Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: 307411

Dear Administrator:

The above facility was surveyed on November 27, 2023 through November 29, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2023

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: November 8, 2023

Dear Administrator:

On November 17, 2023, we informed you of imposed enforcement remedies.

On November 29, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2023.

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

As we notified you in our letter of November 17, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years

from December 2, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 8, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 11/27/23 to 11/29/23, 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 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		1/4/24

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

Electronically Signed | 12/29/2023

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

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E 039	Continued From page 1 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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

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E 039	Continued From page 3 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 4 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 5 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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 039	Continued From page 7 a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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	245184	A. BUILDING _____ B. WING _____	C 11/29/2023

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 9 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two emergency preparedness (EP) exercises, including two full-scale community based exercises, or one community based exercise and a table top exercise, or had activated their plan as a result of a actual event, were completed annually to test their EP program. This had the potential to affect all 55 residents residing at the facility. Findings include: During an interview on 11/29/23, at 3:30 p.m., with registered nurse (RN)-C who was also the corporate vice president of success, stated the facility had not conducted any EP exercises in 2023. The facility emergency operations plan dated 4/11/23, indicated a disaster drill would be held bi-annually, one of which would be community based. A written report of drills and exercises was maintained, and corrective actions were taken as indicated. Staff from all shifts would participate in drills or test exercises. A dated and signed report and evaluation of each drill and rehearsal was maintained and included the signatures of all employees who participated. Additionally, the facility participated in all state and federal drills	E 039	No residents were identified Residents have the potential to be impacted by the alleged practice. Review of policy was completed by the interdisciplinary team and a tabletop exercise was completed on 12/29/2023. The Executive Director provided education to the interdisciplinary team on completing emergency drills and recording these as they occur. Audits of compliance will be completed weekly for four weeks by the Executive Director.	

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E 039	Continued From page 10 when asked to do so by local or state agencies.	E 039		
F 000	INITIAL COMMENTS On 11/27/23 to 11/29/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51847386C (MN98326) H51847387C (MN97689) H51847388C (MN95198) H51847389C (MN94906) H51847390C (MN93936) H51847391C (MN93066) H51847469C (MN98866) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		1/4/24

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F 550	Continued From page 11 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 550		

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F 550	Continued From page 12 Based on observation, interview and document review, the facility failed to ensure served meals were provided in a dignified, homelike manner when the residents food was served on trays, second floor dining room was used as a plating and serving area in 1 of 2 dining rooms reviewed. In addition, staff failed to ensure privacy during insulin administration for 1 of 1 resident (R31). Findings include: During observation on 11/27/23 at 5:45 p.m., nine residents were seated in the second floor dining room, no table settings were present, glassware, or décor. The residents were overheard and made comments they wanted to eat, when do we get to eat, I guess we don't get supper tonight, and wonder if we will ever get our food. At 5:47 p.m., dietary manager (DM)-D was observed and brought an insulated cart with plates and cook-(C)-A brought another insulated cart with food and placed the food in the warmers on the steam table located in the second floor dining room. At 5:50 p.m., nursing assistant (NA)-A and NA-B offered residents seated in the dining room beverages and stated to the residents they would get their food soon. At 6:12 p.m. R8 hollered out, "I guess we don't get supper". At 6:22 p.m., observed DM-D, and C-A plate food, then placed food on a tray, and the tray was placed on a metal cart. There were two metal carts located in the second room dining room located within 20 feet of the residents and within two feet of one of the residents. Five of the residents were seated within ten feet of the steam table. During the plating of food, loud clatter was heard of the plates, C-A and DM-E were observed to exit and enter the dining room kitchen area multiple times as they stated they needed to go the first floor	F 550	R 31 has not voiced concerns about insulin administration in the dining area but has been informed that staff are to provide privacy when giving insulin. Dining room services have been reviewed with dietary staff and changes implemented to ensure residents□ needs are met. Residents who receive insulin and residents who eat in the affected dining room have the potential to be impacted by this practice. Reviewed policy and procedure for insulin administration and residents are to receive insulin in a private area. Review of dining area and identification of changes to be made was completed. Dining area cupboards will be used for storage of condiments and snacks to reduce trips from dining room to kitchen and back. Tables will be set with tablecloths, napkins, and glassware prior to residents' arrival. A liner has been added to the shelf on the steam table to reduce noise from setting lids on the shelf. Residents in dining area will be served first and then one tray cart at a time will be prepared for delivery. The Director of Nursing or designee will provide education to nurses on the need to provide privacy during insulin administration. The Food Service Manager or designee will provide education to dietary staff on the updated process for meal service on the units. Audits of insulin administration will be completed three times weekly for four	

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F 550	Continued From page 13 kitchen to obtain more food items or dining ware. At 6:22 p.m., a tall metal utility cart with meal trays was removed from the second floor dining room and DM-D stated the cart was going to first floor. On 11/27/23 at 6:27 p.m., staff were observed to pass trays from the steam table to the residents seated in the second floor dining room. When residents were served their meals, the plates and beverages were not removed from the serving tray while residents ate. During observations from 5:45 p.m. until 7:10 p.m., meal delivery service and plating of food was observed on the second-floor dining room, with large metal carts observed in the dining room, C-A and DM-D, social worker (SS)-A, and nursing staff entered and exited the dining area several times to obtain food, beverages, dinnerware, and utensils for other floors and room meal delivery. A shelved cart was observed with a garbage and three buckets, and another cart with boxes, food items, plastic bins was observed against the window in dining room in second room dining room with 20 feet of residents in the dining room. On 11/27/23 at 6:46 p.m., R31 was seated at the dining room table on second floor and had a fork in her right hand and food in her left and was approached by registered nurse (RN)-A. RN-A was observed with an insulin pen and injected R31's back of her right arm. RN-A stated she would not typically give insulin while a resident ate in the dining room, but stated R31 said it was fine. RN-A confirmed R31 was not offered to move to a private area.	F 550	weeks by the Director of Nursing or designee. Audits of dining services will be completed by the Executive Director or designee three times weekly for four weeeks. Results of these audits will be submitted to the Quality Assurance Performance Improvement committee for review and recommendations	

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F 550	Continued From page 14 On 11/27/23 at 6:53 p.m., observed DM-remove plates from plate cart and created loud clattering heard throughout the second floor dining area as nine residents ate and observed dietary staff observed dietary staff continue to plate food on second floor for room delivery and food delivery for third floor. On 11/27/23 at 7:13 p.m., DM-E stated he had been the district manager for the facility for four weeks, and comes to the facility weekly. DM-E stated the residents were expected to be served food at 6:00 p.m., and stated the food is prepared in the main kitchen and then brought to second floor dining area steam table and plated for first floor, then second floor, next third floor residents, and then second floor room delivery. DM-E stated the second floor dining environment with staff coming and going, noise level, storage of kitchen items on carts was not homelike. DM-E stated he would expect table settings, a quiet environment for residents to eat and visit, and the current meal service of dietary staff plating the food on second floor dining room was acceptable, but was the current practice at the facility. On 11/27/23 at 7:21 p.m., DM-D stated the meal service and plating of food, staff coming and going through the second floor dining area, loudness of staff and plates, was not a homelike environment for residents and caused a delay in food delivery. DM-D stated the meal service that was observed was ordinary and typical for the facility. On 11/28/23 at 7:58 a.m., food was observed to be removed from insulated carts and placed on steam table on second floor to start the meal service that included plating, serving and placing	F 550		

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F 550	Continued From page 15	F 550		

the food on carts for first and third floor for the facility. Metal carts visible in the second floor dining area while residents ate breakfast, and no table settings were observed.

On 11/28/23 at 10:23 a.m., during interview with the administrator and RN-C known as the vice president of success, the administrator stated the process of kitchen and dining was complicated and there had not been a defined leader since August. The administrator confirmed lot of education and training needs to be done to provide residents a homelike dining experience. The administrator stated the facility practice was for the food to be prepared in the commercial kitchen on first floor then brought to second floor where the food was plated and then delivered to the other floors. The administrator stated she would not expect all the food plated on the second floor though. RN-C stated she was only made aware of the plating of food on second floor since last night [11/28/23]. The administrator and RN-C stated they would expect napkins, tablecloths, and water on the dining tables. The administrator stated she has been aware of the plating practices for about a month. RN-C and the administrator stated a resident should not receive any injections in the dining room, even if the resident stated it was fine.

The facility Dinning Experience policy dated 7/27/22, indicated :

Policy Explanation and Compliance Guidelines
1. Dining areas will have comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of negative odors to accommodate dining.
2. Patients/residents will have adequate space to

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F 550	Continued From page 16	F 550		

enter or exit the dining area with ease.
3. Dining areas will have adequate space for staff to access and assist patients/residents quickly in the event of an emergency.
4. Tables should be properly set (example: forks on the left, knives and spoons on the right). If knives are not provided in certain dining areas and an individual needs their food cut, food should be cut neatly, so the individual can still identify the original food.
8. Use of napkins will be encouraged, and dignified clothing protectors will be available as needed or requested.
13. Individuals at the same table should be served and assisted at the same time.

The facility Dining Experience: Staff Responsibilities policy dated 8/9/22, indicated Policy Explanation and Compliance Guidelines
1. Staff will treat each individual with dignity and respect and strive to meet their personal needs. During meals staff will socialize with, focus on - listen, pay attention, and converse with each individual. During dining service staff will:
a. Respect the confidentiality of any special or pertinent individual directives
b. Be positive. Staff attitudes and actions directly affect the individual's acceptance of the meal.
c. Keep noise levels to a minimum. If music is played in the dining area, the type of music should be appropriate for the population being served.
2. Staff should provide service that will help to make dining a special "event" that individual patients/residents look forward to and that will create lasting memories. This includes but is not limited to:
a. Offering as many choices as possible when it comes to mealtime: choices on what to eat, when

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F 550	Continued From page 17 to eat and who to eat with. b. Providing an attractive, safe, functional, sanitary, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice décor, contrasting colors, and appropriate furniture for patients/residents, staff and the public. c. Providing comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of odors to accommodate dining. Providing adequate space for storing wheelchairs, walkers or other mobility devices for individuals who prefer to sit in a dining room chair. The director of food and nutrition services/Dietary Manager will perform meal rounds routinely to determine if the meals are timely, attractive, nutritious, and meet the needs and preferences of each individual. The director of food and nutrition services/Dietary Manager will observe meals for preferences, portion sizes, temperature, flavor, variety and accuracy. Concerns will be reported to the executive director, director of nursing, registered dietitian nutritionist (RDN) or designee, or other staff as appropriate.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents	F 554	R 51 agreed to have prevagen removed from room so nursing could obtain an	1/4/24

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F 554	Continued From page 18 (R51 and R1) who were observed to have medications in their rooms, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R51's facesheet printed on 11/29/23, included a diagnosis of orthopedic after care following surgery for leg amputation. R51's admission Minimum Data Set (MDS) assessment dated 11/19/23, indicated R51 was cognitively intact, had adequate vision and hearing, could understand and be understood. R51 required assistance or was dependent upon staff for most activities of daily living. R51's care plan initiated on 10/13/23, did not address self-administration of medications. R51's medical record did not include an assessment for self-administration of medications. R51's physician orders did not include an order for self-administration of medications. During an observation and interview on 11/27/23 2:10 p.m., observed a bottle of Prevagen (memory enhancer) Regular Strength dietary supplement, 30 capsules on R51's overbed table next to his bed. R51 stated he had brought them from home and took them for his memory. R51 stated he had been taking them on his own while in the facility. The bottle had only a few capsules in it as noted when bottle was picked up and shaken gently.	F 554	order for the medication and agreed to have nursing administer medication to him with his routine medications. R1 had nystatin removed from room and placed in treatment cart, R1 is agreeable to nursing staff administering medications. Residents who bring in OTC medications or who have orders for topical medications have the potential to be impacted by the alleged practice. Rooms were checked for storage of medications and no additional medications were found in resident rooms. CARES Champion rounds were expanded to include checking resident rooms for medication products in resident rooms. The Director of Nursing or designee educated nursing staff on self-administration of medication, storage of medication in rooms, and reporting medications found in the room. The Executive Director or designee educated the interdisciplinary team on the modification to CARES Champion rounds. The Director of Nursing or designee will complete weekly audits for four weeks to validate there are no medications in rooms. The Executive Director will review CARES Champion audits on an ongoing basis for any medications being stored in rooms. Results of audits will be forwarded to the Quality Assurance Performance Improvement committee for review and recommendations.	

