



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2025

Administrator

Highland Chateau Health And Rehabilitation Center

2319 WEST SEVENTH STREET

SAINT PAUL, MN 55116

RE: CCN: 245028

Cycle Start Date: April 24, 2025

Dear Administrator:

On May 15, 2025, we notified you a remedy was imposed. On July 17, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 8, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 30, 2025 be discontinued as of July 8, 2025. (42 CFR 488.417 (b))

In our letter of May 15, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 30, 2025. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



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August 1, 2025

Administrator

Highland Chateau Health And Rehabilitation Center
2319 WEST SEVENTH STREET
SAINT PAUL, MN 55116

Re: Enclosed Reinspection Results - 3J2L12 and RY2Y-H2

Dear Administrator:

On July 17, 2025 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 24, 2025 and June 6, 2025. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: April 24, 2025

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 24, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 30, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 30, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 30, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Chateau Health And Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 30, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
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 October 24, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

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 tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and **Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent

Highland Chateau Health And Rehabilitation Center

05/15/2025

Page 2

within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

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

PRINTED: 05/31/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(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 4/21/25, to 4/24/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 4/21/25, to 4/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H50282723C (MN00112237) and (MN0011288) H50283167C (MN00108511) H50283169C (MN00105782) H50283171C (MN00103840) The following complaint was reviewed with a deficiency cited at F550: H50283168C (MN00108191) The following complaint was reviewed with a deficiency cited at F925: H50283170C (MN00108094)	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2025

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

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F 000	Continued From page 1	F 000			
F 550 SS=D	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. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or 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.	F 550			5/30/25

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F 550	Continued From page 2 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a dignified experience for 2 of 2 residents (R30 and R1) who did not have clothing to wear and were spoken to in an undignified manner by staff. Findings include: R30's face sheet printed 4/24/25, indicated diagnoses of weakness, adult failure to thrive, morbid obesity, and bipolar disorder with psychotic features. R30's significant change minimum data set (MDS) assessment dated 3/26/25, indicated intact cognition, no rejection of care, use of a wheelchair, substantial assistance with upper body dressing, and dependence on staff for lower body dressing. R30's care plan printed 4/24/25, indicated R30 required extensive assistance of one staff for dressing, and limited assistance of one staff for bed mobility and eating. During interview on 4/21/25 at 3:27 p.m., R30			F 550	R30 and R1 met with facility Social Service Designee and a grievance form was initiated for both and a resolution recorded. Current residents' clothing preferences will be reviewed and care plans updated. Future residents will have their clothing preferences honored and will be treated with dignity and respect by facility staff. The grievance process will continue to be utilized for residents and staff to report concerns to the appropriate IDT member. Facility staff will be in-serviced on the Resident Dignity Policy that residents will always be treated with dignity and respect, the facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. In addition, residents are encouraged to dress in clothing that they prefer, and staff will always speak respectfully to residents. The IDT team, nurses and nurse aides were also in-serviced on the Grievance Procedure with following up with the residents to ensure residents acceptance of plan		

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F 550	Continued From page 3 stated one of the nursing assistants had a terrible attitude and scolded her for accidentally getting vomit on her shirt. R30 stated she did not think it was abuse, but did not appreciate being scolded like a little kid. R30 further stated she had reported this incident to a nurse but could not recall which nurse. R30 identified the nursing assistant who scolded her as a nursing assistant with letters HCAC in her name, but did not know her actual name. R30 further stated this nursing assistant had continued to work with her since the incident. During interview on 4/23/25 at 11:51 a.m., R30 stated she knew the assistant director of nursing (ADON) was notified of the scolding event because a nurse had R30 write up a note to give to the ADON. R30 stated she could not write, so she dictated the note describing the event to the nurse and the nurse was supposed to give it to the ADON. R30 thought the incident happened two weeks ago. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated she was not aware of R30 being scolded by a nursing assistant but that should not have happened. During interview on 4/24/25 at 10:10 a.m., NA-M stated she did not recall scolding R30 and maybe R30 did not understand her or maybe she was talking too loud. NA-M further stated she would not scold a resident. During interview on 4/23/25 at 8:47 a.m., social services (SS)-A stated she was not aware of a nursing assistant scolding R30. SS-A further stated if she had heard that she would have			F 550	resolution. The Social Service is responsible for compliance. Audits on residents dressed in clothing of their choice and staff treatment/response to residents with dignity will begin 2x a week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 550	Continued From page 4 reported it because nursing assistants should not scold residents. During interview on 4/23/25 at 12:23 p.m., ADON stated she recalled a nurse reporting R30 being scolded by a nursing assistant and had asked the nurse to complete a grievance form. ADON was not able to recall name of nurse or nursing assistant. ADON did not recall receiving the grievance form and had not followed up on the report from R30. ADON stated she was trying to make the nurses more accountable. ADON stated the incident likely would not have been addressed if R30 had not brought it up again but it was addressed today. During interview on 4/24/25 at 8:45 a.m., director of nursing (DON) stated nursing assistants should not scold residents, and she expected the ADON to follow up on the reported grievance. DON further stated the grievance had been reported today and would be investigated. R1's face sheet printed 4/24/25, indicated an admission date of 8/11/24, diagnoses of non-pressure chronic ulcer of left ankle, depression, chronic kidney disease, and adult failure to thrive. R1's quarterly MDS assessment dated 2/16/25, indicated moderately impaired cognition, verbal behavioral symptoms directed at others four to six days, rejection of care one to three days, use of a walker, supervision for bathing, and independent with upper and lower body dressing. R1's care plan dated 3/28/25, indicated resident independent with dressing, resistive to cares related to poor impulse control with intervention of			F 550			

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F 550	Continued From page 5 encourage to participate and provide interaction. During interview and observation on 4/21/25 at 5:55 p.m., R1 was naked on her bed and stated she did not have any clothes at the facility and her only clothing was a robe and a pair of slippers. A blue robe was observed hanging on a chair in R1's room. No other clothing was observed. R1 stated she came from the hospital and did not have anyone to bring her clothing. R1 further stated she used to wear gowns provided by the facility, but the facility no longer provided gowns. During observation on 4/22/25 at 1:03 p.m., R1 was in the common dining room in a blue robe and slippers. During observation on 4/24/25 at 8:40 a.m., R1 was in the common dining room in a blue robe and slippers. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated R1 was very particular and wanted her own clothing. During interview on 4/23/25 at 9:15 a.m., licensed practical nurse (LPN)-C stated R1 did not have any clothes. LPN-C stated she recalled social services (SS)-A tried to contact someone to bring R1's personal belongings but had not heard anything since then. LPN-C further stated R1 used to wear gowns provided by the facility but the facility no longer provided gowns so R1 only wore her robe. During interview on 4/23/25 at 8:47 a.m., SS-A stated R1 had no clothing other than a robe due to her clothing being at her previous group home.	F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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F 550	Continued From page 6 SS-A stated she knew R1 wanted her clothing here at the facility and she had tried to work with the previous group home when R1 admitted to the facility but the previous group home did not bring the clothes. SS-A stated she was unaware R1 did not have facility provided gowns and was only wearing a robe with no clothing underneath. SS-A stated that would be a dignity concern to not have any clothing to wear. During interview on 4/23/25 at 12:23 p.m., assistant director of nursing (ADON) stated she knew R1's belongings were at her previous group home and did not know why her belongings were not at the facility yet. ADON stated she would expect after nine months of R1 being at the facility someone would have figured out how to get her clothing. ADON further stated R1 wore facility provided gowns as her clothing prior to the facility no longer providing gowns. During interview on 4/24/25 at 9:15 a.m., R1 stated she had asked someone to get her clothes, and they brought her sweatpants and a button up shirt. R1 stated she did not want to wear those facility provided clothes and preferred her own slacks and blouses. R1 further stated she was told someone would get her clothes a long time ago. During interview on 4/24/25 at 11:07 a.m., administrator stated the facility provided gowns to the first floor residents who were there for short term rehabilitation stays, but no longer provided gowns to second floor residents if residents used them as regular clothing. Administrator stated the facility offered to assist residents who chose to wear gowns as regular clothing with purchasing gowns if they desired them and further stated she	F 550			

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F 550	Continued From page 7 could not confirm whether R1 had replacement gowns or clothing prior to facility gowns being taken away. Facility Dignity policy reviewed 4/24/25, indicated the following: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: c. encouraged to dress in clothing that they prefer. 8. Staff speak respectfully to residents at all times.	F 550			
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and	F 576			5/30/25

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F 576	Continued From page 8 the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays for 4 of 4 residents (R16, R47, R32, R42) who attended the resident council meeting, who verbally confirmed mail was not delivered on Saturdays. This had the potential to affect all 47 residents residing in the facility. Findings include: During an interview on 4/23/25 at 10:05 a.m., R16, R47, R32, R42 stated they had never seen mail delivered on Saturdays. R32 stated the business office manager was not there on Saturdays, and she usually delivered it.			F 576	Facility Social Service designee met with R16, R47, R32, and R42 and filled out a global grievance regarding absence of mail delivery on weekend. Grievance will be completed and resolution recorded and resident satisfaction of resolution recorded. Current and future residents will have mail delivered per facility policy. Facility staff and Activity Director will be in-serviced on the Mail/Electronic Communication policy and procedure with emphasis on Mail and packages will be delivered to the residents within twenty-four (24) hours of delivery on premises (excluding Saturday deliveries).		

