copy of all quarterly fire sprinkler system was sent to Roy Kingsley on May 21, 2021. All records for sprinkler inspections will be maintained in the Director of Maintenance□s office. 2. Quarterly fire sprinkler system inspections are in the Maintenance Connection software to notify the Maintenance department staff that this testing is needed on an ongoing quarterly basis. The facility was in compliance. 3. Maintenance staff will be trained/educated on completion of quarterly fire sprinkler system inspections. This deficiency and POC will be brought to the QAA meeting on 6/24/21. The facility was in compliance. 4. The Director of Maintenance, Executive Director, or designee are responsible for making sure that quarterly fire sprinkler system inspections are completed. 5. This deficiency will be corrected by 6/29/2021.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		6/29/21

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	245267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2021**

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K 372	Continued From page 6 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 smoke barrier construction in accordance with NFPA 101 2012 edition, Life Safety Code, section 19.3.7.3 and 8.5.6.2. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 9:00 AM and 1:00 PM on 5/19/2021, it was revealed that a penetration was found above the ceiling around a small pipe by Room 228. This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 372	1. The area around the pipe by room 228 was fire caulked on 5/25/2021. 2. Facility will monitor for smoke barrier penetrations monthly, and following any construction or repairs. Smoke barrier inspections have been added to the Maintenance Connection software to notify the Maintenance department staff that this inspection is needed on an ongoing monthly basis. 3. Maintenance staff will be trained/educated on the monthly completion of smoke barrier inspections. This deficiency and POC will be brought to the QAA meeting on 6/24/21. 4. The Director of Maintenance, Executive Director, or designee are responsible for making sure that smoke barrier inspections are completed on an monthly basis. 5. This deficiency will be corrected by 6/29/2021.	

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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 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 smoke barrier doors in accordance with NFPA 101 2012 edition, Life Safety Code, section 8.3.4, and NFPA 80 2010 edition, Standard for Fire Doors and Other Opening Protectives, section 6.3.1.7.1. This deficient practice could affect all residents in both smoke compartments. Findings include: On a facility tour between the hours of 9:00 AM and 1:00 PM on 5/19/2021, it was revealed that the smoke barrier doors in the Memory Care Unit by Room 108 did not close tight when tested. This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 374	1. All smoke barrier doors have been checked for proper closure. Midwest Door Company was contracted and repaired the smoke barrier door in the Memory Care Unit by Room 108 on 6/9/2021. Smoke barrier doors will be checked monthly and with activation of fire alarm system. Smoke barrier door closure has been added to the fire drill form. 2. Smoke barrier door inspections, to ensure good working order, have been added to the Maintenance Connection software to notify the Maintenance department staff that this inspection is needed on an ongoing monthly basis. 3. Maintenance staff will be trained/educated on the monthly inspection of smoke barrier doors for	6/29/21

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K 374	Continued From page 8	K 374	good working order. This deficiency and POC will be brought to the QAA meeting on 6/24/21. 4. The Director of Maintenance, Executive Director, or designee are responsible for making sure that smoke barrier door inspections are completed on a monthly basis. 5. This deficiency will be corrected by 6/29/2021.	
K 918 SS=C	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	K 918		6/29/21

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K 918	Continued From page 9 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 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the essential electrical system in accordance with NFPA 99 2012 edition, Health Care Facilities Code, section 6.4.1.1.6.1, and NFPA 110 2010 edition, Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of (9:00-1:00 pm) on 5/19/2021, it was revealed that the KW load capacity for both generators was not noted on the monthly records. Therefore the surveyor could not determine that 30 percent load capacity had been achieved. . This deficient practice was verified by the Facility Asst. Maintenance Director at the time of discovery.	K 918	1. KW load capacity will be logged monthly. The Onan Generator has a readout for KW load under the Genset tab in the diagnostics. The Kohler Generator KW will be logged using the Amps to Kilowatt Calculator as recommended by Cummins, who services our Generators bi-annually. 2. Generator KW load has been added to the Maintenance Connection software to notify the Maintenance department staff that both generators need to be inspected monthly on an ongoing basis. 3. Maintenance staff will be trained/educated on how to inspect the monthly Generator KW load capacity. This deficiency and POC will be brought to the QAA meeting on 6/24/21. 4. The Director of Maintenance, Executive Director, or designee are responsible for making sure that the Generator KW load capacity is completed on an monthly basis.	

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K 918	Continued From page 10	K 918	5. This deficiency will be corrected by 6/29/2021.	