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F 554	Continued From page 19 During an interview and observation on 11/28/23 at 5:50 p.m., registered nurse (RN)-D stated residents could not have medications in their room and stated R51 did not have a self-administration of medication order nor had he been assessed to determine if safe to take medication without supervision. Together with RN-D, went to R51's room. RN-D picked up the bottle of Prevagen and asked R51 if he had been taking the medication and R51 replied he had. RN-D informed R51 she would like to take the medication and get a physician order for it but R51 refused to let her take it. Progress note dated 11/28/2023 at 11:07 p.m., written by RN-D indicated: Resident had a bottle of pills in his room that help with memory loss. Author ask resident to keep it in the med (medication) cart and advised the resident he should not have medication in his room. Resident was upset about it and grabbed the bottle from author's hand. Resident stated, " I am keeping it in my room. It's only three pills left." During an observation and interview on 11/29/23 at 12:31 p.m., together with the interim director of nursing (DON), went to R51's room. The interim DON questioned R51 about the bottle of Prevagen and noted there was one pill left in the bottle. R51 admitted he took the medication every day and had taken one that morning. Family member (FM)-F who was present, stated she brought the bottle of Prevagen to the facility. The interim DON explained to R51 and FM-F that she would need to take the medication and get a doctor order for it to be kept in R51's room. After exiting R51's room, the interim DON stated she could not explain why staff had not secured the medication earlier when the bottle of Prevagen	F 554		

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had been in plain sight. R51 had been admitted to the facility on 10/12/23.
R1's facesheet printed on 11/29/23, included a diagnosis of eczema (a skin condition causing dry, itchy patches of skin).

R1's quarterly Minimum Data Set (MDS) assessment dated 11/29/23, indicated R1 was cognitively intact.

R1's care plan initiated on 9/11/18, did not address self-administration of medications.

R1's physician orders dated 3/31/23, included Nystatin powder (a medicated powder used to treat fungal infections) 100000 units per gram to be applied to the groin two times per day, and AmLactin (a medicated lotion to treat dry, scaly skin) 12-percent lotion to be applied to upper and lower extremities two times per day but did not include an order for self-administration of medications.

During an observation and interview on 11/28/23 at 8:21 a.m., a bottle of Nystatin powder and a bottle of AmLactin 12-percent lotion were observed to be on the dresser next to where R1 was sitting in her recliner. R1 stated the staff applied the lotion and powder for her in the morning and at bedtime.

During an interview on 11/28/23 at 2:04 p.m., RN-A and RN-C known as the vice president of success stated for a resident to have self-administration of medications they would need to be assessed, have provider orders and be addressed in the care plan.

The facility Self-Administration by Resident policy

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F 554	Continued From page 21 dated 11/17, indicated residents who desired to self-administer medications were permitted to do so with a prescriber ' s order and if the nursing care center ' s interdisciplinary team had determined the practice to be safe, and the medications appropriate and safe for self-administration. The results of the interdisciplinary team assessment were recorded on the Medication Self-Administration Assessment, which was placed in the resident ' s medical record.	F 554		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess the root cause of falls and incorporate new fall interventions to prevent falls and injury for 1 of 1 resident (R45) who had frequent falls. Findings include: R45's facesheet printed on 11/29/23, included diagnoses of acute and chronic respiratory failure, COPD (chronic obstructive pulmonary disease), arthritis of both knees, muscle weakness, unsteadiness on feet, and lack of coordination.	F 689	The interdisciplinary team completed an in-depth review of R 45□s falls in the past quarter and revised care plan with updated interventions. Staff assisted resident with organizing personal items to reduce potential for falls due to clutter in room. Residents who experience falls have the potential to be impacted by the alleged practice. Residents who have experienced three or more falls in the past three months will be reviewed for root cause analysis and appropriate interventions. The falls binders on each	1/4/24

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F 689	Continued From page 22 R45's quarterly Minimum Data Set (MDS) assessment dated 11/2/23, indicated R45 was cognitively intact, had adequate vision and hearing, could understand and be understood. R45 was independent in most activities of daily living (ADL's) and did not walk due to medical condition. R45's care plan dated 8/31/22, indicated R45 was at risk for falls due to impaired mobility. Interventions included gripper socks, commonly used articles within easy reach, reinforced need to call for assistance and to wait for assistance with transfers. In addition, R45's care plan updated 8/1/23, indicated cognitive loss due to non-compliance with oxygen usage and resistance/non-compliance with treatments and care. Further, 45's care plan updated 11/9/23, indicated R45 had hoarding tendencies. R45's physician orders dated 10/26/23, included OT (occupational therapy) and PT (physical therapy) to evaluate and treat. A progress note dated 10/11/2023, indicated that at 10:45 a.m., R45 had been found lying on the floor in front of her bed and was difficult to arouse. When asked how she got on the floor, R45 stated she fell. R45 was transferred to the hospital via ambulance. Fall incident reports provided by registered nurse (RN)-C who was the vice president of success, indicated R45 had six falls on the following dates: 10/1/23, two falls on 10/10/23, 10/11/23, 10/21/23, and 11/21/23. Despite six falls, the only new fall interventions to prevent further falls had been to remind R45 to call for assistance and for	F 689	floor were reviewed and updated to include information on choosing an intervention that is related to the probable cause of the fall and updating the care plan to reflect this intervention, fall care plan will be printed and new intervention will be highlighted and put in the binder and nursing staff educated to look at every day that they work for new interventions. The interdisciplinary team will review falls during the morning clinical meetings and ensure that the new intervention implemented addresses the root cause of the fall. The Director of Nursing or designee provided education to nurses on identifying cause of a fall and how to update care plan interventions at the time of the fall. A post test of falls scenarios was reviewed with nurses to help broaden their understanding of root cause analysis. The Vice President of Success educated the interdisciplinary team on updating care plans and entering a summary note in the resident□s electronic health record. Audits of falls will be completed daily by the clinical team consisting of the Director of Nursing or designee, nurse manager, social services, and executive director. Results of audits will be submitted to the Quality Assurance and Performance Improvement committee for review and recommendations.	

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F 689	Continued From page 23 therapy to screen for wheelchair positioning. Post Fall Assessments had been completed for only four of the six falls. Three of four interventions indicated R45 had been educated to call staff for help when she wanted something. The fourth assessment did not indicate an intervention to prevent further falls. During an interview and observation on 11/28/23, at 6:00 p.m., R45 was sitting on the side of her bed in her room, barefoot, with oxygen cannula in her nose with hose running across the floor to an oxygen concentrator toward the foot of the bed. R45 was in a double room and her side of the room was next to the window. A curtain seperated R45's space from her roommates. R45's personal space was very limited from the curtain to her bed; approximately a width of 4 feet. In the space was a bedside table, wheelchair and a significant amount of personal items/clutter on the floor. R45 stated she had been working on cleaning it up. R45 stated she had frequent falls because her carbon dioxide levels got too high. Other times she fell when she went to sit in her wheelchair and slid out of it. R45 was not sure how many times she had fallen recently but admits to having gone to the hospital once or twice after falling where they found she had pneumonia. R45 stated she did not want to tell anyone when she fell because she was worried about getting in trouble. R45 stated she broke her arm during one fall, but could not recall when that occurred. During an interview on 11/29/23, at 8:18 a.m., nursing assistant (NA)-E stated she thought the cause of R45's falls were from R45 removing her oxygen which caused her to lose her balance and fall. NA-E stated R45 had many offers from staff	F 689		

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F 689	Continued From page 24 to help clean and organize the personal items in her room, but R45 refused staff assistance. NA-E stated fall interventions for R45 included keeping clutter out of her path and to remind her to ask for help to reach things. NA-E stated R45 was independent with mobility and could transfer from bed to wheelchair by herself and could toilet herself. During an interview on 11/29/23 at 1:44 p.m., with RN-C, went through the incident reports for each of six falls. All of the falls were documented as being unwitnessed; five occurred in R45's room and one in the dining room. After the fall on 10/11/23, R45 was transported to the hospital, returning on 10/18/23. A hospital discharge summary dated 10/18/23, indicated R45 was noted to be quite altered and lethargic with multiple bruises noted most significantly on her left orbital area, but also upper and lower extremity, shoulders and back. X-rays revealed chronic fractures, deformity of proximal right humerus and left clavicle; no acute fracture. R45 was also found to have pneumonia. During the same interview, RN-C acknowledged the incident reports were brief and did not include documentation of comprehensive assessments, nor was information documented elsewhere to determine the root cause of R45's frequent falls and to determine patterns or trends, nor did they indicate documentation of new interventions. When an incident report indicated the fall had been reviewed by IDT, there had been no documentation to indicate if R45's falls were indeed analyzed by IDT, what was discussed and whether new fall interventions had been identified to prevent further falls. RN-C stated the facility had conducted performance improvement	F 689		

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F 689	Continued From page 25 projects (PIPs) around falls in 2023, but improvement efforts had not been sustained. RN-C stated with new leadership at the facility - administrator and director of nursing (DON) -- they would need to resume fall performance improvement efforts. The facility Fall Prevention and Management Guidelines dated 11/8/22, suggested interventions for residents determined to be at higher risk for falls may include providing interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. When any resident experienced a fall, the facility would complete a post-fall assessment and review including resident and/or witness statements, contributing factors to the fall, medication changes (new or discontinued), mental status changes and any new diagnoses. An incident report would be completed in Risk Management. The residents care plan would be reviewed and updated with any new interventions put in place to try to prevent additional falls. Documentation of all assessments and actions. Obtain witness statements from other staff with possible knowledge or relevant information. Each fall would be reviewed during the next morning meeting/clinical meeting with the interdisciplinary team (IDT). Actions of the IDT may include: a. Review of investigation and determination of potential root cause of fall b. Review fall risk care plan and any updates to plan of care completed post-fall c. Additional revisions to the plan of care including any physical adaptation to room, furniture, wheelchair, and/or assistive devices d. Education of staff as to any care plan revisions	F 689		