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F 576	Continued From page 9 R16's annual Minimum Data Set (MDS) assessment dated 2/15/25, indicated intact cognition. R47's quarterly MDS assessment dated 2/17/25, indicated intact cognition. R32's quarterly MDS assessment dated 2/4/25, indicated intact cognition. R42's quarterly MDS assessment dated 4/1/25, indicated intact cognition. During an interview on 4/23/25 at 3:52 p.m., business office manager (BOM)-D stated she delivered mail to residents during the week, but no one was assigned to deliver mail on Saturdays. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated mail was not delivered on Saturdays since BOM-D, who delivered mail during the week did not work on Saturdays. Facility Mail and Electronic Communication policy dated 4/23/25, indicated mail and packages would be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).	F 576	Saturday mail will be delivered by the facility charge nurse. Saturday mail will be delivered on the same day to residents when the mail is delivered to the facility. The Activity Director is responsible for compliance. Audits on mail delivery date to facility, was mail delivered to the resident within 24hrs of arrival to the facility and if mail was received by facility resident on Saturday will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		
F 580 SS=D	Notify of Changes (Injury/Delcline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580			5/30/25

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F 580	Continued From page 10 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580			

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F 580	Continued From page 11 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification to a family member for change of condition and hospitalization for 1 of 1 resident (R22) reviewed for change in condition. Findings include, R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. A review of R22's progress notes contained the following information: - Progress noted dated 2/4/25, indicated R22 was coughing more than usual, and blood was coming out of his mouth. R22 had bitten his lower lip. Progress note indicated the nurse practitioner was updated and gave an order for cough medication as needed. - Progress note dated 2/5/25, indicated change in health condition. Progress note indicated the nurse practitioner was updated and ordered to send R22 to the hospital for further evaluation. - Progress notes lacked documentation regarding R22's family being notified about the change in condition, new orders, and/or transfer to the	F 580	R22 family was contacted by DON and notified family members of absence of notification for R22's hospitalization on 2/25/2025. R22's family representative response will be recorded in the resident electronic medical record. Current residents who were transferred from the hospital from survey exit to current, their records will be reviewed and updated for family representative notification as needed. Future residents who transfer from the facility for a change in condition, their resident representative will be notified per facility policy. Licensed Nurses will be in-serviced on the Transfer/Discharge Emergency policy with emphasis on item #4 that notifications must be made to the MD, transferring facility and to resident representative. In addition, the licensed nurses will also be in-serviced on the required items that must accompany resident transfer i.e., POLST, 30-day transfer form, Bed Hold, medication list and monthly ombudsman monthly notification. The Director of Nursing is responsible for compliance. Audits on MD and family documented changes in condition and notification of emergent transfer will begin weekly x 4 weeks, then monthly to ensure sustained		

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F 580	Continued From page 12 hospital. During interview on 4/21/25 at 5:23 p.m., family member (FM)-A indicated R22 was sent to the hospital in February, and she was not notified. FM-A learned R22 was sent to the hospital when she received a call from a hospital doctor who called her to discuss treatment options for R22. FM-A stated R22 had been at the hospital for one hour and forty-five minutes. FM-A called the facility and asked why she was not notified about R22's change of condition and transfer to the hospital. FM-A stated the facility stated they didn't have time. During interview on 4/23/25 at 11:10 a.m., the director of nursing (DON) stated the family or responsible party should be notified about change in condition as soon as we know, and before sending the resident to the hospital. The DON verified the facility didn't notify FM-A about his change of condition or transfer. A facility policy about notification of change in condition and transfer to a hospital was requested but not received.	F 580	compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584			5/30/25

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F 584	Continued From page 13 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to investigate a report of missing clothing for 1 of 1 resident (R30) who reported missing clothing items to nursing staff. Findings include:	F 584	Social Service Designee met with R30 on 5/19/2025 and initiated a grievance concerning missing clothing. R30 grievance resolution was investigated, and grievance resolution was completed on 5/19/2025. All current resident residents with outstanding grievances,		

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F 584	Continued From page 14 R30's face sheet printed 4/24/25, indicated diagnoses of weakness, adult failure to thrive, morbid obesity, and bipolar disorder with psychotic features. R30's significant change Minimum Data Set (MDS) assessment dated 3/26/25, indicated intact cognition, no rejection of care, use of a wheelchair, substantial assistance with upper body dressing, and dependence on staff for lower body dressing. R30's care plan printed 4/24/25, indicated R30 required extensive assistance of one staff for dressing, and limited assistance of one staff for bed mobility and eating. During interview on 4/21/25 at 3:32 p.m., R30 stated she was missing clothing and had told a nurse about it but could not recall the nurse's name. R30 stated the nurse responded that she would look into the missing clothing, but R30 had not heard anything further. R30 further stated she thought the clothing had been missing for a few months. During interview on 4/23/25 at 11:51 p.m., R30 stated she recalled which clothing was missing and listed a green shirt, light green pullover sweatshirt, and navy blue sweatshirt. R30 stated she told an unknown nurse about the missing clothing but did not fill out a formal grievance form. During interview on 4/23/25 at 8:47 a.m., social services (SS)-A stated she was not aware of R30's missing clothing items, R30 was a reliable reporter, and if a nurse was made aware of missing clothing items a grievance form should	F 584	from survey exit until present, their grievances will be reviewed, completed and resolved. Future residents with missing items these items will be recorded via the grievance process, investigated and resolution recorded by the facility policy. The facility staff will be in-serviced on the Personal Property Policy and Procedure with emphasis that the facility Grievance Coordinator will promptly investigate any complaints of misappropriation or mistreatment of resident property. In addition, the resident council will also review the Personal Property and Grievance Policy at the next resident council tentatively scheduled for 5/21/2025. The Social Service Designee is responsible for compliance. Audits on missing resident item reports and resolution will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 584	Continued From page 15 have been filled out. During interview on 4/23/25 at 12:23 p.m., assistant director of nursing (ADON) stated she had not heard about R30's missing clothing items prior to this week. ADON further stated if R30 had reported the missing items to a nurse, the nurse should have completed a grievance form so it could get to the right people for an investigation. ADON stated recently there had been more complaints of missing clothing. During interview on 4/23/25 at 1:38 p.m., director of nursing (DON) stated she would have expected a grievance form to be completed about R30's missing clothing items. Facility Personal Property reviewed 10/18/22, stated the following: 7. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.	F 584			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 2 residents (R16) reviewed for MDS accuracy. Findings include: R16's annual MDS assessment dated 2/15/25,	F 641	R16 MDS for anticoagulant therapy was modified, a care plan initiated, and physician order updated with dx and indication for use. All current residents who receive anticoagulant therapy, their MDS, orders and care plans will be reviewed and updated as needed. Future admissions, the resident will have the		5/30/25

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F 641	Continued From page 16 indicated R16 had limited range of motion of upper extremities and was cognitively intact with diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation. Section N0415 indicated R16 was taking an antidepressant, an antibiotic but didn't indicate taking an anticoagulant. A section of the RAI labeled, "Section N-Medications", outlined directions for coding the subsequent sections including N0415: High-risk Drug Classes. High-risk drug classes included antipsychotics, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic or none of the above. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated the MDSs were completed by a person at the corporate office. DON stated she was the MDS coordinator prior to assuming her current position as DON and was knowledgeable of the RAI process. The DON verified R16 received an anticoagulant medication during the MDS review period but was not coded. DON stated we [facility] will have to redo the assessments or make a correction. DON stated the MDS was the base for payment and care planning and needed to be accurate. Facility MDS Error Correction policy dated 12/9/21, indicated: If an error is discovered after the encoding period and the record in error is an OBRA assessment, determine if the error is major or minor. a. A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to the QIES ASAP system. b. A major error is one that inaccurately reflects the resident's clinical status and/or may result in	F 641	appropriate diagnosis and indication for use entered the resident medication orders and a care plan will be initiated by the facility policy. The MDS coordinator will be in-serviced on the RAI Manual Section N pages 6-8 which the coordinator will review the resident current medication and record the high-risk medications correctly in the MDS section of the report and on the MDS Error Policy with emphasis on how to identify minor and major errors with the correction and submission process. In addition, the licensed nurses will be in-serviced that the appropriate diagnosis and indication for use must be entered into resident medication orders. The MDS coordinator is responsible for compliance. Audits on coding accuracy for Section N of the MDS for coding medication accuracy and accompanying care plan, medication diagnosis and indication for use will begin weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 641	Continued From page 17 an inappropriate plan of care. For major errors: (1) correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; AND (2) perform a new significant change in status (if this has occurred) OR a new significant correction to a prior assessment with a new observation period and assessment reference date.	F 641			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655			5/30/25

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F 655	Continued From page 18 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident's representative for 1 of 1 resident (R36) reviewed for baseline care plan. Findings include: R36's Clinical Profile dated 4/23/25, identified an admission date of 3/12/25, with diagnoses of infection and inflammatory reaction due to unspecified internal joint prosthesis. R36's admission Minimum Data Set (MDS) assessment dated 3/12/25, indicated R36 was admitted to the facility on 3/12/25, was cognitively intact, and had no behaviors or delusions. MDS indicated resident was on a pain management program, received medications for pain as needed, had a surgical wound, had oxygen, and received occupational and physical therapy	F 655	R36 baseline care plan was initiated on 3/12/2025 with items to provide immediate care. R36 care plan had additional focus items added to address pain, fall risk, respiratory medication usage on 5/27/2025 and an updated copy of the care plan was delivered to the resident on 5/28/2025. R36's next quarterly care conference is scheduled tentatively for June 12, 2025. All newly admitted residents from survey exit until current, their baseline care plan was reviewed and/or updated as needed. Future resident admissions, their baseline care plan will be developed within the 48 hours of the resident admission, and a meeting will be scheduled by social service designee with the resident/resident representative per the resident/resident representative meeting preference date/time to review base line care plan per		

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F 655	Continued From page 19 services. R36's Electronic Medical Record (EMR) lacked evidence of a baseline care plan had been provided to R36. R36's EMR included a progress note authored by social services (SS)-A dated 4/4/25, indicating R36 wished to discharge to a sober house once he meets his goal ... care conference will be scheduled quarterly and as needed. During interview on 4/21/25 at 7:03 p.m., R36 stated he didn't remember receiving a care plan or having a care conference. During interview on 4/23/25 at 2:28 p.m., social services (SS)-A indicated initial care conferences were scheduled 48 to 72 hours after admission. During the initial care conference residents received a copy of their baseline care plan. SS-A verified R36 was admitted on 3/12/25. SS-A stated the progress note dated 4/2/25, was a late entry and added, "perhaps I was out that week, maybe we didn't have the care conference, and the 72 hours base line care plan was not given". SS-A stated she will look for a copy of the signed care conference form and the copy of R36's baseline care plan. During interview on 4/24/25 at 10:13 a.m., SS-A stated she was unable to provide documentation of a care conference held with the resident, therapist, nurse and SS. Furthermore, SS-A was unable to provide a copy of R36's baseline care plan. SS-A stated baseline care plans were usually provided to residents at the initial care conference. During interview on 4/24/25 at 2:41 p.m., director	F 655	facility policy. A copy of the signature page will indicate that the 48-hour care plan review took place, and a copy of the care plan will be provided to the resident/resident representative. Licensed Nurses and the IDT Team will be in-serviced on the Facility Baseline Care Plans that indicate the resident baseline plan of care is needed to meet the residents' immediate health and safety needs and is required within 48 hours of admission. Licensed nurses were also in-serviced on care plan items that need to be activated upon admission i.e. skin, elopement risk (if identified), pain, high risk medication, fall risk and ADL needs. In addition, the resident will be given a copy/summary of the comprehensive care plan at the completion of the care plan and a progress note will be created to reflect this task. The Director of Nursing is responsible for compliance. Audits on baseline care plan initiation and resident care conference meeting will begin 2x week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 655	Continued From page 20 of nursing (DON) stated initial care conferences were scheduled 48 to 72 hours after a resident was admitted to the facility. The residents meet with the Interdisciplinary Team (IDT) which included SS, therapies, recreational therapist, nursing, dietary manager, resident, and family. DON stated residents should receive a copy of the baseline care plan during the initial care conference. DON added baseline care plans help to determine residents' care goals, discharge planning, community services and equipment needs. Facility Baseline Care Plans dated 4/24/25, indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty hours of admission. The policy also indicated the resident and/or representative is provided a written summary of the baseline care plan, and the provision of the summary to the resident and/or resident representative is documented in the medical record.	F 655			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656			5/30/25