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F 689	Continued From page 26 e. Scheduling resident/family conferences If after IDT review it was determined that existing interventions in the care plan are most appropriate, rationale would be documented to describe any additional actions taken.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement activity programming for 1 out of 3 residents (R15) with dementia residing in a secure dementia care unit. Findings include: R15's admission Minimum Data Set (MDS) dated 8/7/23, identified severe cognitive impairment and diagnoses of Alzheimer's dementia, dementia with mood disturbance, major depressive disorder, and insomnia. R15's MDS identified observation of wandering behavior on up to three of seven days, and very important for her to listen to music she liked, to do things with groups of people, to get fresh air, and to attend religious activities. R15 required extensive assistance with her activities of daily living. R15's care plan identified a focus for activities, initiated on 8/18/23, which included interests of music, pets, group activities, outdoors and	F 744	The Activities Coordinator updated an activities assessment with R 15. Self□directed and social activity preferences were identified or confirmed, and care plan was updated to include activities of choice. Residents on the memory care unit have the potential to be impacted by the alleged practice. Updated activities assessments were completed for all residents on the Memory care Unit either by resident or family , significant other interview. Care plans were updated as indicated. An inventory of activity supplies in the facility was reviewed and new supplies ordered when indicated. Activity offerings specifically targeted towards the memory care population were implemented and an activity calendar was implemented for the Memory Care Unit.	1/4/24

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F 744	Continued From page 27 religious practices. Facility staff were to provide transport for R15 to and from activities of choice, to attend activity therapy exercise programming, encourage participation in group activities of interest, offer activities consistent with known interests, physical and intellectual abilities, offer redirection and diversion as needed, and to provide materials for leisure activities as needed. R15's care plan also identified a focus for behaviors of wandering and pacing related to cognitive impairment, restlessness, and disruptive calling out. Interventions for R15 included administering medications as ordered, to distract, if possible, explain and explore effects of behavior on others, provide privacy, remove from area, provide supervision in social gatherings, remain calm and provide redirection. R15's provider orders current on 11/29/23, identified Remeron (an antidepressant medication) 30 mg at bedtime for dementia, melatonin 3 mg at bedtime for insomnia, and Risperdal (an antipsychotic medicine that works by changing the effects of chemicals in the brain) 0.5 mg two times per day for dementia with mood disturbance. R15's progress notes, from admission of 7/31/23 to current, revealed documented participation in arts and crafts, trivia, and story time on September 20, 21, 25, 26, 27, 29, and October 10, 2023. A progress note dated 10/24/23, identified R15 continued to yell out and show signs of anxiety. On 10/23/23 the pharmacist consultant requested a dose increase for Remeron for continued behaviors of depression and restlessness, or consider a cross-taper and adding duloxetine (an	F 744	The Activities Coordinator or designee provided education to the nursing team on the memory care unit regarding activity offerings, supplies in stock and those that have been ordered, the activity schedule/calendar and activities that are self□directed or staff led were reviewed. The Executive Director of designee will complete observations of participation in activities on the memory care unit twice weekly for four weeks and then weekly for four weeks. Results of audits will be forwarded to the Quality Assurance Performance Improvement committee for review and recommendations.	

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antidepressant medication which can also help nerve pain) if R15's calling out and restlessness were related to pain.

On 11/27/23, R15 was observed:

-2:20 p.m., self-propelling wheelchair up and down the hall calling out and asking where she should go. Staff were not in the area at that time.

-5:20 p.m., 14 residents were seated in the dining room, all were served a glass of water or milk. A television was on with the volume turned up loud, the dining tables were void of any decoration, place settings or activity-type materials for distraction or entertainment.

-5:50 p.m., R15 had been seated with her back to the television for about 30 minutes when she began calling out "help me". Nursing assistant (NA)- H sat with R15 and assured her dinner was coming soon. R15 called out "take me home".

-6:21 p.m., NA-H pushing R15's wheelchair up and down the hall.

-6:34 p.m., setting in wheelchair at the opposite end of the hallway as the dining room with another resident.

R15 was observed on 11/28/23:

-11:37 a.m., in dining room self-propelling wheeling chair while pushing a dining room chair across the floor. There were eight residents in the dining area. The television was on, and a radio was playing. There was nothing on the tables in front of the residents.

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-2:20 p.m., R15 was amongst five other residents sitting in the dining room, one was watching television, the others were staring off. The activity calendar was on the wall in the hallway outside the dining room. Today was nail care at 10 a.m. on the third floor, at 11 a.m. on second floor and coloring on the first floor at 2 p.m. Three or four residents were assisted from the third floor to the first floor for that activity, R15 was not amongst those residents.

-3:22 p.m., R15 wheeling herself backwards down the hall talking about "mother and daughter and friend, this needs to be looked at". The two NAs were assisting the residents requiring two-person transfers to use the bathroom and there were no other NAs on the unit. There were two other residents going up and down the hall in their wheelchairs, there were eight residents in the dining room and television was on, however they were not watching it.

-3:34 p.m., an unidentified resident pushed R15 from the hallway to a table in the dining room and locked the right wheel of her wheelchair. Trained medication aid (TMA)-B was sitting in the dining room at the time and told that resident R15 just liked to "roll around". Seeing what had happened, NA-I came and unlocked the right wheel and removed R15 from the dining room.

During an interview on 11/28/23 at 2:25 p.m., TMA-B stated she wasn't sure how it was decided which residents got to go off the unit for activities, activities were the ones who decided who got to go.

During an interview on 11/28/23 at 4:00 p.m., NA-I stated the activity aid left about 2 p.m., so

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they had to do their own activities for the residents, along with caring for their other needs, for the past few months since the activities director left. NA-I further stated they didn't have a whole lot to provide for activities, there were some coloring books and some crayons. If they wanted to use snacks as an activity, they needed to go downstairs and get something from the kitchen. They used to have snacks stocked on the unit, but that hadn't been happening for a while.

During an interview on 11/28/23 at 12:18 p.m., activity aid (AA)-A stated she worked 20 hours a week and there were no other activity staff since around August of 2023. AA-A provided they did not have much for pre-set activities the nursing staff could easily grab and use with residents. There were three planned activities each day, on Fridays they did karaoke downstairs, on the memory care unit they did mind games and nail care once a week, and on days she was not working the residents did BINGO. AA-A stated she would pick residents from the memory care unit to bring downstairs for activities, usually whoever she could manage to bring down there. She stated there were coloring books and crayons in the storage room if the staff wanted to do an activity.

During an interview on 11/29/23 at 7:37 a.m., social worker (SW)-A stated she and an RN were doing the activity assessments and related MDS duties, there was only one activity aid working part time in activities but they had a new director starting on Friday. SW-A added she agreed there weren't enough activities, it really wasn't a debate.

During an interview on 11/29/23 at 12:40 p.m., the

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F 744	Continued From page 31 administrator stated they had not had an activity director since August 2023, and there was one 20-hour per week activity aid for 55 residents who reported to her. The administrator added she had a passion for activities and had been a certified therapeutic recreations director in the past. The aid was responsible for making the activity calendars and arranging the activities and then the administrator would review them before they were posted. The administrator stated she would expect there should be activities after 2 p.m.. During an interview on 11/29/23 at 3:57 p.m., the interim director of nursing (DON) stated she felt activities were important to keep residents busy, and to help decrease behaviors on a memory care unit. The interim DON was not aware of what the expectation for documenting activities was. Policies regarding activity programming or activities in general was requested, and a policy on Activity Interest Reviews was received and did not provide insight into activity planning and programming.	F 744		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		1/4/24

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F 761	Continued From page 32 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an insulin pen stored in the medication cart was labeled for one resident (R31) and the facility failed to ensure eye drops were discarded per manufactures instructions for one resident (R26). Findings include:. R26's medication administration record (MAR) dated 11/1/23-11/30/23, indicated netarsudil dimesylate (Rhopressa eye drop used to lower eye pressure) ophthalmic solution 0.02 % instill one drop in both eyes at bedtime and Latanoprost (eye drop used to treat certain kinds of glaucoma) instill one drop in both eyes at bedtime. R31's MAR dated 11/1/23-11/30/23, indicated an order for Novolin N Flexpen subcutaneous suspension pen-injector 100 unit/ml inject 29 unit subcutaneous in the evening.	F 761	Identified medications for R 26 and R 31 were discarded and replaced with new medication that was labeled with resident name and date opened. Residents who receive multidose medication such as insulin or eye drops, have the potential to be impacted by the alleged practice. Medication carts were audited, and any medications noted to lack appropriate labeling with resident name and date opened were removed from the medication cart. When indicated medications were reordered and replaced. The Director of Nursing or designee provided education to nurses and TMAs on the need to label eye drops and insulin pens or multiuse vials with the resident□s name and the date opened. Weekly audits will be conducted by the Director of Nursing or designee of	

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F 761	Continued From page 33 During an observation and interview on 11/27/23 at 6:46 p.m., registered nurse (RN)-A removed an insulin pen from R31's labeled designated space from the medication cart, the insulin pen was labeled with a manufacturers sticker with Novolin N Flexpen subcutaneous suspension pen-injector 100 unit/ml. RN-A confirmed R31's insulin pen had been opened before today and lacked a label with the opened date, expiration date, or resident name. RN-B stated she used the EMR to obtain directions for R31's insulin dose. During the medication storage tour on 11/29/23 at 7:36 a.m., with the interim director of nursing (DON) of the first floor medication cart, the following was observed: R26's Latanoprost eye drops had a date of 10/12 hand wrote with black marker. R26's Rhopressa eye drops had no open date and no expiration date. During an interview on 11/29/23 at 7:39 a.m., interim DON stated staff were expected to write the open date and expiration date on the eye drop bottle. The interim DON stated the eye drops would be expired 28-30 days after the eye drop was opened and, the interim DON further stated she would review the manufactures instructions and confirm the expiration dates of eye drops after they are opened. During a follow up interview the interim DON stated the Latanoprost eye drops should have been discarded 42 days after the open date. The interim DON stated all medications were expected to be labeled with resident name, open date, and expiration date and stated would expect insulin pens labeled with resident name and date opened.	F 761	medication storage to ensure proper labeling is completed. These audits will be continued until compliance is validated. Results of audits will be forwarded to the Quality Assurance and Performance Improvement committee for review and recommendations.	