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F 656	Continued From page 21 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 2 of 2 residents reviewed, (R7) who was assessed for facility acquired pressure			F 656	R7 will have a new Braden, pain and ADL assessment completed. R7 will have the care plan and current orders reviewed and updated as needed. R7 will be reviewed by therapy for bed mobility and		

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F 656	Continued From page 22 ulcers and (R4) for respiratory cares. Findings include: R7's face sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated 2/14/25, indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated "not assessed". Risk of pressure ulcers (PU) was answered "no" and R7 had no unhealed pressure ulcers. A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care, dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-personal physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown.	F 656	recommendations will be initiated by resident preference. Current residents who have in-house acquired pressure wounds will have their care plans reviewed and updated as needed. R4 had a respiratory care plan initiated on 5/3/2025 to address non-invasive mechanical ventilator use. R4's MD will be made aware that the resident was not utilizing the NIV per order. All current residents who utilize non-invasive mechanical ventilators will have their orders and care plans reviewed and updated. Future residents who admit will have the appropriate comprehensive care plan initiated by the facility policy. The facility IDT team will be in-serviced on the Comprehensive Care Plan Policy with focus on item #7 that the comprehensive care plan must include measurable objectives and timeframes and include any specialized services that are needed to build on residents' strengths and interventions are chosen only after data gathering has occurred. The nurse and nurse aide will be invited to attend the comprehensive care plan meeting for input and any changes will be reported by the nurse and nurse aide during shift change. The Director of Nursing is responsible for compliance. Audits on comprehensive care plan completion date, CAA area care plans initiated per resident diagnosis and if all disciplines are represented in the comprehensive care plan will begin weekly x 4 weeks, then monthly to ensure		

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F 656	Continued From page 23 On interview 4/23/25, at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been a high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K indicated she does wound rounds weekly and R7 is always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K indicated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back. NP-K added she requested a heel protector boots for both feet also. On 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-B indicated R7 has a plan of care to reposition every 2 hours. LPN-B stated they were getting R7 up once a day but since she returned from the hospital, they don't have order to get her out of bed. LPN-B stated it takes 2 staff to turn R7 which has not changed since her admission in February. On 4/23/25 at 2:24 p.m., LPN-A indicated R7 should be repositioned every 2 hours and believes that is part of her plan of care. R4's face sheet printed 4/24/25, indicated R4 had diagnosis including morbid (severe) obesity, chronic pain, reduced mobility, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R4's admission MDS assessment dated 2/13/25, indicated R4 had intact cognition, no behaviors including refusal of care. Special treatments included non-invasive mechanical ventilator. Oxygen was not checked as being used.	F 656	sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 656	Continued From page 24 Activities of daily living section was not completed and included "not assessed". On observation 4/22/25 at 8:24 a.m., an oxygen concentrator was present in R4's room. R4 had a nasal cannula in her nose and oxygen concentrator was set at 2 liters oxygen flow. There was a non-invasive mechanical ventilator present in the room but was not on the resident at this time. R4's plan of care dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfer included total assist using 600 pound full body lift with 4 persons to transfer. The care plan did not include R7 was risk or had a potential for impairment of the respiratory system. Physician orders dated 1/9/25, included Noninvasive Ventilator (NIV) Trilogy PC/AVAPS PC01 > or = to 52 mm HG, target tidal volume 550 with rate at 14 IPAP min: 10IPAP max: 30 EPAP 08 and full face mask every shift. The physician orders did not include an order for oxygen. On interview 4/24/25 at 10:17 a.m., LPN-A stated R4 has been on oxygen since she came here in January 2025. LPN-A indicated R4 had a plan of care addressing R4's respiratory issues that included the NIV, oxygen and inhalers R4 uses. LPN-A upon review of R4's medical record and stated there was not an order for oxygen and there was not a plan of care addressing R4's respiratory issues which she should have. On interview 4/24/25 at 12:03 p.m., the director of	F 656			

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F 656	Continued From page 25 nursing (DON) confirmed R7 did not have a plan of care to prevent skin breakdown but stated she should have one. The DON confirmed R4 did not have a respiratory plan of care and indicated she would expect one with R7's current medical conditions and using NIV and oxygen. Facility Care Plans, Comprehensive Person-Centered policy dated 1/20/25, included: -The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: (1)services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident ' s stated goals upon admission and desired outcomes; d. builds on the resident ' s strengths; and e. reflects currently recognized standards of practice for problem areas and condition -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.	F 656			

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F 656	Continued From page 26	F 656			
F 657 SS=D	b. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care conference was	F 657		5/30/25	
			R31 had a care conference on 4/29/2025. R3 care plan was placed in review on		

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F 657	Continued From page 27 conducted for 3 of 3 residents (R31, R3 and R36) reviewed for care planning. Findings include: R3's quarterly MDS assessment dated 2/20/25, indicated R3 had moderate cognitive impairments, needed set up for eating, required substantial assistance with dressing and was dependent for oral hygiene, toileting, personal hygiene, bed mobility and transfers. MDS indicated diagnoses of lumbar spinal stenosis, heart failure, hypertension, renal insufficiency, diabetes, and depression. R3's electronic medical record (EMR) report of care conferences indicated resident had care conferences on 6/19/24 and 5/14/24. During interview on 4/23/25 at 12:11 p.m., family member (FM)-B indicated a care conference (CC) was scheduled in March 2025 for R3. FM-B stated he was not available and requested to change the CC to be moved to the following week. FM-B talked to social services (SS)-A who informed him the CC couldn't be scheduled the following week but was going to call him later to re-schedule the CC. FM-B stated SS-A never followed up and the CC was never rescheduled. During interview on 4/24/25 at 10:21 a.m., SS-A stated R3 conference was scheduled on 3/13/25, but it was canceled because family was unable to attend. SS-A stated R3's family asked if the CC could be rescheduled the following week, but the CC schedule for the following week was full. SS-A stated she had not talked to the R3's son again and had not scheduled a new CC. SS-A stated she needed to prioritize CC and if it's urgent a	F 657	5/16/2025 and the care conference is scheduled for 5/16/2025. R36 had an initial care conference on 4/18/2025 and is scheduled for a quarterly care plan review and care conference at or around 6/12/2025. All current residents care conference schedule and care plan review will be reviewed and updated as needed. Future resident care conferences will be scheduled and an invitation sent for resident/resident representative participation. Licensed nurses and the IDT team was in-serviced on the Facility Resident Care Conference/Care Plan Review policy which explains the purpose of the care conference is to develop a plan of care and to ensure that the resident goals and preferences were discussed and established and to aid in better resident care outcomes for our long-term, and safe discharges to the community for our short-term residents. In addition, the IDT team was in-serviced on timing of care plan reviews which should occur upon admission (baseline), quarterly, significant change, annually and as needed. If designee is off, activities and/or DON/ADON will conduct care conferences to ensure they are timely. The Social Service designee is responsible for compliance. Audits on initial care conference, quarterly care conference and care plan intervention updates will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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F 657	Continued From page 28 new CC would be re-scheduled. During interview on 4/24/25 at 2:47 p.m., director of nursing DON stated we (facility) needed to accommodate CCs to facilitate residents and family participation. R36's admission MDS assessment dated 3/20/25, indicated R36 was admitted to the facility on 3/12/25, was cognitively intact, and had no behaviors or delusions. MDS indicated resident was on a pain management program, received pain medications as needed, had a surgical wound, had oxygen, and received occupational and physical therapy services. R36's Clinical Profile dated 4/23/25, identified an admission date of 3/12/25, with diagnosis of infection and inflammatory reaction due to unspecified internal joint prosthesis. During review of R36's Care Conference Summary section of the electronic medical record (EMR), R36's MR lacked evidence of any care conference since 3/12/25, despite MDS data submitted on 3/20/25. R36's EMR included a progress note titled "care conference", dated 4/4/25, and authored by SS-A indicated R36 wished to discharge to a sober house once he meets his goal ... care conference will be scheduled quarterly and as needed. During interview on 4/21/25 at 7:03 p.m., R36 stated he didn't remember having a care conference, not like other places. R36 stated "I talk to the therapists during the therapy sessions and maybe I talked to the SW." R36 added he did not meet as a group with SS, therapist, and a	F 657	take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 657	Continued From page 29 nurse to talk about his care plan or rehabilitation goals. During interview on 4/23/28 at 2:28 p.m., SS-A stated she scheduled the initial, quarterly, significant changes and discharge care conferences. SS-A indicated initial care conferences are scheduled 48 to 72 hours after admission and during the initial care conference residents receive a copy of their baseline care plan. SS-A stated the progress note dated 4/2/25, was a late entry and added maybe she was out that week, maybe we didn't have the care conference. SS-A stated R36 did not meet with the interdisciplinary team which includes a nurse, therapist, and SS. During interview on 4/24/25 at 10:13 a.m., director of nursing (DON) stated initial care conferences were scheduled 48 to 72 hours after a resident was admitted to the facility. The residents meet with the Interdisciplinary Team (IDT) which included SS, therapies, recreational therapist, nursing, dietary manager, resident, and family. DON stated when a care conference was canceled or missed, a new care conference should be rescheduled as soon as possible. R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, protein calorie malnutrition, and depression. R31's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was able to transfer from bed to wheelchair independently and self-propel wheelchair throughout the facility.	F 657			

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F 657	Continued From page 30 R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care. During an interview on 4/22/25 at 9:42 a.m., R31 stated she did not recall having had a care conference. A care conference was explained to her, and she still did not recall having had one. During an interview on 4/23/25 at 12:19 p.m., social services (SS)-A stated care conferences were conducted quarterly, as needed, or at family or resident request. SS-A provided two care conference notes for R31 titled Social Services Care Conference - one dated 6/5/24, and one dated 4/18/25. Both notes indicated R31 was in attendance as well as members of the IDT (interdisciplinary team). During an interview on 4/24/25 at 12:06 p.m., SS-A stated when a resident was due for a care conference, she asked the resident if he/she wanted her to schedule one. SS-A stated sometimes R31 stated she did not want a care conference in which case a care conference was not conducted. Further, SS-A stated when a resident declined their care conference, the IDT team did not always meet without the resident or resident representative to review various areas such as nursing, dietary, activities and/or therapy. During an interview at 4/24/25 at 12:45 p.m., the director of nursing (DON) stated SS-A spoke to her about this and stated SS-A misunderstood the requirement about frequency of care conferences. The DON stated SS-A thought care conferences should be conducted every 92 days IF needed, or IF the resident wanted one. The DON stated she expected care conferences to be	F 657			

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F 657	Continued From page 31 conducted every 92 days, regardless if the resident attended. Facility Resident Care Conference/Care Plan Review policy dated 6/27/22, indicated the purpose of the care conference was to develop a plan of care and to ensure that the resident goals and preferences were discussed and established. The overall care conference goal process would aid in better resident care outcomes for our long-term, and safe discharge to the community for our short-term residents. Once a conference date and time was established, an email invite would be sent to the IDT team members, including therapy alerting of this meeting. During conferences, the following items would be discussed: resident diagnosis, review of the comprehensive care plan, therapy course, and any other care areas (wound, medication therapy, psychotropic therapy, diet, appointments, etc.) along with the code status and POLST (Physician Orders for Life Sustaining Treatment). If the resident refused to meet, this would be noted in the resident chart. Quarterly care conferences would include a review of the care plan by the IDT team prior to the conference to ensure focuses, goals and interventions are accurate. In addition, the resident orders should be reviewed and updated as needed for accuracy.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677			5/30/25

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F 677	Continued From page 32 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia (paralysis of arms and legs), essential hypertension, and seizure disorders. R22's care plan printed 4/24/25, indicated R22 had a self-care deficit with bathing, dressing and feeding. This care plan directed staff to assist R22 with activities of daily living (ADL). A care plan titled Current Functional Performance identified R22 needed total assist with personal hygiene. During observation on 4/21/25 at 4:10 p.m., resident was sleeping in bed. R22's fingernails were about half an inch long and had black debris underneath his fingernails. During observation and interview on 4/21/25 at 4:13 p.m., nursing assistant (NA)-D verified R22's fingernails were long and had black debris underneath his fingernails. NA-D stated he usually worked overnight shifts and didn't know when or who trims R22's nails. During interview on 4/21/25 at 12:38 p.m., family	F 677	R22 received a full bed bath, nail care and a weekly bath audit was completed on 5/23/2025. R22's care plan was reviewed and updated as needed. All current residents who are dependent and require personal care, their care plans and bath audits were reviewed and updated as needed. Monday through Friday daily visual observation and documentation on all dependent residents will occur for the next 6 weeks by the facility DON and ADON. Future residents who are dependent on staff for personal care, their personal care will be rendered, by facility staff, to maintain or improve their ability to carry out ADLs per facility policy. Licensed nurses and nurse aides will be in-serviced on the ADL supporting Policy and procedure with emphasis on policy statement which directs that any residents that are unable to carry out activities of daily living independently will receive the services necessary by the facility staff to maintain good nutrition, grooming and personal and oral hygiene. Nurses and nurse aides were in-serviced to report and document that resident care was received and the nurse must visually verify and document that care was rendered. The Director of Nursing is responsible for compliance. Audits on visual post bath audits i.e., nail, hair, clothing and ADL care plan interventions will begin daily x 14 days, 2x a week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance.		

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F 677	Continued From page 33 member (FM)-A stated she visited R22 on 4/13/25, and observed his fingernails were long and dirty. FM-A stated on 4/13/25 she left a voice mail for who she believed was the charge nurse. FM-A stated she left a voice mail to request R22's nails be cleaned and trimmed. During interview on 4/22/25 at 12:38 p.m., NA-E verified R22's nails were long. NA-E stated she gave a sponge bath to R22 this morning and planned to trim his nails before the end of her shift. During observation on 4/23/25 at 8:24 a.m., R22's fingernails were long and had black debris underneath them. During interview on 4/23/25 at 1:55 p.m., licensed practical nurse (LPN)-C stated residents nails are checked on their bath day and trimmed as needed. LPN-C stated R22 is a diabetic, therefore nurses are responsible to trim his nails. During interview on 4/23/25 at 2:56 p.m., director of nursing (DON) stated she expected the facility's residents' nails will be cut on bath days or on a weekly basis. DON added. if a resident had contractures there was a risk to produce skin alterations, and was an infection and dignity issue. Facility Care of Fingernails/Toenails policy dated 4/24/25, indicated the purpose was to clean the nail bed, to keep nails trimmed, and to prevent infections. Activities of Daily Living	F 677	Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			5/30/25

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F 684	Continued From page 34 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly transcribe and implement physician orders for a resident requiring edema and surgical incision monitoring for 1 of 1 resident (R36) reviewed for edema and skin conditions. Findings include, R36's Clinical Profile dated 4/23/25, identified an admission date of 3/12/25. R36's Clinical Diagnoses report printed 4/23/25, indicated diagnoses of infection and inflammatory reaction due to unspecified internal joint prosthesis, presence of right artificial knee joint, acute on chronic diastolic heart failure, cellulitis of right lower extremity, and acute and chronic respiratory failure. R36's admission Minimum Data Set (MDS) assessment dated 3/20/25, indicated R36 was admitted to the facility on 3/12/25. R36 was cognitively intact, had no behaviors or delusions. MDS indicated resident was on pain management, received medications for pain as needed, received intravenous antibiotics, had a surgical wound, used oxygen, and received	F 684	R36 physician orders for wound care and compression hose were reviewed and updated as needed with MD care items. R36 MD will be made aware that the order was not processed or followed per MD order. The MD response will be recorded in the electronic medical record. R36 also had an initial care conference with care plan review on 4/18/2025. All current residents physician interventions orders will be added to the resident care plan and/or updated as needed. Future residents orders will also be reflected in the resident care plan per facility policy. Licensed Nurses and Nurse Aides will be in-serviced on the Comprehensive Person Center Care plan with focus on item #8 that services provided for or arranged by the facility are outlined in the resident care plan. Nurses and nurse aides will also be in-serviced on where to locate these items in the Kardex and care plan. Nurses will also be in-serviced that upon a resident return from hospital or MD appointment, orders must be processed and the HUC and DON/ADON will check to ensure these orders are processed and implemented per MD order.		

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F 684	Continued From page 35 occupational and physical therapy services. R36's Clinical Orders report printed 4/23/25, included the following orders: - Below the knee Ted hose stocking for compression. On in the morning, off at night. Order dated 3/12/25, no end date. - Dressing change with gauze, ABD (large, highly absorbent sterile gauze pad used for managing heavily draining wounds) and Ace wrap. Keep incision dry. Let steri-strips fall off on their own. As needed (PRN). Order dated 3/12/25 at 10 p.m., and discontinued on 3/12/25 at 9:25 p.m. R36's medication administration record (MAR) and treatment administration record TAR) for March 2025 indicated: - "Leave wound dressing in place for two weeks or until orthopedic follow-up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance". Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. It was documented as done between 3/12/25 and 3/31/25. - "Daily dressing change with gauze, tape, and Ace wrap for compression. Keep incision dry, one time a day". Order starting date 3/20/25, and ending date 3/26/25. Documented as done. - "Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN". Order starting date 3/26/25, no ending date. No dressing changes were documented. - March's MAR or TAR did not included the order for Ted stockings. R36's medication administration record (MAR) and treatment administration record TAR) for April 2025 indicated:	F 684	The Director of Nursing is responsible for compliance. Audits on resident orders, care plan interventions, auditing of tasks/interventions and what care plan changes were made will begin 2x week for 2 weeks, weekly x 1 week for 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 684	Continued From page 36 - "Leave wound dressing in place for two weeks or until orthopedic follow up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance". Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. Documented as done. - "Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN." Order starting date 3/26/25, no ending date. No dressing changes were documented. - "Below the knee Ted hose stockings for compression. On in the morning, off at night". Space for documentation was crossed out. No documentation was done. R36's care plan titled Wound Management Post-Surgical dated 3/12/25, indicated the wound will be free of signs or symptoms of infections. The care plan also indicated "Administer antibiotic therapy as prescribed. Wound dressing to remain intact until ortho visit. Do not get dressing wet." No reviews or updates to the care plan were done since 3/12/25. R36's edema and order for ted stockings was not addressed in his care plan. During interview on 4/21/25 at 7:16 p.m., R36 stated he was at the facility after his 7th right knee surgery. R36 was not wearing ted stockings. R36's left shin skin color was darker with some red and dry spots, but the skin was intact. R36 stated "A few weeks ago I removed my ted stockings and pulled off some of the skin. It's healed now." R36 had a gauze present below his right knee. R36 stated he had problems with edema and was supposed to wear ted stockings	F 684			

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F 684	Continued From page 37 during the day and remove them at night before going to bed. R36 stated the staff did not put on the ted stockings or remove them. R36 added "never done it for me. I do it by myself." During interview on 4/22/25 at 12:33 p.m., R36 was not wearing ted stockings and had a dressing present below his left knee. R36 stated he probably scratched a little scab and the area was draining so he put a gauze over the affected area. R36 stated he kept some gauze and dressings in his room, and he took care of his wounds. R36 stated he was admitted to the facility on 3/12/25, and had a surgical dressing on for 2 weeks. R36 stated on 3/26/25, the surgeon removed the surgical dressing and for a week "or so" the nurses changed my dressings every day. R36 added "after that week I had taken care of my wounds." During observation and interview on 4/22/25 at 2:47 p.m., R36's lower leg was swollen and red. R36 stated his right leg didn't hurt, but compared to his left leg, it felt warmer. R36 was not wearing ted stockings. During interview on 4/23/25 at 8:41 a.m., the assistant director of nursing (ADON) verified R36 had orders for ted stockings and wound care. ADON stated the orders can be seen under physician orders but not under the Point Click Care (PCC) TAR or MAR used every shift by the nurses. During interview on 4/23/25 at 1:37 p.m., LPN-C stated she didn't know R36 had ted stockings or current wound care orders. LPN-C stated this morning the ADON asked her to investigate. LPN-C stated the ted stocking order was	F 684			

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F 684	Continued From page 38 transcribed on 3/12/25, but was not properly processed and the nurses couldn't see the order as a daily assignment. LPN-C stated the only way to know was to look at the physician orders. LPN-C verified R36's order for PRN (as needed) wound care. LPN-C stated the order for wound care dated 3/26/25 was transcribed, but was not appropriately processed and was not included in the nurses' daily assignments. LPN-C stated "Yesterday, I put a dressing on his [R36] knee because he had a small wound and he is taking antibiotics." During interview on 4/23/25 at 2:50 p.m., director of nursing (DON) stated the ted stockings and wound care orders were not properly carried over PCC for nurses to follow orders. DON stated the mistake was done by the nurse transcribing the orders. DON stated R36 had a history of infection on the right leg and edema. DON stated not putting the ted stockings on to help with the fluid built up, not doing dressing changes and assessing his wounds could be a risk for infection and decline in condition for R36. Facility Comprehensive Person-Centered Care Plans dated 1/20/25, indicated a comprehensive, person centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686			5/30/25