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F 761	Continued From page 34 The facility Medication Storage policy dated 1/21, indicated 12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens then first used. The opened insulin vial may be stored in refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal Facility undated document titled PharMerica Did You Know Abridged List of Medications with Shortened Expiration Dates indicated: Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert (PI) under the "How Supplied/Storage & Handling" section. A drug product's Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (see BUD Notes below), whichever comes first. These In-Use medications should be labeled such that the "DATE OPENED" is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration.	F 761		

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F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to ensure all residents were consistently offered and provided a nutrient and/or calorie substantive snack after the dinner meal and before bedtime for 7 of 7 residents (R3, R8, R24, R25, R30, R35, R49) who voiced a concern. Findings include: R3's significant change Minimum Data Set (MDS) assessment dated 10/28/23, indicated intact cognition. R8's quarterly MDS assessment dated 10/17/23,	F 809	R 3, R 8, R 24, R 25, R30, R 35 and R 49 have been educated on the availability of snacks and that these will be offered at routine times during the day and evening shifts. Residents have the potential to be impacted by the alleged practice. Dietary will stock snacks on each unit and will be responsible for routine restocking and removal of any outdated snacks in refrigerator or dining area cupboards. Dietary will provide a snack cart to be used to distribute snacks at routine times. Nursing	1/4/24

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F 809	Continued From page 36 indicated intact cognition. R24's quarterly MDS assessment dated 9/1/23, indicated intact cognition. R25's quarterly MDS assessment dated 10/20/23, indicated intact cognition. R30's quarterly MDS assessment dated 9/1/23, indicated intact cognition. R35's quarterly MDS assessment dated 11/1/23, indicated intact cognition. R49's quarterly MDS assessment dated 9/2/23, indicated intact cognition During an interview on 11/28/23 at 2:57 p.m., at a resident council meeting, residents were asked if they received snacks after dinner and before bedtime. All seven residents in attendance (R3, R8, R24, R25, R30, R35, R49), who resided on second floor shook their heads no, or stated they did not receive snacks. R25 stated no snacks were offered at any time. R30 stated they used to get snacks at bedtime, but now do not receive any snacks, not morning, afternoon or after dinner. Residents (R3, R8, R25, R30, R35, R49) acknowledged they would like a snack before bedtime and thought they could get a snack if they asked for one, but R24 stated she did not know if staff had access to snacks. During an interview on 11/29/23 at 8:31 a.m., (NA)-E on second floor stated snacks were offered to residents at 10:00 a.m., 2:00 p.m. and 8:00 p.m. NA-E could not explain why residents who resided on second floor indicated during resident council they were not offered snacks.	F 809	staff will be responsible for snack distribution at routine times on each unit. The Food Service Manager or designee will educate dietary staff on the process for snack distribution and what food items will be offered for snacks. The Director of Nursing or designee will educate nursing staff on routine times for offering snacks and recording snack intake. Audits will be completed three times weekly for four weeks by the Executive Director or designee to validate snacks are being provided and offered. Results of audits will be submitted to the Quality Assurance Performance Improvement committee for review and recommendations.	

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F 809	Continued From page 37	F 809		

NA-E stated snacks were located in the second floor kitchenette and stated up until about a month ago, they did not have snacks until a new dietary manager started at the facility.

During an interview on 11/29/23 at 8:37 a.m., dietary manager (DM)-D stated he put snacks on each floor in the dining rooms. DM-D stated he had been trying to increase the variety of snacks. When informed residents stated they were not being offered snacks and didn't know snacks were available, DM-D stated they needed to get the word out about snacks.

During an interview on 11/29/23 at 10:36 a.m., nursing assistant (NA)-F on third floor stated there were no snacks stocked on third floor. If a resident wanted a snack, NA-F stated staff would need to get something from the kitchen or ask the kitchen to bring something to third floor.

During an interview on 11/29/23 at 10:50 a.m., with registered nurse (RN)-C who was also the vice president of success, the interim director of nursing (DON) and registered nurse (RN)-A who was also the assistant director of nursing, RN-A stated snacks were available on the units and some residents could help themselves. RN-C, the DON and RN-A acknowledged not all residents would be able to help themselves. RN-C, the DON and RN-A could not confirm whether or not residents were offered snacks after dinner and before bedtime.

During an interview on 11/29/23 at 12:32 p.m., (NA)-G on first floor stated she did not offer snacks to residents but would get them food from the kitchen if they requested it. NA-G stated there were no snacks on first floor that she was aware

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F 809	Continued From page 38 of. During observations on 11/29/23 from 2:57 p.m. to 3:13 p.m., of the first, second and third floor refrigerators and kitchenettes, no nutrient and/or calorie substantive snacks were observed; only some pudding in refrigerators, ice cream in the freezers and a bin of chips on second floor. During observations on all three survey dates: 11/27/23 from 1:00 p.m. to 7:30 p.m., on 11/28/23 from 8:00 a.m. to 5:00 p.m., and 11/29/23 from 8:00 a.m. to 4:00 p.m., no observations were made of snacks being passed or offered to residents on any of the three floors. The facility Snack policy dated 9/2017, indicated HS (bedtime) snacks would be provided for all residents. The dining services department would assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime. Nursing services was responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents.	F 809		
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	F 812		1/4/24

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F 812	Continued From page 39 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored in accordance with professional standards for food service safety by failing to label and date food, to remove expired food from food storage areas. In addition , the facility failed to ensure proper cleaning for 1 of 1 commercial mixer, ensure pans in the kitchen were completely dry before storing, accurately monitor chemical sanitization for 1 of 1 dish machine, and perform hand hygiene while serving food. These practices had the potential to affect all residents, staff and visitors consuming food at the facility. Findings include: During a tour of the kitchen's dry storage on 11/29/23 at 10:42 a.m., dietary manager (DM)-H confirmed the following observations: -an undated, opened package of marshmallows, manufacturer's expiration date of July 2023, which was not tied shut. -canned goods were not removed from their shipping flats and shrink wrap, just cut open and cans taken out from the middle. DM-H identified two dented cans of Campbell's Cream of Chicken soup amongst a flat of of soup still in shrink wrap and cardboard. The shrink wrap was torn open on	F 812	No specific residents were identified. The dietary storage areas were inspected and any expired or improperly stored foods were discarded. All residents have the potential to be impacted by the alleged practice. Checklists for safe storage of food items in dry and cold storage have been posted for quick reference by dietary staff when storing, rotating, dating, and discarding food items. Checklists for dish room were posted for quick reference by dietary staff. The Food Service Manager or designee will provide education to dietary staff on storage, checklists, and routine handwashing during meal service. The Executive Director or designee will audit dietary storage and compliance with hand hygiene three times weekly for four weeks and then weekly per routine. Results of audits will be submitted to the Quality Assurance Performance Improvement committee for review and recommendations. Storage rack in clean dish room will be used to air dry pans prior to putting them away. A cleaning list shall be posted by	

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F 812	Continued From page 40 top with two cans gone from the middle of the flat. DM-H removed the dented cans. During an interview on 11/29/23 at 10:48 a.m., DM-H stated there didn't seem to be a real system for rotating the stock. DM-H stated the expectation was to use a first in and first out rotation system for the canned and dry goods. DM-H added there were stickers available for indicating which stock should be used first and any dented cans should be removed from food storage areas and placed on the "dented cans to be returned" shelf. During a tour of the kitchen's walk-in cooler on 11/29/23 at 10:51 a.m., DM-H confirmed the following observations and removed the items from food storage areas: -an unlabeled storage container of about 10 biscuits. -a labeled storage container of turkey lunch meat, expired on 11/23/23. -a labeled storage container of chopped green peppers, expired on 11/27/23. -a labeled storage container with three peeled, hard boiled eggs, expired on 11/26/23. During a tour of the kitchen's equipment on 11/29/23 at 10:56 a.m., DM-H pulled a baking pan from a stack of clean baking pans. DM-H confirmed the pan was wet and the expectation would be for dishes to air dry before being stacked. The commercial mixer had dried streaks of an off-white batter-like substance dried to the mechanics of the mixer where there would be a risk of pieces falling off into the mixing bowl. The DM-H stated could lead to contamination of food and attract rodents.	F 812	the office with tasks needing to be completed each day, week and monthly. All dietary staff will sign off on this as they complete the tasks. see # 10 attachment. All equipment will be cleaned after each use and signed off on the cleaning log. All Dietary staff will be inserviced on the cleaning schedule Dishmachine chemical testing is to be done three times a day and recorded on the proper log along with the temperature of the wash and rinse cycles. Test strips should be matched with the guide on the bottle for accurate ppm	

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F 812	Continued From page 41 During a tour of the kitchen's dish room on 11/29/23 at 11:07 a.m., DM-H verified the dishwasher sanitized dishes via chemical sanitization and was checked with Ecolab brand test strips, manufacturer expiration date 11/2025, for the parts per million (PPM) of the sanitizing chemicals during a wash cycle after each meal service. A Dish Machine Log form indicated testing during breakfast, lunch, and dinner. There was a column for the wash and rinse cycle temperatures, the PPM result and the initials of the person recording the values. The values under the column marked PPM for breakfast, lunch and dinner all indicated "300" on each entry for all 28 days of this month. At the bottom of the form there was a key for normal temperature and chemical PPM values should. The recommendation for chemical values was 50 to 200 PPM. At 11:15 am, on the side of the dish room where the clean dishes go, there was observed to be food particles and water on the stainless counter where clean dishes would dry. DM-H stated she was not sure why it was like that but that it should not be as that is where the clean dishes go. During an interview on 11/29/23 at 12:11 p.m., the registered dietician nutritionist (RDN) stated she had done a monthly sanitation audit at this facility, most recently on 11/15/23. The RDN had noted at that time food labeling wasn't being done, and identified a bag of expired flour, so she provided education to the dietary manager (DM)-D about food labeling expectations. The RDN further stated it "had been a work in progress". During a tour of the dish room at 11/29/23 at 1:12 p.m., with the administrator and DM-H the chemical PPM from the dishwasher chemical test	F 812		

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F 812	Continued From page 42 strip was observed at 100 PPM. During an interview on 11/29/23 at 4:55 p.m., DM-E stated he would expect someone would have said something if the PPM were consistently out of range. It was important to check and monitor to make sure the germs were getting killed. Policies and procedures regarding food storage, kitchen cleaning, and dishwasher testing were requested but not received. Hand Hygiene During an observation on 11/27/23 from 5:47 p.m. to 7:06 p.m., cook (C)-A was observed in the second floor dining area handling multiple food items, food serving utensils, plates, and surfaces while wearing blue gloves; and at no time during this observation did C-A perform hand hygiene. C-A was observed plating food while standing at the steam table, would leave the dining room area with blue gloves, return, and enter the plating area and failed to perform hand hygiene. C-A (gloved hands) and dietary manger (DM)-E (bare handed) handled multiple paper meal slips, plates, drinking cups, and meal trays, placed mandarin oranges on plates using a scoop, placed sandwiches on the plates, then covered the plates with a plastic thermal cover and set the plate on the steam table or tray that was placed on a metal utility cart an. This process was repeated until all resident food orders had been filled, without hand hygiene observed. During an observation on 11/27/23 at 6:30 p.m., DM-E was observed to remove a cell phone from his front shirt pocket with his bare hand talk on the cell phone and return the cell phone to his	F 812		

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F 812	Continued From page 43 shirt pocket, and was observed to continue to plate food and failed to perform hand hygiene. During an observation on 11/27/23 at 7:06 p.m., DM-E took a bowl from a resident in the dining room, entered the kitchen area placed food in the microwave to reheat, stirred the food with a spoon, took the temperature of the food, and returned the food to the resident in the dining area, reentered the kitchen area and failed to complete hand hygiene. During an interview on 11/27/23 at 7:10 p.m., C-A stated she wore gloves in the kitchen area and when plating food and confirmed hand hygiene was not performed when entering the kitchen area, and further stated that's why she wore the gloves. During interview on 11/27/23 at 7:13 p.m., DM-E stated he was the district food service manager and confirmed hand hygiene should be completed if touching personal items such as glasses, entering or exiting the kitchen area, when touching the microwave and after phone use. DM-E stated there was no hand sanitizer available for staff when entering the kitchen area on second floor or sink available for staff and confirmed staff had failed to properly disinfect hands during meal preparation. During an interview on 11/28/23 at 10:01 a.m. with the administrator and registered nurse (RN)-C, who was the vice president of success, the administrator stated there was lots of education and training that needs to be done with dietary staff. The administrator stated she had witnessed things such as dietary staff not washing hands, not wearing hair or beard nets,	F 812		