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F 686	Continued From page 39 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to prevent the development of new pressure ulcers for 1 of 3 residents (R7) who were reviewed for pressure ulcers. Findings include: R7's Face Sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated 2/14/25, indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated "not assessed". Risk of pressure ulcers (PU) was "no" and R7 had no unhealed pressure ulcers.	F 686	R7 will have a new Braden, turning and repositioning schedule developed and implemented as resident allows, pain and ADL assessment completed. R7 will have the care plan and current orders reviewed and updated as needed. R7 will be reviewed by therapy for bed mobility and recommendations will be initiated by resident preference. All current residents who have open wounds, their Braden, treatment orders and care plan and Kardex interventions were reviewed and updated as needed. Future residents who experience skin alterations, the licensed nurse will utilize the physician standing orders to implement the appropriate treatment per facility policy. The facility licensed nurses and nurse aides will be in-serviced on the facility Medline skin formulary along with the Physician Standing Order Policy which indicates immediate interventions that can be applied to address skin concerns and will have education on the facility Charting		

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F 686	Continued From page 40 A Care Area Assessment (CAA) dated 2/14/25 included a risk for wound care plan will be initiated. A PU/injury will not be addressed in the plan of care. Diagnosis and condition putting patient at increase risk includes diabetes and chronic end stage renal liver, heart disease, depression and pain. Meds affecting potential skin injury include antipsychotics and antidepressants. In addition R7 has come cognitive loss and is incontinent. Needs special mattress or seat cushion. A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-person physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown. Weekly bath audit forms included: 2/13/25: R7 had an open area above the coccyx (fissure) and an open area on the right breast due to dampness. 2/27/25: No new alterations in skin noted during this observation. 3/7/25: No new alternation in skin noted during			F 686	and Documentation policy with emphasis on documentation should reflect objective observations, changes in resident conditions and treatments or services performed, and any reports of new concerns must immediately be addressed. Lastly, upon admission, interventions will be implemented for future residents that have the potential and/or prevent skin breakdown and those measures will be added to the care plan and Kardex for nurses and Nurse Aides to view and during nurse shift to shift report. The Assistant Director of Nursing is responsible for compliance. Audits on appropriate care plan interventions, resident wound location, was the wound assessed weekly, wound improvement/decline documentation, ordered treatment applied, and visual treatment completion by the licensed nurse will begin 2x week for 2 weeks, weekly x 6 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 686	Continued From page 41 this observation. 3/9/25: No new alternation in skin noted during this observation. 3/13/25: No new alternation in skin noted during this observation. 3/20/25: No new alternation in skin noted during this observation. 3/27/25: No new alternation in skin noted during this observation. 4/3/25: No new alternation in skin noted during this observation. Resident refused shower/bath. Resident said will take shower/bath at another time. An Integrated Wound Care note from 3/12/25, included R7 is being seen for evaluation and treatment recommendations for a fissure (small tear in thin tissue) to the gluteal fold (fold of the buttock horizontal crease) and open lesion to the right breast. She is incontinent of urine and bowel and her mobility is limited by her body habitus (shape and size), weakness and recent surgery to repair a fracture of the right tibia. R7's Braden score is 12 high risk for pressure injury. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol. Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 3/19/25 and 3/26/25, included a Braden score of 12 which is high risk for pressure injury and requires assistance with bed mobility. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol.			F 686			

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F 686	Continued From page 42 Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 4/4/25, included R7 is incontinent of urine and bowel and her mobility is limited by her body habitus, weakness and recent surgery to repair a fracture of the right tibia. Her Braden score is 12 which is high risk for pressure injury. New wound was noted on this visit which is an unstageable pressure ulcer to left heel. Treatment orders were placed. Plan of care was discussed with facility staff and the patient. Heel unstageable ulcer was 100% eschar (hardened, dry, black or brown crust caused by dead tissue) and measured 1.5 x 0.7 x 0 centimeter (cm). Treatment recommendation included paint pressure ulcer on heel with Betadine (antiseptic medicine use to treat skin infections) every day. Wound evaluation dated 4/16/25, included abrasion measuring 4.5 cm x 1.7 cm., new wound, in house acquired. Granulation (indicates wound healing) 100% of wound with light serous (serum, the clear watery part of liquid in the body) exudate (body fluid) present. Foam dressing applied. An Integrated Wound Care note dated 4/23/25 included unstageable pressure ulcer left heel was 1.3 x 0.9 x 0 cm with 100% eschar present. Progress improving. No drainage present. Pressure ulcer left gluteus (group of muscles that make up area commonly known as the buttocks) - stage 3 (wound that affects the top two layers of skin, as well as fatty tissues) measured 0.8 x 0.5 x 0.1 cm with scant serosanguinous (serous fluid and blood) drainage. 30% granulation with 70% slough (dead tissue yellow or white appearance)			F 686			

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F 686	Continued From page 43 present. Periwound (skin around the wound) is fragile. Wound treatment to left heel included cleanse wound and surrounding area with saline. Do not dry the wound surface. Spread Iodosorb (substance that helps clean and heel wounds) in 1/8-1/4" thickness over wound bed and cover with super absorbent pad. Change three times a week and as needed. Plan is to address factors affecting wound healing include incontinence care as needed, turn and reposition, offload pressure per facility protocol, air mattress and heel offloading. On interview and observation 4/22/25 at 8:09 a.m., R7 was lying on her back in her bed with head of bed at 20 degrees. R7 stated she got back from the hospital yesterday and has been having problems with abdominal pain and loose stools. R7 stated her Foley catheter was removed over a month ago. R7 stated she does have some wounds on her bottom and one on her heel. R7 stated she has one wound on her bottom since she came in that she has had off and on for a long time. The other wound on her bottom is new as is the heel wound in the past month. R7 stated she isn't able to move or position herself in the bed and requires assistance to reposition. R7 stated prior to her going to the hospital she was getting up in her chair at least once a day. R7 had a heel protector on her left leg. On interview 4/23/25 at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been at high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K stated it was hard to determine if the 2 new pressure ulcers were preventable or not. NP-K added she does wound rounds weekly and R7 is	F 686			

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F 686	Continued From page 44 always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K stated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back and has educated the resident of this also. NP-K added she had seen on past visits the staff were placing a pillow under R7's lower legs in attempt to float her heels but the heels were often times resting on the pillow. NP-K added she recommended heel protector boots for both of her heels after her left heel ulcer was discovered. On observation and interview 4/23/25 at 10:35 a.m., NP-K, registered nurse (RN)-G, also identified as assistant director or nursing (ADON), and nursing assistant (NA)-A entered the room to complete wound evaluation, care and treatment. See above 4/23/25 Integrated Wound note above for wound descriptions. NP-K educated R7 and all staff in the room on importance of offloading and staying off her back. Also recommended heel protector for the right heel as one wasn't present and the heel was resting on a pillow. R7 did have a heel protector on her left heel. Continuous observation started on 4/23/25 at 10:38 a.m. for R7: 10:38 a.m., NA-A positioned R7 on her left side using a pillow. 10:56 a.m., no change in position. R7 is dozing off and on. 11:08 a.m., no change in position. 11:26 a.m., no change in position. No staff into her room. 11:45 a.m., no change in position. 12:07 p.m., no change in position. No staff into her room.	F 686			

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F 686	Continued From page 45 12:19 p.m., no change in position. 12:29 p.m., NA-A into room with lunch tray. NA-A raised the head of the bed but did not reposition R7. Pillow remains tucked behind R7 positioned slightly on her left side. 12:33 p.m., P7 is awake and eating lunch. R7 states she has not been repositioned since after the wound care this morning. 12:55 p.m., remains in the same position and continues to eat her lunch. 1:06 p.m., no change in position and R7 continues to eat her lunch. NA-A went into room but did not reposition R7 and said she would come back in a bit to get her tray. 1:09 p.m., NA-A into room with trash bags. Did not reposition R7. 1:26 p.m., R7 remains in the same position. NA-A indicated when she took R7's lunch tray into the room she pulled the pillow down slightly behind R7's back but did not reposition her. NA-A indicated R7 should be repositioned every 2 hours per the plan of care. NA-A entered the room and checked to ensure R7's pad was dry and repositioned R7 on her opposite side with pillow placed behind her back. NA-A lowered the head of the bed to approximately 20 degrees. R7 did have heel protector on her left heel, but right heel was resting on the bed with no pillow or heel protector present. NA-A stated she used the pillow under R7's right heel to use behind her back for positioning. Another pillow was present on a chair in the room but did not have a pillow case on it. On interview 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-A stated R7 should be repositioned every 2-3 hours. On interview 4/23/25 at 2:22 p.m., licensed	F 686			

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F 686	Continued From page 46 practical nurse (LPN)-B indicated R7 has a plan of care to reposition every 2 hours. LPN-B stated they were getting R7 up once a day but since she returned from the hospital, they don't have order to get her out of bed. LPN-B stated it takes 2 staff to turn R7, which has not changed since her admission in February. On interview 4/23/25 at 2:24 p.m., LPN-A indicated R7 should be repositioned every 2 hours and believes that is part of her plan of care. LPN-A stated R7 came in with one wound on her coccyx area but the heel and other coccyx area is new since being at the facility. LPN-A stated R7 requires assist of 2 to reposition. On interview 4/24/25 at 9:50 a.m., NA-I stated R7 should be repositioned every 2 hours. NA-I stated R7 is cooperative with repositioning and requires assist of 1 to complete. On interview 4/24/25 at 9:03 a.m., the director of nursing (DON) confirmed there was no plan of care related to prevention of skin breakdown and would expect if R7 has a pressure ulcer injury, repositioning should occur ever 1-2 hours unless the resident refuses. The DON stated if a resident refuses it should be care planned that the risks and benefits were explained. The DON confirmed R7 should have a heel protectors on both feet. Facility Prevention of Pressure Injuries policy dated 9/29/21, included: - Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the	F 686			

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F 686	Continued From page 47 risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. -Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident ' s risk factors, and prior to discharge. 2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; and c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. - Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by	F 686			

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F 686	Continued From page 48 the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident ' s risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.			F 686			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility was unaware of and failed to comprehensively assess a resident for safe vaping practices for 1 of 1 resident (R37) reviewed for accidents. Findings include: R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. R37's quarterly Minimum Data Set (MDS)			F 689	R37 had a new self-administration assessment completed and has subsequently discharged to the hospital on 5/22/2025. R37 was admitted with medical cannabis. R37s sister began managing the oil based medically approved cannabis. As of this writing, there are no residents with medical approved cannabis. Current residents who smoke, their smoking assessments and care plans will be reviewed and updated as needed. Future residents who admit to the facility will not be allowed to vape cannabis per facility policy.		5/30/25

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F 689	Continued From page 49 assessment dated 2/26/25, indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent on staff for some activities of daily living and could walk short distances with the aid of a walker. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's physician orders did not indicate use of medical marijuana or vaping THC (tetrahydrocannabinol). R37's care plan did not indicate use of medical marijuana or vaping THC. Smoking assessments dated 8/21/24, 11/25/24, and 2/24/25, indicated R37 was a non-smoker. Vaping was listed as an option on the electronic assessment tool but had not been checked. Consequently, an assessment for safe vaping had not been conducted. During an interview on 4/23/25 at 11:05 a.m., with R37 and family member (FM)-L, while lying in bed, R37 started vaping with a pen; smoking coming out of his mouth as he exhaled. R37 stated it was weed (marijuana). FM-L stated R37 was on a cannabis program and had a medical marijuana card. FM-L brought the supplies to the facility and R37 stated he vaped multiple times daily. During an interview on 4/23/25 at 4:26 p.m., the director of nursing (DON) and assistant director of nursing (ADON) stated they were not aware of any residents who vaped. The DON stated she knew R37 had a medical marijuana card due to cancer pain. The DON stated, "We all knew he	F 689	Admissions, Licensed Nurses, Nurse aides and IDT team was in-serviced on the Medical Cannabis policy with emphasis on #2 that at no time is vaporized medical cannabis or smoking dried cannabis is allowed for use within the facility or on the facility grounds. If medical cannabis is used, the facility must verify form of cannabis before admission to the facility. The Director of Nursing is responsible for compliance. Audits on resident smoking assessments, smoking in designated areas and smoking care plans will be audited weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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F 689	Continued From page 50 was using it" (marijuana) but did not know how he ingested it. The DON stated when R37 was admitted (in August 2024), he was given a locked box to store his marijuana supplies, but she never looked at the supplies nor asked how he planned to ingest it. The DON stated she was instructed not to put marijuana use on R37's care plan, and stated the facility did not do anything with the marijuana or supplies -- it was up to the resident and family to manage it. Nursing progress note dated 4/23/25 at 4:50 p.m., was written as follows by the DON: Writer was informed that resident was vaping medical cannabis in his bed while talking with a surveyor. Resident was admitted with a medical cannabis card and the terms of use were initially explained. Writer approached resident after learning about resident vaping in his bed and asked to speak with him about facility medical cannabis policy. Writer explained to resident that he is not allowed to vape the cannabis within the facility or on facility grounds. Writer encouraged resident to use manual wheelchair and leave facility property if he feels like he needs to use the medication. Resident voiced understanding and stated he would not use the cannabis within the facility nor on facility grounds. Writer left resident with facility policy. In an email request on 4/23/25, at 7:38 p.m., the DON was asked if R37's provider was aware of R37 vaping marijuana, and if so, provide that documentation. Documentation was not received. During an interview on 4/24/25 at 12:16 p.m., the DON stated she talked to R37 late yesterday afternoon (4/23/25), about the facility policy on vaping. In addition, the DON informed R37's	F 689			

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F 689	Continued From page 51 provider last night via email of R37's marijuana use and did not know if the provider was aware. The DON stated, we won't know if R37 continued to vape in his room, stating we are hands off; the supplies are in his locked box. The DON stated the facility would have to monitor R37 for vaping in his room. A note in R37's electronic medical record indicated the facility should have been aware R37 was vaping THC in his room. The note was documented by physician assistant certified (PA-C)-M and indicated date of service of 4/17/25, and included R37 had a primary hospice diagnosis of malignant neoplasm of the bladder with metastases. Within this note were three other dates: --10/17/24, indicated R37 seemed to be heavily under the influence of THC and was holding his vape pen in his hand and noted to be quite comfortable. --11/7/24, indicated R37 was resting, and FM-L via telephone stated it [vaping THC] helped relieve R37's anxiety and gave him a break from everything. "It helps a lot with his pain, too." --12/4/24, indicated R37's THC continued to help. Facility Medical Cannabis policy dated 7/28/23, indicated: 1. The resident's physician must support the resident's use of medical cannabis. 2. The resident and/or the resident's representative must provide documentation of confirmation that the resident is on the State Medical Cannabis Patient Registry. 3. Confirmation of the resident's certified qualifying medical condition. 4. Confirmation that any individual who intended to assist the resident with administration of the	F 689			

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F 689	Continued From page 52 medical cannabis was identified as a Registered Designated Caregiver. 5. If the resident's supply of medical cannabis was to be stored within the facility, it must be stored in a locked secured storage. The facility would provide the resident with a lockable container and secure it within the room if requested. 6. If the resident intended to administer the medical cannabis independently, the resident would be assessed for safe self-administration of medication by the interdisciplinary team. This assessment would be maintained within the resident's medical record. 7. Vaporizing medical cannabis or smoking dried cannabis flower was not allowed within the facility or on facility grounds. Only liquid (oral suspensions, tincture, sublingual spray), pills/capsules, or topicals (balms or oils), or gummies or chews were permitted. 8. Documentation - The use of medical cannabis would not be documented in the resident's medication administration record. However, the resident's plan of care would be updated to reflect that he/she was authorized to use medical cannabis and had been educated on and met the facility's restriction for use of medical cannabis as outlined by this policy. Facility Residents Smoking Policy with reviewed date of 1/20/22, indicated: Prior to, and upon admission, residents would be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking was only permitted in designated resident smoking areas, which were located outside of the building. Electronic cigarettes would be permitted outside			F 689			

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F 689	Continued From page 53 in designated areas only. Otherwise, smoking was not allowed inside the facility under any circumstances. The resident would be evaluated on admission to determine if he or she was a smoker or non-smoker. If a smoker, the evaluation would include method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); ability to smoke safely with or without supervision (per a completed Smoking Observation). The staff would consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely would be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) would be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues .	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690			5/30/25

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F 690	Continued From page 54 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 resident (R21) reviewed for bladder incontinence. Findings include R21's face sheet printed 4/24/25, included diagnoses of orthopedic aftercare (hip replacement), mixed incontinence, pressure ulcer of right buttock and muscle weakness. R21's admission Minimum Data Set (MDS) assessment dated 3/30/25, identified R21 was cognitively intact and did not have	F 690	R21 was discharged from the facility on 5/15/2025. All current residents will have a review of their bowel and bladder screener assessments, and their care plan interventions will be reviewed and updated as needed. Future residents will have a bowel and bladder screener completed upon admission and results from these tools will be incorporated into the resident care plan per resident preference. Facility nurses and nurse aides will be in-serviced on the Urinary Continence and Incontinence Policy with emphasis on screening and provide scheduled toileting, prompt voiding or other interventions to try		

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F 690	Continued From page 55 rejection/refusal of care behaviors. The MDS identified R21 required substantial to maximum assistance for lower body dressing and footwear. R21 requires supervision or touching assistance for toilets transfers. The MDS indicated R21 was always incontinent of urine and bowel. MDS identified no toileting program had been or is currently being attempted. A Care Area Assessment (CAA) dated 3/30/25 included R21 is always incontinent of bowel and bladder. R21 requires assist with transfers needed with toileting tasks. Several skin alterations noted including surgical incision and pressure ulcers present. Will address in care plan. R21's plan of care did not include an incontinence care plan. R21's current functional performance plan of care last updated 4/16/25, included limited to assist of one person for personal hygiene and toilet use. Transfers included extensive assist of one person physical assist. On review of R21's medical record, no bladder/bowel incontinence assessment was found. On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room and R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and	F 690	to manage incontinence. In addition, the licensed nurses will be given visual instructions on how the bowel and bladder triggers suggested toileting plans. The Director of Nursing is responsible for compliance. Audits on scheduled bowel and bladder screeners, bowel/bladder care plan interventions and visual/verbal confirmation toileting observations for timeliness will begin 2x week x 2 weeks, weekly x2 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and any deviations will be presented to the QAPI committee for recommendations. Compliance: 05/30/2025		

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F 690	Continued From page 56 answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help. R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated this is ridiculous, "you shouldn't have to, where are the aides?" LPN-A entered R21's shortly after and assisted with changing his wet pad. On observation 4/23/25 at 11:53 a.m., R21 placed call light on while NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A still in the hallway, stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00 p.m., and NA-A stated she needed to help someone else and would be right back from the hallway. R21 stated "all you are doing is wandering around." On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he was left laying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happens almost every day and gets nothing but excuses over and over. R21 stated again "I layed in a wet pad for over 2 hours this morning" and added the nurse had to change the pad because the NA never did come into his room and he saw her wandering the halls. R21 stated they never toilet him and he just has to "go" in his pad. On observation on 4/23/25 at 12:12 p.m., NA-A entered R21's room and closed the door.	F 690			

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F 690	Continued From page 57 On interview 4/23/25 at 12:43 p.m., LPN-A indicated R21 was upset this morning and she did change his wet pad. LPN-A stated R21 is incontinent of urine and requires assist of one to change his pad. LPN-A stated she was not aware R21 had been waiting for assistance for over 2 hours until R21 told her. On interview 4/23/25 at 1:30 p.m., NA-A indicated R21 had his call light on multiple times this morning but she was assisting other residents at the times he was requesting assistance. NA-A indicated she informed him she would assist him as soon as she could. NA-A stated she was the only NA down this hallway. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. Facility Urinary Continence and Incontinence - Assessment and Management policy, last reviewed 10/18/22 included: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.	F 690			

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F 690	Continued From page 58 4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include the following: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.); b. Associated pain or discomfort (dysuria); and c. Type of incontinence 8. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis). 16. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including: a. tapering, stopping, or changing medications that may be causing or exacerbating incontinence; b. managing pain and/or providing adaptive equipment to help mobilize individuals suffering from arthritis, contractures, neurological impairments, etc.; c. incorporating environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) to facilitate toileting; d. treating underlying conditions that may impair continence (e.g., delirium causing urinary incontinence related to acute confusion); and e. implementing a fluid and/or bowel management program to meet assessed needs. 18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. a. As appropriate, based on assessing the category and causes of incontinence, the staff will	F 690			

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F 690	Continued From page 59 provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. b. Toileting programs will start with a 3- to 5-day toileting assistance trial. c. If the individual requires assistance from more than one person to transfer to the toilet, staff will address his or her mobility problems before attempting a toileting assistance trial. d. Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption. e. Prompted voiding is not helpful at night (e.g., between the hours of 10 p.m. and 5 a.m.) and has been shown to disrupt sleep.			F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			F 692			5/30/25