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	245184	A. BUILDING _____ B. WING _____	C 11/29/2023

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F 812	Continued From page 44 and provided on the spot education. RN-C stated staff were expected to wash hands when entering the kitchen area or disinfect hands, and using gloves did not replace hand hygiene. RN-C and the administrator stated nursing staff had received education on cup handling and would expect staff to handle the cups on the side not on the rims The facility Hand Washing - Food and Nutrition Services policy dated 8/16/22, indicated: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures. Hand washing facilities will be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans and signage outlining hand washing procedures. Policy Explanation and Compliance Guidelines Hands and exposed portions of arms should be washed immediately before engaging in food preparation. 1. When to wash hands: a. When entering the kitchen at the start of a shift. b. After touching bare human body parts other than clean hands and clean, exposed portions of arms. c. After using the restroom. d. After caring for or handling service animals or aquatic animals. e. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking. f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks.	F 812		

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F 812	Continued From page 45 h. When switching between working with raw food and working with ready to eat food. i. Before donning disposable gloves for working with food and after gloves are removed. j. After engaging in other activities that contaminate the hands. 3. Staff will be educated on the importance of hand washing and retrained and reminded as necessary on the above guidelines. 4. Hand washing procedures will be posted by each hand-washing sink. 5. Food preparation and/or pot sinks will not be used for handwashing.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F 851		1/4/24

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F 851	Continued From page 46 §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete	F 851	No residents were identified Residents have the potential to be	

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F 851	Continued From page 47 data for staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 3, 2023), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The facility PBJ (Payroll Based Staffing) data report triggered for excessively low weekend staffing for Quarter 3, April 1 - June 30, 2023. During review of nursing staff schedules for this time frame, staffing was verified to be the same, seven days a week. During an interview on 11/28/23 at 11:54 a.m., nursing scheduler (NS)-G stated she was responsible for completing nursing staff schedules which included scheduling for registered nurses, licensed practical nurses, trained medication aides and nursing assistants, and there was no reduction in nursing staff on weekends. During an interview on 11/28/23 at 12:20 p.m., registered nurse (RN)-C who was also the vice president of success, was aware the PBJ report had triggered for excessively low weekend staffing for quarter 3. RN-C stated agency staff had not been included in the PBJ report and once identified, had been corrected. The Facility Assessment dated 11/2022, identified nursing staffing ratios, and did not indicate staffing would be altered on weekends.	F 851	impacted by the alleged practice. Corrections to the process for recording agency staff were implemented in July 2023 and corrections were made to the previous quarter□s report in July 2023. Agency staff have been added to the payroll roster to ensure these hours carry over to PBJ reporting. The Executive Director educated the scheduler on entering the agency hours in the schedule in the facility database for PBJ. The Executive Director or designee will audit schedule and daily staffing grid weekly for four weeks for inclusion of agency staff. Results of audits will be submitted to the Quality Assurance Performance Improvement committee for review and recommendations.	

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F 880	Continued From page 48	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		1/4/24

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F 880	Continued From page 49 (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 staff completed proper hand hygiene and glove use during meal preparation and distribution of meals, and failed to properly disinfect a glucometer for 1 of 2 residents (R2) . This had the ability to affect all 55 residents who consumed food in the facility. Finding include:	F 880	Residents who receive assistance with meal delivery, set up, or assistance with eating meals have the potential to be impacted by the alleged practice. The staff were educated on hand hygiene, glove use, and following infection control principles when carrying containers of food and completed a hand hygiene competency 1st week of January 2024.	

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F 880	Continued From page 50 Hand Hygiene During an observation on 11/27/23 at 6:53 p.m., nursing assistant (NA)-H removed a three-ring binder from a table and brought it to the counter. Without performing hand hygiene, NA-H got a resident meal tray from the delivery cart, removed the plate cover, and cut the sloppy joe into pieces with a fork. NA-H then started stacking plate covers from trays onto the counter, grabbed some ketchup packets, brought them to a resident table and opened one squeezing the contents onto the plate. NA-H then proceeded to gather dirty glasses by the rims, dropped them off at the counter and got two clean mugs, filled them with water and dropped them off at a resident table. During an observation on 11/27/23 at 7:03 p.m., trained medication aid (TMA)-A was wearing gloves while preparing a resident's tray. She turned and grabbed a chair with arms by the arms and dragged it to the table. TMA-A then used her same gloved hands to grab the handles of a four-wheeled walker and move it out of the way, and then sat down next to the resident and proceeded to feed them. During an interview on 11/27/23 at 7:12 p.m., NA-H stated they should be washing their hands between resident's trays, but they just got in such a hurry with the meal being so late, they should have used hand sanitizer or something. NA-H confirmed there was not a hand sanitizer dispenser in the dining room. During an interview on 11/27/23 at 7:22 p.m., TMA-A stated she wore gloves so that she didn't	F 880	Signs were posted in dining areas and near serving stations to remind staff of the need to complete hand hygiene and to wear gloves when assisting the resident with oral intake and do hand hygiene after doffing gloves and or prior donning gloves. Availability of hand hygiene products in the dining area was reviewed and validated. Hand hygiene policy was reviewed by the Director of Nursing/Infection Preventionist and remains current. Residents who require blood sugar checks have the potential to be impacted by the alleged practice. Nurses were educated on the importance of cleaning disinfecting glucometers prior to placing them back in the glucometer case and back in the med Cart according to manufacturer’s instructions regardless of if they are intended for single resident or multiple resident use. Facility elected to use one glucometer per resident and not to share between residents. A sign was placed on each glucometer case to remind nurses to disinfect after use and prior placing the glucometer back in the case. The Director of Nursing or designee will provide education to nurses on the need to disinfect glucometer after each use and provide education to all staff that are assisting residents with meal intake to perform hand hygiene. The Director of Nursing or designee will complete audits of hand hygiene and	

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F 880	Continued From page 51 transmit germs from one table to the next, but acknowledged hand hygiene should be performed between different residents. TMA-A added she would use hand sanitizer, but they didn't have any in the dining room, and the nearest one was about 10 yards away down the hall away from there. TMA-A recalled they had one on the wall in the dining room, but a resident took it down and she had told housekeeping and maintenance, but they still didn't have one there. TMA-A confirmed there weren't any portable bottles of hand sanitizer in the dining area or on the dining carts. During an interview on 11/28/23 at 10:01 a.m., the administrator and registered nurse (RN)-C who was known as the vice president vice president of success stated they would expect employees to be washing their hands between assisting residents in the dining room, there were bathrooms nearby. Both the administrator and the vice president of success agree there should be hand sanitizer available to staff when serving in the dining room. On 11/29/23 at 9:51 a.m., the administrator stated she expected there to be some hand sanitizer closer to the kitchen, she estimated the distance to be about 20 feet to the nearest one for the dining room. Glucometer R2's Medication Administration Record (MAR) dated 11/1/23-11/30/23, indicated blood glucose four times a day related to type 2 diabetes. On 11/29/23 at 8:20 a.m., RN-E removed a black case with R2's name on it from the medication cart, and removed a glucometer. RN-E entered	F 880	glucometer cleaning and disinfecting after use. Audits will be monitor three times weekly for four weeks, twice weekly for four weeks, then weekly until compliance is achieved. Results of audits will be forwarded to the facility Quality Council for review and recommendations.	

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F 880	Continued From page 52 R2's room, donned gloved, placed a test strip in the glucometer, used a alcohol wipe and wiped R2's finger, used a lancet to obtain a drop of blood from R2's finger and placed a drop of blood on the test strip, removed the test strip from the glucometer, and RN-E removed her gloves, exited the room, washed hands and placed the glucometer back in R2's glucometer case. RN-E stated each resident had their own glucometer and residents did not share glucometers, and stated she did not know rule for disinfecting personal glucometers. RN-E stated her current practice was not to wipe them down after each use, and stated I guess it would be a good idea to wipe them between each resident if they are kept in the medication cart and handled by multiple people. On 11/29/23 at 10:50 a.m. RN-C who was known as the vice president of success stated all glucometers should be wiped after resident use. On 11/29/23 at 3:44 p.m., RN-A, the infection prevention nurse, stated each resident had their own glucometer and staff were expected to disinfect glucometer after every use . The facility Glucometer Disinfection policy dated 11/11/22, indicated : Policy: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions: "Cleaning" is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with	F 880		

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F 880	Continued From page 53 detergents or enzymatic products. "Disinfection" is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer ' s instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter will not be used for multiple residents. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 4. Glucometers will be cleaned and disinfected after each use and according to manufacturer ' s instructions regardless of whether they are intended for single resident or multiple resident use. 5. Procedure: a. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes. b. Wash hands. c. Explain the procedure to the resident. d. Provide privacy. e. Put on gloves. f. Obtain capillary blood glucose sampling according to facility policy. g. Remove and discard gloves, perform hand hygiene prior to exiting room. h. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. i. Retrieve disinfectant wipe(s) from container.	F 880		

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F 880	Continued From page 54 j. Clean and disinfect the glucometer thoroughly with the disinfectant wipe(s), following the manufacturer ' s instructions. Allow the glucometer to air dry. k. Discard disinfectant wipes in waste receptacle. l. Perform hand hygiene.	F 880		

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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 11/29/2023. At the time of this survey, ROCHESTER EAST HEALTH SERVICES 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	K 000		

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

Electronically Signed | 12/29/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. 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. ROCHESTER EAST HEALTH SERVICES is a 3-story building with full basement. ROCHESTER EAST HEALTH SERVICES building was constructed in 1968 and was determined to be Type II (222) construction. The facility is fully protected throughout by an	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2023**

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K 000	Continued From page 2 automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 111 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the following locations exhibited slab-to-slab height changes greater than one-half inch presenting potential trip or fall hazards: Entrance sidewalk to the facility; East exit egress pathway potential trip or fall	K 211	Slab to slab height changes were made on the front door concrete sidewalk on or about 12/14 to even out the grade. East access egress was completed on 12/27/2023. Will continue to monitor on a quarterly basis.	1/4/24

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K 211	Continued From page 3 hazard. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that exit sign located on the 1st floor - Central stairwell exit area was not illuminated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293	Not illuminated central stairwell exit 1st floor. The exit sign has been replaced and is now illuminated. Illumination devices at exits will be monitored on a monthly basis moving forward. Exit signs will be replaced as needed.	1/4/24
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		1/4/24

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K 353	Continued From page 4 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: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1., NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section(s), 8.1, 8.5.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Basement	K 353	18 inch clearance from ceiling in the basement activity storage area have been recleaned, all items have been removed from top of storage container. Signage has been placed as a reminder to not place things in these areas. Area will be checked on a quartely basis.	

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K 353	Continued From page 5 Activities Storage Room, items stacked and stored vertically closer than 18 inches to the fire sprinkler head. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2.1.2, 7.2.4, 7.3.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation, that fire extinguisher located in the following locations were missing inspection dates and sign-off for the months of July thru November: Basement Elevator Rooms 1 & 2, and Basement Fire Panel Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	Fire Extinguishers in elevator rooms have been checked for the month of December. Will print out an extinguisher list to coordinate the completion of checking all extinguishers.	1/4/24

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K 374	Continued From page 6	K 374		
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 the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation on the 3rd Floor, adjacent to RM 314, that one of the doors of fire / smoke assembly exhibited signs of warping from top to bottom, allowing the movement and passage of smoke between smoke compartments. 2. On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation on the 3rd Floor, adjacent to RM 317, that fire / smoke assembly	K 374	Door number 1 We would like to request a Temporary Waiver for K374. We have contacted a vender to receive a quote for the repair of the door at this time it appears that the door and the entire door jam must be replaced. The vendor has indicated that these will need to be ordered and the lead time will be 8-10 weeks. They anticipate they will receive these by 03/15/2024. With scheduling and labor time they anticipate another two-three weeks for the installation to be completed. Are completion date will be 04/15/2024	1/4/24

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K 374	Continued From page 7 doors exhibited an air-gap greater than 1/8 inch, allowing the movement and passage of smoke between smoke compartments. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Door number 2 (too big of gap between the doors) the sweep on the door has been moved to close the gap. Doors are checked on a monthly basis	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by review of available documentation that no documentation was present to confirm that fire drills were conducted for: 1st Shift in 4th quarter; 2nd shift in 4th quarter; and 3rd shift in 2nd, and 3rd quarters.	K 712	Performance of fire drills will be completed moving forward. A follow-up for this will be added to the QAPI agenda for the next quarter.	1/4/24

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K 712	Continued From page 8 An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to execute on the finds and outcome(s) identified by electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 914	We have contacted a vender to quote the replacement of the outlets that did not pass inspection. We met with the vendor this morning 12/29/2023 . The vendor has indicated that these will need to be ordered and the lead time will be 2-4 weeks. They anticipate they will receive these by 2/04/2024. With scheduling and labor time they anticipate another two to three weeks for the installation to be completed. Are	1/4/24

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K 914	Continued From page 9 On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that action had been taken to replace electrical outlets that did not pass testing - conducted in Q1 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	completion date will be 04/01/2014	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		1/4/24

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K 920	Continued From page 10 Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/29/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the 1st Floor - Business Office that daisy-chained power-strips were found in use. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Power strips have been unlinked and are no longer daisy chained. Will be checked quarterly moving forward.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/27/23 to 11/29/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued: H51847386C (MN98326) H51847387C (MN97689) H51847388C (MN95198) H51847389C (MN94906) H51847390C (MN93936) H51847391C (MN93066) H51847469C (MN98866) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess the root cause of falls and incorporate new fall interventions to prevent falls and injury	2 830	corrected	1/4/24

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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) COMPLETE DATE
2 830	Continued From page 3 for 1 of 1 resident (R45) who had frequent falls. Findings include: R45's facesheet printed on 11/29/23, included diagnoses of acute and chronic respiratory failure, COPD (chronic obstructive pulmonary disease), arthritis of both knees, muscle weakness, unsteadiness on feet, and lack of coordination. R45's quarterly Minimum Data Set (MDS) assessment dated 11/2/23, indicated R45 was cognitively intact, had adequate vision and hearing, could understand and be understood. R45 was independent in most activities of daily living (ADL's) and did not walk due to medical condition. R45's care plan dated 8/31/22, indicated R45 was at risk for falls due to impaired mobility. Interventions included gripper socks, commonly used articles within easy reach, reinforced need to call for assistance and to wait for assistance with transfers. In addition, R45's care plan updated 8/1/23, indicated cognitive loss due to non-compliance with oxygen usage and resistance/non-compliance with treatments and care. Further, 45's care plan updated 11/9/23, indicated R45 had hoarding tendencies. R45's physician orders dated 10/26/23, included OT (occupational therapy) and PT (physical therapy) to evaluate and treat. A progress note dated 10/11/2023, indicated that at 10:45 a.m., R45 had been found lying on the floor in front of her bed and was difficult to arouse. When asked how she got on the floor, R45 stated she fell. R45 was transferred to the	2 830		

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	00953	A. BUILDING: _____ B. WING _____	C 11/29/2023

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2 830	Continued From page 4 hospital via ambulance. Fall incident reports provided by registered nurse (RN)-C who was the vice president of success, indicated R45 had six falls on the following dates: 10/1/23, two falls on 10/10/23, 10/11/23, 10/21/23, and 11/21/23. Despite six falls, the only new fall interventions to prevent further falls had been to remind R45 to call for assistance and for therapy to screen for wheelchair positioning. Post Fall Assessments had been completed for only four of the six falls. Three of four interventions indicated R45 had been educated to call staff for help when she wanted something. The fourth assessment did not indicate an intervention to prevent further falls. During an interview and observation on 11/28/23, at 6:00 p.m., R45 was sitting on the side of her bed in her room, barefoot, with oxygen cannula in her nose with hose running across the floor to an oxygen concentrator toward the foot of the bed. R45 was in a double room and her side of the room was next to the window. A curtain seperated R45's space from her roommates. R45's personal space was very limited from the curtain to her bed; approximately a width of 4 feet. In the space was a bedside table, wheelchair and a significant amount of personal items/clutter on the floor. R45 stated she had been working on cleaning it up. R45 stated she had frequent falls because her carbon dioxide levels got too high. Other times she fell when she went to sit in her wheelchair and slid out of it. R45 was not sure how many times she had fallen recently but admits to having gone to the hospital once or twice after falling where they found she had pneumonia. R45 stated she did not want to tell anyone when she fell because she was worried about getting in	2 830		

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2 830	Continued From page 5 trouble. R45 stated she broke her arm during one fall, but could not recall when that occurred. During an interview on 11/29/23, at 8:18 a.m., nursing assistant (NA)-E stated she thought the cause of R45's falls were from R45 removing her oxygen which caused her to lose her balance and fall. NA-E stated R45 had many offers from staff to help clean and organize the personal items in her room, but R45 refused staff assistance. NA-E stated fall interventions for R45 included keeping clutter out of her path and to remind her to ask for help to reach things. NA-E stated R45 was independent with mobility and could transfer from bed to wheelchair by herself and could toilet herself. During an interview on 11/29/23 at 1:44 p.m., with RN-C, went through the incident reports for each of six falls. All of the falls were documented as being unwitnessed; five occurred in R45's room and one in the dining room. After the fall on 10/11/23, R45 was transported to the hospital, returning on 10/18/23. A hospital discharge summary dated 10/18/23, indicated R45 was noted to be quite altered and lethargic with multiple bruises noted most significantly on her left orbital area, but also upper and lower extremity, shoulders and back. X-rays revealed chronic fractures, deformity of proximal right humerus and left clavicle; no acute fracture. R45 was also found to have pneumonia. During the same interview, RN-C acknowledged the incident reports were brief and did not include documentation of comprehensive assessments, nor was information documented elsewhere to determine the root cause of R45's frequent falls and to determine patterns or trends, nor did they indicate documentation of new interventions.	2 830		

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2 830	Continued From page 6 When an incident report indicated the fall had been reviewed by IDT, there had been no documentation to indicate if R45's falls were indeed analyzed by IDT, what was discussed and whether new fall interventions had been identified to prevent further falls. RN-C stated the facility had conducted performance improvement projects (PIPs) around falls in 2023, but improvement efforts had not been sustained. RN-C stated with new leadership at the facility - administrator and director of nursing (DON) -- they would need to resume fall performance improvement efforts. The facility Fall Prevention and Management Guidelines dated 11/8/22, suggested interventions for residents determined to be at higher risk for falls may include providing interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. When any resident experienced a fall, the facility would complete a post-fall assessment and review including resident and/or witness statements, contributing factors to the fall, medication changes (new or discontinued), mental status changes and any new diagnoses. An incident report would be completed in Risk Management. The residents care plan would be reviewed and updated with any new interventions put in place to try to prevent additional falls. Documentation of all assessments and actions. Obtain witness statements from other staff with possible knowledge or relevant information. Each fall would be reviewed during the next morning meeting/clinical meeting with the interdisciplinary team (IDT). Actions of the IDT may include: a. Review of investigation and determination of potential root cause of fall	2 830		

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2 830	Continued From page 7 b. Review fall risk care plan and any updates to plan of care completed post-fall c. Additional revisions to the plan of care including any physical adaptation to room, furniture, wheelchair, and/or assistive devices d. Education of staff as to any care plan revisions e. Scheduling resident/family conferences If after IDT review it was determined that existing interventions in the care plan are most appropriate, rationale would be documented to describe any additional actions taken. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, and revise policies and procedures related to resident falls. The DON or designee could develop a process for falls to be comprehensively assessed by IDT (interdisciplinary team) to determine root cause and to identify new interventions to prevent further falls. The DON or designee could educate staff and leadership on the process. The DON or designee could monitor and audit falls and take those findings to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work	21000		1/4/24

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21000	Continued From page 8 as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper glove use and hand hygiene techniques were used during food service. These practices had the potential to affect all residents, staff and visitors consuming food at the facility. Findings include: During an observation on 11/27/23 from 5:47 p.m. to 7:06 p.m., cook (C)-A was observed in the second floor dining area handling multiple food items, food serving utensils, plates, and surfaces while wearing blue gloves; and at no time during this observation did C-A perform hand hygiene. C-A was observed plating food while standing at the steam table, would leave the dining room area with blue gloves, return, and enter the plating area and failed to perform hand hygiene. C-A (gloved hands) and dietary manger (DM)-E (bare handed) handled multiple paper meal slips, plates, drinking cups, and meal trays, placed mandarin oranges on plates using a scoop, placed sandwiches on the plates, then covered the plates with a plastic thermal cover and set the plate on the steam table or tray that was placed on a metal utility cart an. This process was repeated until all resident food orders had been filled, without hand hygiene observed. During an observation on 11/27/23 at 6:30 p.m.,	21000	Corrected	

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21000	Continued From page 9 DM-E was observed to remove a cell phone from his front shirt pocket with his bare hand talk on the cell phone and return the cell phone to his shirt pocket, and was observed to continue to plate food and failed to perform hand hygiene. During an observation on 11/27/23 at 7:06 p.m., DM-E took a bowl from a resident in the dining room, entered the kitchen area placed food in the microwave to reheat, stirred the food with a spoon, took the temperature of the food, and returned the food to the resident in the dining area, reentered the kitchen area and failed to complete hand hygiene. During an interview on 11/27/23 at 7:10 p.m., C-A stated she wore gloves in the kitchen area and when plating food and confirmed hand hygiene was not performed when entering the kitchen area, and further stated that's why she wore the gloves. During interview on 11/27/23 at 7:13 p.m., DM-E stated he was the district food service manager and confirmed hand hygiene should be completed if touching personal items such as glasses, entering or exiting the kitchen area, when touching the microwave and after phone use. DM-E stated there was no hand sanitizer available for staff when entering the kitchen area on second floor or sink available for staff and confirmed staff had failed to properly disinfect hands during meal preparation. During an interview on 11/28/23 at 10:01 a.m. with the administrator and registered nurse (RN)-C, who was the vice president of success, the administrator stated there was lots of education and training that needs to be done with dietary staff. The administrator stated she had	21000		