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F 692	Continued From page 60 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R46) reviewed for nutrition and weight loss had received ice cream to increase calorie intake and weight per provider order. Findings include: R46's face sheet printed 4/24/25, included diagnoses of unspecified severe protein-calorie malnutrition, chronic kidney disease, depression, and repeated falls. R46's significant change Minimum Data Set (MDS) assessment dated 1/30/25, indicated intact cognition, no rejection of care, weight loss of five percent or more in the last month or loss of ten percent or more in the last six months, and setup assistance for eating. R46's care plan revised 2/16/25, indicated resident has a nutritional problem related to diagnosis of adult failure to thrive with goal of maintaining adequate nutritional status as evidenced by maintaining weight within five percent of 124 pounds or gain three to four pounds per month to reach 130 pounds and consume 50 percent of meals. Interventions included provide, serve diet as ordered. R46's physician's orders printed 4/24/25, failed to include an order for ice cream three times per day in between meals to increase calorie intake.			F 692	R46 orders were reviewed and updated with health shake 3 times a day. R46 dietary care plan was reviewed and updated as needed. R46's MD will be made aware that weekly weights were not obtained per MD order. The MD's response will be recorded in the resident electronic medical record. All current residents' dietary recommendations from survey exit to present, their orders and care plans were reviewed and updated as needed. Current residents' weekly weight orders will be reviewed and updated. Future residents will have dietary recommendations and weights obtained and implemented per facility policy. Licensed nurses and the Dietary Director will be in-serviced on the Dietary Recommendation Procedure that any of the RDN's or designee's recommendations related to food and beverage preferences will be given to the director of food and nutrition services, who will follow through and implement them in the facility. (Informing staff, making necessary changes on the meal identification (ID) card/ticket, etc.). The director of food and nutrition services will follow through on these recommendations when they are received. The Director of Dietary is responsible for compliance. Audits on dietitian visit recommendations and dietary order processing will begin		

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F 692	Continued From page 61 During interview on 4/21/25 at 6:30 p.m., R46 stated he had lost weight. R4 further stated he was offered a supplement but declined and had agreed to ice cream three times per day but had not received ice cream yet. During interviews on 4/22/25 at 1:14 p.m. and 3:17 p.m., R46 stated he still had not been offered ice cream and he would eat some if someone would give him some. A dietary note dated 4/1/25, stated registered dietician (RD) met with resident regarding ongoing weight loss. Resident stated he would prefer to weigh 180 pounds. He does not want any supplements such as Ensure or Boost but would agree to ice cream. RD recommends offering ice cream three times per day between meals to help with weight maintenance/gain. A review of R46's electronic medical record (EMR) on 4/23/25, indicated the following weights: 4/23/25-141.0 4/1/25-142.8 3/21/25-148.1 3/10/25-140.4 3/1/25-143.9 2/22/25-150.9 1/25/25-151.6 1/4/25-149.7 12/27/24-161.4 11/30/24-160.8 11/6/24-161.0 During interview on 4/23/25 at 7:50 a.m., licensed practical nurse (LPN)-D stated he had not given R46 ice cream and did not have an order to give R46 ice cream. LPN-D further stated he was	F 692	weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 692	Continued From page 62 unaware of any discussion about ice cream for R46. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated she had not seen R46 offered ice cream and was not aware he was supposed to get ice cream three times per day. During interview on 4/23/25 at 9:15 a.m., LPN-C stated she was not aware R46 was supposed to be getting ice cream three times per day. LPN-C further stated usually if there was something the dietician ordered it would be put on the medication administration record (MAR) for the nurses to give. LPN-C stated an order for ice cream was not on the MAR for R46. During interview on 4/23/25 at 1:15 p.m., assistant director of nursing (ADON) stated she was unsure why R46 had not received ice cream and did not know how the orders from the RD were processed. ADON further stated she did not handle dietician orders. During interview on 4/23/35 at 1:38 p.m., director of nursing (DON) stated she did not know the order for ice cream from the RD had not been implemented. DON further stated she would expect diet recommendations to be implemented as soon as possible, and not a month later. DON stated she would need to look at the facility's process for diet orders. During interview on 4/23/25 at 1:45 p.m., RD stated he recalled a discussion with R46 regarding weight loss and R46 agreed to eat ice cream three times per day. RD stated he emailed the recommendation to the DON. RD further stated he expected diet orders implemented	F 692			

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F 692	Continued From page 63 timely and would have expected R46's order for ice cream to be implemented by now to prevent further weight loss. Facility Medication Orders policy reviewed 4/19/24, stated the following: 2. A current list of orders must be maintained in the clinical record of each resident. 7. Dietary Supplements- When recording orders for dietary supplements, specify the type, amount, and frequency.	F 692			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693			5/30/25

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F 693	Continued From page 64 Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube care for 1 of 1 resident (R22) reviewed for tube feeding. Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia, essential hypertension, moderate protein-calorie malnutrition, and seizure disorders. R22's Clinical orders printed 4/23/25, indicated Jevity 1.5 feeding at 65 milliliters (ml) per hour for 22 hours daily. R22's care plan dated 10/25/24, indicated R22 required a tube feeding and was NPO (nothing per mouth). Care plan indicated R22 will be free of aspiration through the review date and maintain adequate nutritional and hydration status. R22's care plan indicated R22's head of bed (HOB) needed to be elevated 45 degrees during and thirty minutes after tube feeding. R22's medical record indicated three hospitalizations within the last 12 months. On 2/5/25, R22 was hospitalized with a diagnosis of influenza A, pneumonia and sepsis. On 12/12/ 24, R22 was hospitalized with a diagnosis of acquired community pneumonia. On 10/12/24, R22 was hospitalized with a diagnosis of sepsis of unknown source with suspected pulmonary versus oropharyngeal source.			F 693	R22's HOB was elevated during surveyor observation on 4/23/2025. R22's MD will be made aware that the HOB was not elevated per facility policy and standard of practice. R22's MD response will be recorded in the electronic medical record. There were no ill effects experienced during this deficient practice. Current and future residents who are admitted to the facility and are receiving gastrostomy or NG feeding, the staff will ensure after the admission assessment that the resident HOB will be elevated and a sign placed by resident bed indicating that the HOB be elevated during feeding administration and the care plan and Kardex will be initiated per facility policy. Licensed nurses and nurse aides will be in-serviced on the Enteral Feeding Policy that directs the staff to always elevate the HOB at least 30-45 degrees during tube feeding and at least 1 hour after and a return demonstration of positioning bed 30-45 degree will be discussed. The HOB elevation will be added to all residents who have enteral feeding orders and care plan. The Director of Nursing is responsible for compliance. Audits on visual HOB elevation during continuous feeding and care plan intervention for HOB elevation will begin daily x 1 week, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 693	Continued From page 65 During observation on 4/21/25, at 4:10 p.m., R22 was laying in bed in supine position and the head of the bed was not elevated. A tube feeding pump was infusing Jevity 1.5 at 65 ml per hour. During interview on 4/21/25 at 4:13 p.m., NA-D entered R22's room and stated "the bed is flat, and it shouldn't be flat. The HOB should be elevated at least 30 degrees. We don't want him to aspirate." NA-D approached and elevated R22's HOB to about 45 degrees. During interview on 4/23/25 at 2:04 p.m., licensed practical nurse (LPN)-C stated R22's HOB should be elevated at least 30 degrees during TF infusion to prevent aspiration. During interview on 4/23/25 at 3:05 p.m., director of nursing (DON) stated the HOB of a resident receiving a tube feeding infusion had to be up at least 30 degrees to prevent aspiration. Facility Safety Precautions Enteral Feedings policy dated 4/24/25, indicated "Always elevate the head of the bed (HOB) at least 30°- 45° during tube feeding and at least 1 hour after."	F 693			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695			5/30/25

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F 695	Continued From page 66 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure non-invasive ventilator (uses positive pressure to increase lung volume and decrease work of breathing, and allows for support of breathing without breathing tube) was used in accordance with physician orders to meet the individual needs for 1 of 1 resident (R4) reviewed for respiratory care and services. In addition, the facility failed to have an oxygen administration order for R4 who was on continuous oxygen. Findings include: R4's face sheet printed 4/24/25, indicated R4 had diagnoses including morbid (severe) obesity, chronic pain, reduced mobility, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R4's admission Minimum Data Set (MDS) assessment dated 2/13/25, indicated R4 had intact cognition, no behaviors including refusal of care. Special treatments included non-invasive mechanical ventilator. Oxygen was not checked as being used. Activities of daily living section was not completed and included "not assessed". R4's plan of care dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfer included total assist using 600 pound full body lift with 4 persons to transfer. The care plan did not include R7 was risk or had a potential for impairment of the	F 695	R4 had an oxygen order requested by the MD and this order was entered into the electronic medical record on 4/24/2025. R4 also had a respiratory care plan initiated on 5/3/2025 to address non-invasive mechanical ventilator use. R4's MD will be made aware that the resident was not utilizing the NIV per order and was using oxygen without oxygen orders. All current residents who utilize non-invasive mechanical ventilators will have their orders and care plans reviewed and updated. Future residents who admit will have the appropriate comprehensive care plan initiated by the facility policy. Licensed Nurses will be in-serviced on the Oxygen Administration Policy with emphasis on verifying that there is a physician order, assessing the care plan for any special needs and ensuring that the equipment and supplies are available. In addition, the nurses will be in-serviced on the Mechanical Ventilator policy and video to accompany resident current non-invasive ventilator. In addition, nurses were instructed to complete walking rounds and check for orders before administering medication to potentially correct errors. Lastly, the DON, ADON and HUC will perform a check of resident orders to ensure orders were processed correctly and are implemented. The Director of Nursing is responsible for compliance. Audits on oxygen orders, equipment, care		