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21000	Continued From page 10 witnessed things such as dietary staff not washing hands, not wearing hair or beard nets, and provided on the spot education. RN-C stated staff were expected to wash hands when entering the kitchen area or disinfect hands, and using gloves did not replace hand hygiene. RN-C and the administrator stated nursing staff had received education on cup handling and would expect staff to handle the cups on the side not on the rims The facility Hand Washing - Food and Nutrition Services policy dated 8/16/22, indicated: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures. Hand washing facilities will be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans and signage outlining hand washing procedures. Policy Explanation and Compliance Guidelines Hands and exposed portions of arms should be washed immediately before engaging in food preparation. 1. When to wash hands: a. When entering the kitchen at the start of a shift. b. After touching bare human body parts other than clean hands and clean, exposed portions of arms. c. After using the restroom. d. After caring for or handling service animals or aquatic animals. e. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking. f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing	21000		

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21000	Continued From page 11 tasks. h. When switching between working with raw food and working with ready to eat food. i. Before donning disposable gloves for working with food and after gloves are removed. j. After engaging in other activities that contaminate the hands. 3. Staff will be educated on the importance of hand washing and retrained and reminded as necessary on the above guidelines. 4. Hand washing procedures will be posted by each hand-washing sink. 5. Food preparation and/or pot sinks will not be used for handwashing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager (CDM) could audit the service of food on a periodic basis and take those findings to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21035	MN Rule 4658.0620 Subp. 2 Frequency of Meals; Snacks Subp. 2. Snacks. The nursing home must offer evening snacks daily. "Offer" means having snacks available and making the resident aware of that availability.	21035		1/4/24

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21035	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation interview and document review the facility failed to ensure all residents were consistently offered and provided a nutrient and/or calorie substantive snack after the dinner meal and before bedtime for 7 of 7 residents (R3, R8, R24, R25, R30, R35, R49) who voiced a concern. Findings include: R3's significant change Minimum Data Set (MDS) assessment dated 10/28/23, indicated intact cognition. R8's quarterly MDS assessment dated 10/17/23, indicated intact cognition. R24's quarterly MDS assessment dated 9/1/23, indicated intact cognition. R25's quarterly MDS assessment dated 10/20/23, indicated intact cognition. R30's quarterly MDS assessment dated 9/1/23, indicated intact cognition. R35's quarterly MDS assessment dated 11/1/23, indicated intact cognition. R49's quarterly MDS assessment dated 9/2/23, indicated intact cognition During an interview on 11/28/23 at 2:57 p.m., at a resident council meeting, residents were asked if they received snacks after dinner and before bedtime. All seven residents in attendance (R3, R8, R24, R25, R30, R35, R49), who resided on second floor shook their heads no, or stated they	21035	Corrected	

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21035	Continued From page 13 did not receive snacks. R25 stated no snacks were offered at any time. R30 stated they used to get snacks at bedtime, but now do not receive any snacks, not morning, afternoon or after dinner. Residents (R3, R8, R25, R30, R35, R49) acknowledged they would like a snack before bedtime and thought they could get a snack if they asked for one, but R24 stated she did not know if staff had access to snacks. During an interview on 11/29/23 at 8:31 a.m., (NA)-E on second floor stated snacks were offered to residents at 10:00 a.m., 2:00 p.m. and 8:00 p.m. NA-E could not explain why residents who resided on second floor indicated during resident council they were not offered snacks. NA-E stated snacks were located in the second floor kitchenette and stated up until about a month ago, they did not have snacks until a new dietary manager started at the facility. During an interview on 11/29/23 at 8:37 a.m., dietary manager (DM)-D stated he put snacks on each floor in the dining rooms. DM-D stated he had been trying to increase the variety of snacks. When informed residents stated they were not being offered snacks and didn't know snacks were available, DM-D stated they needed to get the word out about snacks. During an interview on 11/29/23 at 10:36 a.m., nursing assistant (NA)-F on third floor stated there were no snacks stocked on third floor. If a resident wanted a snack, NA-F stated staff would need to get something from the kitchen or ask the kitchen to bring something to third floor. During an interview on 11/29/23 at 10:50 a.m., with registered nurse (RN)-C who was also the vice president of success, the interim director of	21035		

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21035	Continued From page 14 nursing (DON) and registered nurse (RN)-A who was also the assistant director of nursing, RN-A stated snacks were available on the units and some residents could help themselves. RN-C, the DON and RN-A acknowledged not all residents would be able to help themselves. RN-C, the DON and RN-A could not confirm whether or not residents were offered snacks after dinner and before bedtime. During an interview on 11/29/23 at 12:32 p.m., (NA)-G on first floor stated she did not offer snacks to residents but would get them food from the kitchen if they requested it. NA-G stated there were no snacks on first floor that she was aware of. During observations on 11/29/23 from 2:57 p.m. to 3:13 p.m., of the first, second and third floor refrigerators and kitchenettes, no nutrient and/or calorie substantive snacks were observed; only some pudding in refrigerators, ice cream in the freezers and a bin of chips on second floor. During observations on all three survey dates: 11/27/23 from 1:00 p.m. to 7:30 p.m., on 11/28/23 from 8:00 a.m. to 5:00 p.m., and 11/29/23 from 8:00 a.m. to 4:00 p.m., no observations were made of snacks being passed or offered to residents on any of the three floors. The facility Snack policy dated 9/2017, indicated HS (bedtime) snacks would be provided for all residents. The dining services department would assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime. Nursing services was responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents.	21035		

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21035	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review or revise policies, and devleop a process for staff to offer residents a snack after the dinner meal and before bedtime. The DON or designee could train staff on the new process. The Quality Assessment and Performance Improvement (QAPI) committee could conduct random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21035		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored in accordance with professional standards for food service safety by failing to label and date food, to remove expired food from food storage areas. These practices had the potential to affect all residents, staff and visitors consuming food at the facility. Findings include: During a tour of the kitchen's dry storage on 11/29/23 at 10:42 a.m., dietary manager (DM)-H confirmed the following observations:	21100	Corrected	1/4/24

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21100	Continued From page 16 -an undated, opened package of marshmallows, manufacturer's expiration date of July 2023, which was not tied shut. -canned goods were not removed from their shipping flats and shrink wrap, just cut open and cans taken out from the middle. DM-H identified two dented cans of Campbell's Cream of Chicken soup amongst a flat of of soup still in shrink wrap and cardboard. The shrink wrap was torn open on top with two cans gone from the middle of the flat. DM-H removed the dented cans. During an interview on 11/29/23 at 10:48 a.m., DM-H stated there didn't seem to be a real system for rotating the stock. DM-H stated the expectation was to use a first in and first out rotation system for the canned and dry goods. DM-H added there were stickers available for indicating which stock should be used first and any dented cans should be removed from food storage areas and placed on the "dented cans to be returned" shelf. During a tour of the kitchen's walk-in cooler on 11/29/23 at 10:51 a.m., DM-H confirmed the following observations and removed the items from food storage areas: -an unlabeled storage container of about 10 biscuits. -a labeled storage container of turkey lunch meat, expired on 11/23/23. -a labeled storage container of chopped green peppers, expired on 11/27/23. -a labeled storage container with three peeled, hard boiled eggs, expired on 11/26/23. During an interview on 11/29/23 at 12:11 p.m., the registered dietician nutritionist (RDN) stated she had done a monthly sanitation audit at this facility, most recently on 11/15/23. The RDN had noted at	21100		

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21100	Continued From page 17 that time food labeling wasn't being done, and identified a bag of expired flour, so she provided education to the dietary manager (DM)-D about food labeling expectations. The RDN further stated it "had been a work in progress". Policies and procedures regarding food storage, kitchen cleaning, and dishwasher testing were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the quality assurance performance improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be	21134		1/4/24

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21134	Continued From page 18 given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately monitor chemical sanitization for 1 of 1 dish machine. These practices had the potential to affect all residents, staff and visitors consuming food at the facility. Findings include: During a tour of the kitchen's dish room on 11/29/23 at 11:07 a.m., dietary manager (DM)-H verified the dishwasher sanitized dishes via chemical sanitization and was checked with Ecolab brand test strips, manufacturer expiration date 11/2025, for the parts per million (PPM) of the sanitizing chemicals during a wash cycle after each meal service. A Dish Machine Log form indicated testing during breakfast, lunch, and dinner. There was a column for the wash and rinse cycle temperatures, the PPM result and the initials of the person recording the values. The values under the column marked PPM for breakfast, lunch and dinner all indicated "300" on each entry for all 28 days of this month. At the bottom of the form there was a key for normal temperature and chemical PPM values should. The recommendation for chemical values was 50 to 200 PPM. At 11:15 am, on the side of the dish room where the clean dishes go, there was observed to be food particles and water on the stainless counter where clean dishes would dry. DM-H stated she was not sure why it was like that	21134	Corrected	

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21134	Continued From page 19 but that it should not be as that is where the clean dishes go. During a tour of the dish room at 11/29/23 at 1:12 p.m., with the administrator and DM-H the chemical PPM from the dishwasher chemical test strip was observed at 100 PPM. During an interview on 11/29/23 at 4:55 p.m., DM-E stated he would expect someone would have said something if the PPM were consistently out of range. It was important to check and monitor to make sure the germs were getting killed. Policies and procedures regarding food storage, kitchen cleaning, and dishwasher testing were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, and revise policies and procedures related to monitoring of chemicals for a dishwasher that relies on chemical sanitization. The administrator or designee could educate dietary staff and leadership on the process. The administrator or designee could audit chemical testing for the dishwasher and take those findings to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21134		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance	21385		1/4/24

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21385	Continued From page 20 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff completed proper hand hygiene and glove use during meal preparation and distribution of meals, and failed to properly disinfect a glucometer for 1 of 2 residents (R2) . This had the ability to affect all 55 residents who consumed food in the facility. Finding include: Hand Hygiene During an observation on 11/27/23 at 6:53 p.m., nursing assistant (NA)-H removed a three-ring binder from a table and brought it to the counter. Without performing hand hygiene, NA-H got a resident meal tray from the delivery cart, removed the plate cover, and cut the sloppy joe into pieces with a fork. NA-H then started stacking plate covers from trays onto the counter, grabbed some ketchup packets, brought them to a resident table and opened one squeezing the contents onto the plate. NA-H then proceeded to gather dirty glasses by the rims, dropped them off at the counter and got two clean mugs, filled them with water and dropped them off at a resident table. During an observation on 11/27/23 at 7:03 p.m., trained medication aid (TMA)-A was wearing	21385	corrected	

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21385	Continued From page 21 gloves while preparing a resident's tray. She turned and grabbed a chair with arms by the arms and dragged it to the table. TMA-A then used her same gloved hands to grab the handles of a four-wheeled walker and move it out of the way, and then sat down next to the resident and proceeded to feed them. During an interview on 11/27/23 at 7:12 p.m., NA-H stated they should be washing their hands between resident's trays, but they just got in such a hurry with the meal being so late, they should have used hand sanitizer or something. NA-H confirmed there was not a hand sanitizer dispenser in the dining room. During an interview on 11/27/23 at 7:22 p.m., TMA-A stated she wore gloves so that she didn't transmit germs from one table to the next, but acknowledged hand hygiene should be performed between different residents. TMA-A added she would use hand sanitizer, but they didn't have any in the dining room, and the nearest one was about 10 yards away down the hall away from there. TMA-A recalled they had one on the wall in the dining room, but a resident took it down and she had told housekeeping and maintenance, but they still didn't have one there. TMA-A confirmed there weren't any portable bottles of hand sanitizer in the dining area or on the dining carts. During an interview on 11/28/23 at 10:01 a.m., the administrator and registered nurse (RN)-C who was known as the vice president vice president of success stated they would expect employees to be washing their hands between assisting residents in the dining room, there were bathrooms nearby. Both the administrator and the vice president of success agree there should be	21385		

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21385	Continued From page 22 hand sanitizer available to staff when serving in the dining room. On 11/29/23 at 9:51 a.m., the administrator stated she expected there to be some hand sanitizer closer to the kitchen, she estimated the distance to be about 20 feet to the nearest one for the dining room. Glucometer R2's Medication Administration Record (MAR) dated 11/1/23-11/30/23, indicated blood glucose four times a day related to type 2 diabetes. On 11/29/23 at 8:20 a.m., RN-E removed a black case with R2's name on it from the medication cart, and removed a glucometer. RN-E entered R2's room, donned gloved, placed a test strip in the glucometer, used a alcohol wipe and wiped R2's finger, used a lancet to obtain a drop of blood from R2's finger and placed a drop of blood on the test strip, removed the test strip from the glucometer, and RN-E removed her gloves, exited the room, washed hands and placed the glucometer back in R2's glucometer case. RN-E stated each resident had their own glucometer and residents did not share glucometers, and stated she did not know rule for disinfecting personal glucometers. RN-E stated her current practice was not to wipe them down after each use, and stated I guess it would be a good idea to wipe them between each resident if they are kept in the medication cart and handled by multiple people. On 11/29/23 at 10:50 a.m. RN-C who was known as the vice president of success stated all glucometers should be wiped after resident use.	21385		

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21385	Continued From page 23 On 11/29/23 at 3:44 p.m., RN-A, the infection prevention nurse, stated each resident had their own glucometer and staff were expected to disinfect glucometer after every use . The facility Glucometer Disinfection policy dated 11/11/22, indicated : Policy: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions: "Cleaning" is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. "Disinfection" is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer ' s instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter will not be used for multiple residents. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 4. Glucometers will be cleaned and disinfected after each use and according to manufacturer ' s instructions regardless of whether they are intended for single resident or multiple resident use. 5. Procedure:	21385		

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21385	Continued From page 24 a. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes. b. Wash hands. c. Explain the procedure to the resident. d. Provide privacy. e. Put on gloves. f. Obtain capillary blood glucose sampling according to facility policy. g. Remove and discard gloves, perform hand hygiene prior to exiting room. h. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. i. Retrieve disinfectant wipe(s) from container. j. Clean and disinfect the glucometer thoroughly with the disinfectant wipe(s), following the manufacturer ' s instructions. Allow the glucometer to air dry. k. Discard disinfectant wipes in waste receptacle. l. Perform hand hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to quality assurance performance improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		

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21565	Continued From page 25	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R51 and R1) who were observed to have medications in their rooms, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R51's facesheet printed on 11/29/23, included a diagnosis of orthopedic after care following surgery for leg amputation. R51's admission Minimum Data Set (MDS) assessment dated 11/19/23, indicated R51 was cognitively intact, had adequate vision and hearing, could understand and be understood. R51 required assistance or was dependent upon staff for most activities of daily living. R51's care plan initiated on 10/13/23, did not address self-administration of medications. R51's medical record did not include an assessment for self-administration of medications. R51's physician orders did not include an order	21565	Corrected	1/4/24

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21565	Continued From page 26 for self-administration of medications. During an observation and interview on 11/27/23 2:10 p.m., observed a bottle of Prevagen (memory enhancer) Regular Strength dietary supplement, 30 capsules on R51's overbed table next to his bed. R51 stated he had brought them from home and took them for his memory. R51 stated he had been taking them on his own while in the facility. The bottle had only a few capsules in it as noted when bottle was picked up and shaken gently. During an interview and observation on 11/28/23 at 5:50 p.m., registered nurse (RN)-D stated residents could not have medications in their room and stated R51 did not have a self-administration of medication order nor had he been assessed to determine if safe to take medication without supervision. Together with RN-D, went to R51's room. RN-D picked up the bottle of Prevagen and asked R51 if he had been taking the medication and R51 replied he had. RN-D informed R51 she would like to take the medication and get a physician order for it but R51 refused to let her take it. Progress note dated 11/28/2023 at 11:07 p.m., written by RN-D indicated: Resident had a bottle of pills in his room that help with memory loss. Author ask resident to keep it in the med (medication) cart and advised the resident he should not have medication in his room. Resident was upset about it and grabbed the bottle from author's hand. Resident stated, " I am keeping it in my room. It's only three pills left." During an observation and interview on 11/29/23 at 12:31 p.m., together with the interim director of nursing (DON), went to R51's room. The interim	21565		

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21565	Continued From page 27 DON questioned R51 about the bottle of Prevagen and noted there was one pill left in the bottle. R51 admitted he took the medication every day and had taken one that morning. Family member (FM)-F who was present, stated she brought the bottle of Prevagen to the facility. The interim DON explained to R51 and FM-F that she would need to take the medication and get a doctor order for it to be kept in R51's room. After exiting R51's room, the interim DON stated she could not explain why staff had not secured the medication earlier when the bottle of Prevagen had been in plain sight. R51 had been admitted to the facility on 10/12/23. R1's facesheet printed on 11/29/23, included a diagnosis of eczema (a skin condition causing dry, itchy patches of skin). R1's quarterly Minimum Data Set (MDS) assessment dated 11/29/23, indicated R1 was cognitively intact. R1's care plan initiated on 9/11/18, did not address self-administration of medications. R1's physician orders dated 3/31/23, included Nystatin powder (a medicated powder used to treat fungal infections) 100000 units per gram to be applied to the groin two times per day, and AmLactin (a medicated lotion to treat dry, scaly skin) 12-percent lotion to be applied to upper and lower extremities two times per day but did not include an order for self-administration of medications. During an observation and interview on 11/28/23 at 8:21 a.m., a bottle of Nystatin powder and a bottle of AmLactin 12-percent lotion were observed to be on the dresser next to where R1	21565		

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21565	Continued From page 28 was sitting in her recliner. R1 stated the staff applied the lotion and powder for her in the morning and at bedtime. During an interview on 11/28/23 at 2:04 p.m., RN-A and RN-C known as vice preseint of success stated for a resident to have self-administration of medications they would need to be assessed, have provider orders and be addressed in the care plan. The facility Self-Administration by Resident policy dated 11/17, indicated residents who desired to self-administer medications were permitted to do so with a prescriber ' s order and if the nursing care center ' s interdisciplinary team had determined the practice to be safe, and the medications appropriate and safe for self-administration. The results of the interdisciplinary team assessment were recorded on the Medication Self-Administration Assessment, which was placed in the resident ' s medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review policies and procedures to ensure residents were assessed to determine if self-administration of medication is appropriate. The DON or designee could provide staff with re-education of policies and process pertaining to self-administration of medications. The DON or designee, could conduct random audits to ensure medication administration is supervised for residents not assessed for self-administer of medications. The results of the audits could be brought to the quality assurance and performance (QAPI) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one	21565		

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21565	Continued From page 29 (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an insulin pen stored in the medication cart was labeled for one resident (R31) and the facility failed to ensure eye drops were discarded per manufactures instructions for one resident (R26). Findings include:. R26's medication administration record (MAR) dated 11/1/23-11/30/23, indicated netarsudil dimesylate (Rhopressa eye drop used to lower eye pressure) ophthalmic solution 0.02 % instill one drop in both eyes at bedtime and Latanoprost (eye drop used to treat certain kinds of glaucoma) instill one drop in both eyes at bedtime. R31's MAR dated 11/1/23-11/30/23, indicated an order for Novolin N Flexpen subcutaneous suspension pen-injector 100 unit/ml inject 29 unit subcutaneous in the evening. During an observation and interview on 11/27/23 at 6:46 p.m., registered nurse (RN)-A removed an insulin pen from R31's labeled designated space from the medication cart, the insulin pen was labeled with a manufacturers sticker with Novolin N Flexpen subcutaneous suspension pen-injector 100 unit/ml. RN-A confirmed R31's insulin pen	21620	Corrected	1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 30 had been opened before today and lacked a label with the opened date, expiration date, or resident name. RN-B stated she used the EMR to obtain directions for R31's insulin dose. During the medication storage tour on 11/29/23 at 7:36 a.m., with the interim director of nursing (DON) of the first floor medication cart, the following was observed: R26's Latanoprost eye drops had a date of 10/12 hand wrote with black marker. R26's Rhopressa eye drops had no open date and no expiration date. During an interview on 11/29/23 at 7:39 a.m., interim DON stated staff were expected to write the open date and expiration date on the eye drop bottle. The interim DON stated the eye drops would be expired 28-30 days after the eye drop was opened and, the DON further stated she would review the manufactures instructions and confirm the expiration dates of eye drops after they are opened. During a follow up interview the interim DON stated the Latanoprost eye drops should have been discarded 42 days after the open date. The interim DON stated all medications were expected to be labeled with resident name, open date, and expiration date and stated would expect insulin pens labeled with resident name and date opened. The facility Medication Storage policy dated 1/21, indicated 12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens then first used. The opened insulin vial may be stored in	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21620	Continued From page 31 refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal Facility undated document titled PharMerica Did You Know Abridged List of Medications with Shortened Expiration Dates indicated: Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert (PI) under the "How Supplied/Storage & Handling" section. A drug product's Beyond Use Date (BUD) is the manufacturer supplied expiration date OR the shortened date after opening (see BUD Notes below), whichever comes first. These In-Use medications should be labeled such that the "DATE OPENED" is noted, clearly visible and securely attached to a part of the package to not be discarded. This date is to be referenced when auditing to clear medications prior to expiration. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), consulting pharmacist or designee could review, revise, or create policies and procedures for proper labeling and storage of medications. The DON, consulting pharmacist or designee could educate nursing and/or trained medication aide staff to those changes. The DON, consulting pharmacist or	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21620	Continued From page 32 designee, could routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to quality assurance performance improvement (QAPI) committee to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 29, 2024

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: November 8, 2023

Dear Administrator:

On December 19, 2023, we notified you a remedy was imposed. On January 17, 2024, 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 January 4, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 2, 2023 be discontinued as of January 4, 2024. (42 CFR 488.417 (b))

In our letter of December 19, 2023, 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 December 2, 2023. 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.

Correction of the Life Safety Code deficiency(ies) cited under K374, K914 at the time of the November 8, 2023 standard survey, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of April 1, 2024 and April 15, 2024, have been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 29, 2024

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Reinspection Results
Event IDs: 307412 and ZH0812

Dear Administrator:

On January 17, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 8, 2023 (ZH0811) and the survey completed on November 29, 2023 (307411). At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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