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F 695	Continued From page 67 respiratory system. Physician orders dated 1/9/25 included Noninvasive Ventilator (NIV) Trilogy PC/AVAPS PC01 > or = to 52 mm HG, target tidal volume 550 with rate at 14 IPAP min: 10IPAP max: 30 EPAP 08 and full face mask every shift. The physician orders did not include an order for oxygen. Standing Orders for Skilled Nursing Facilities, last revised for 2025 included: - Initiate and titrate supplemental oxygen from 1-4 L/min via nasal cannula prn for dyspnea (shortness of breath), hypoxia (O2 saturation < 90% or <88% for COPD) or acute angina to keep O2 saturations >90%; immediately update provider with nursing assessment. - May wean supplemental oxygen per nursing judgment to maintain oxygen saturation > 90%; monitor O2 saturations three times a day and 3 days after oxygen is discontinued, including one oxygen saturation during night-time sleep. -Orders initiated should be communicated to the provider the next business day. On observation 4/22/25 at 8:24 a.m., an oxygen concentrator was present in R4's room. R4 had a nasal cannula in her nose, and oxygen concentrator was set at 2 liters oxygen flow but tubing was not connected to the concentrator. There was a NIV present in the room but was not on the resident at this time. Registered nurse (RN)-A was asked to check oxygen saturation which was 87%. RN-A stated the tubing needs to be connected to the concentrator for R4 to receive oxygen and proceeded to connect the tubing.	F 695	plan intervention and any adverse or non-compliance with oxygen therapy will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 695	Continued From page 68 On observation and interview 4/23/25 at 12:39 p.m., R4 had nasal cannula at 2 liters of oxygen flow. R4 stated she hasn't worn her NIV for the past four or five nights because they ran out of fluid for the machine. R4 added staff told her the "state" told them she can't have 2 machines in the room, pointing at her oxygen concentrator and her NIV. On interview 4/24/25 at 8:50 a.m., licensed practical nurse (LPN)-A stated R4 hasn't used the NIV for the past few nights and stated they ran out of fluid for the machine some time over the past weekend, but she wasn't aware about it until Tuesday, 4/22/25. LPN-A stated she needed to get an order from the provider, who is coming today, before she can order the fluid for the machine. LPN-A stated R4 does refuse to use the NIV or sometimes only wears it for a few hours before requesting to have it taken off and then requests oxygen by nasal cannula. LPN-A indicated she was not sure if the provider was aware R4 was not wearing the NIV every shift. On interview 4/24/25 at 10:06 a.m., physician assistant (PA-C)-M stated R4 needs her NIV at night due to hypercapnia (abnormally high level of carbon dioxide in the blood, which occurs when the body can't effectively exhale it) and obstructive sleep apnea. PA-C-M was not aware R4 was refusing her NIV and stated he should be notified if she refuses to wear it. PA-C-M stated he was unaware they ran out of fluid for the machine but added, the order she came with from the hospital should cover the need for reordering the fluids or any supplies needed. PA-C-M stated he has not ordered oxygen use for R4 but was aware from previous visits that she was using 2 liters of oxygen via a nasal cannula.	F 695			

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F 695	Continued From page 69 On interview 4/24/25 at 10:17 a.m. LPN-A reviewed R4's record and confirmed that there was no oxygen order present and R4's record lacked a plan of care for respiratory care related to oxygen use, NIV and inhaler use. On interview 4/24/25 at 10:30 a.m., nursing assistant (NA)-I stated R4 usually wears her nasal cannula with oxygen throughout the day. NA-I states he hasn't seen her wear her NIV mask in awhile. Review of Trilogy NIV machine use indicated 4/21/25, was left blank and lacked documentation. 4/22 and 4/23/25 were documented as not used due to bag of sterile water for hydration to use with the NIV was not available. Review of use of oxygen lacked documentation in the medical record. On interview 4/24/25 at 11:57 a.m., the director of nursing (DON) stated oxygen can be implemented up to 2 liters per nasal cannula per standing orders but is temporary and a provider order is required within 72 hours. The DON would expect staff to contact the provider for the resident's need for oxygen and get an order. The DON stated she would expect staff to have adequate supplies on hand for the NIV and if not available to resolve the problem right away and not wait. The DON stated the provider should be notified if R4 is refusing to wear the NIV. Facility Oxygen Administration policy dated 11/1/21, included: -Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. -Preparation	F 695			

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F 695	Continued From page 70 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. -Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable. -After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment.	F 695			

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F 695	Continued From page 71 A Mechanical Ventilation: Setup and Monitoring policy dated 4/23/25 included: - Review the resident's care plan to assess for any special needs of the resident. - Documentation: After initiating mechanical ventilation, the following information should be recorded in the resident's medical record: 1.The date and time that the procedure was performed. 2.The name and title of the individual who performed the procedure. 3. The mechanical ventilator settings, including: a. Tidal volume; b. Ventilatory rate; c. Peak flow rate; d. Pressure limit; e. Sensitivity; f. Oxygen concentration; g. Mode (assist control or rate control); and h. Special parameters such as positive end expiratory pressure (PEEP) settings. 4. All assessment data obtained before, during, and after the procedure. 5. How the resident tolerated the procedure. 6. If the resident refused the procedure, the reason(s) why and the intervention taken. 7. The signature and title of the person recording the data. -Reporting: 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.	F 695			
F 725 SS=F	Sufficient Nursing Staff	F 725			5/30/25

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F 725	Continued From page 72 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient staffing and/or oversight of non-licensed nursing staff to ensure 7 of 7 residents (R16, R37, R12, R38, R8, R4, R21) received care and assistance as needed and in a timely manner. These deficient practices had the potential to affect all 47 residents who resided in the facility.	F 725	R16, R37, R12, R38, R8 and R4 met with the facility Social Service designee and a grievance was completed for each resident concern listed in the facility 2567 report. R21 has since been discharged from the facility. Resident grievances will be completed and resolution recorded. A root cause analysis will be conducted for		

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F 725	Continued From page 73 Findings include: Refer to F677: The facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Refer to F690: The facility failed to have comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 residents (R21) reviewed for bladder incontinence. Refer to F726: The facility failed to ensure agency nursing assistants (NA's) received appropriate orientation, training and supervision. Refer to F807: The facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. RECORD REVIEW: R4's face sheet received on 4/24/25, indicated R4 had diagnoses including morbid (severe) obesity, chronic pain, reduced mobility. R4's admission minimum data set (MDS) assessment dated 2/13/25, indicated R4 had intact cognition. R4's care plan dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfers required total assist using 600 pound full-body lift with 4 persons to transfer.			F 725	call-light response times, staffing assignments, staff schedules and facility staff cell phone usage. From the root cause analysis, a plan of correction will be identified and initiated. The facility will continue to staff based on resident needs, plan of care and staffing ratios. Facility staff will be in-serviced on the Call System policy which indicates that calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately and on the Personal Cell Phone Usage Policy that personal cell phones will only be used while on break or lunch. Cell phones at any other times must be off or on silenced. The DON and HR director will review staffing schedules 2-3x a week to review current and upcoming staff schedules to ensure staffing needs are met. The facility assessment was reviewed and the facility assessment addresses ongoing staffing recruitment and retention efforts that include competitive compensation and benefits, tuition reimbursement to name few. There were no changes warranted at this time. The facility continues to recruit employees through job postings and employee referrals with current incentives to attract licensed staff. On the spot interviews and immediate job offers are encouraged. The Director of Nursing is responsible for compliance. Audits on resident call light response time and staff call light response time, resident		

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F 725	Continued From page 74 R8's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. R8's significant change MDS assessment dated 1/23/25, indicated intact cognition, clear speech, could understand and be understood. R8 was dependent upon staff for toileting and most ADL's. R8 was always incontinent of urine and occasionally incontinent of bowel. R8's care plan dated 3/27/25, indicated R8 required extensive physical assist for most ADL's. R12's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. R12's quarterly MDS assessment dated 3/11/25, indicated intact cognition, clear speech, he could understand and be understood. R12 required supervision with toileting transfers, and was dependent upon staff for toileting hygiene. R12 was frequently incontinent of bowel and bladder. R12's care plan dated 3/28/25, indicated R12 required extensive physical assist for most ADL's. R16's annual MDS assessment dated 2/15/25, indicated R16 was cognitively intact, had clear speech, could understand and be understood. R16 required partial to substantial staff assist with dressing and substantial assist with toileting; was occasionally incontinent of urine and always incontinent of bowel. Diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation.	F 725	room assignment w/call light response time and any cell-phone usage witnessed w/disciplinary action issued will begin 3x week for 3 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 725	Continued From page 75 R16's care plan dated 4/25/25, indicated R16 required extensive assistance with dressing, bed mobility, toileting and transfers. R16's care plan also indicated risk for skin impairment and directed staff to apply barrier cream after each incontinent episode. R21's face sheet received on 4/24/25, included diagnoses of orthopedic aftercare for left hip replacement, pressure ulcer of right heel stage 3, and pressure ulcer of right buttocks stage 2. R21's admission MDS assessment dated 3/30/25 indicated R21 was cognitively intact, had clear speech, could understand and be understood. No behaviors or delirium; was always incontinent of bowel and bladder and required assistance of staff for toileting. R21's care plan dated 3/24/25 and updated 4/16/26 did not include a plan for bowel and bladder incontinence. R31's face sheet received on 4/24/25, included diagnosis of left below the knee amputation. R31's quarterly MDS assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was frequently incontinent of bowel and bladder, used briefs for toileting and was dependent upon staff for toileting hygiene. R31's care plan with revised date of 3/27/25, indicated R31 was incontinent of bladder and bowel related to immobility and would remain free from skin breakdown due to incontinence and brief use. Care plan dated 10/29/24, indicated R31 was a total assist/one-person	F 725			

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F 725	Continued From page 76 physical assist. R33's face sheet received on 4/24/25, included chronic venous hypertension of bilateral lower legs (persistent high blood pressure in veins of legs). R33's quarterly MDS assessment dated 1/27/25, was cognitively intact, had clear speech, could understand and be understood. R33 was independent with activities of daily living R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. R37's quarterly MDS assessment dated 2/26/25, indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most activities of daily living (ADL's) and could walk short distances with the aid of a walker. R37 was occasionally incontinent of bladder and bowel. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's care plan dated 9/24/24, indicated R37 received hospice care, would be comfortable and would not have an interruption in normal activities due to pain. R37's care plan with revised date of 3/27/25, indicated R37 required one-person physical assist for most ADL's. R38's face sheet received on 4/24/25, included diagnosis of stroke affecting her non-dominate left side. R38's significant change MDS assessment dated			F 725			

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F 725	Continued From page 77 3/7/25, indicated intact cognition, clear speech, could understand and be understood. R38 was dependent upon staff assist for most ADL's including toileting. R38 was always incontinent of bowel and bladder. R38's care plan with revised date of 3/27/25, indicated R38 required extensive physical assist for most ADL's. RESIDENT OBSERVATIONS: R4 On observation 4/23/25 at 11:30 a.m., nursing assistant (NA)-A entered R4's room and R4 told her she needed the bed pan and NA-A stated she needed to get more help. At 11:32 a.m. NA-B entered R4's room and R4 told her she needed to use the bed pan NA-B informed her she needed to get more assistance and left the room. R4 called the front desk of the facility stating she needed help and to send some as "I don't want anyone to have to clean up my mess". At 11:36 a.m. licensed practical nurse (LPN)-A went into R4's room but was not able to locate NA-A or NA-B and told R4 she couldn't get her on the bed pan alone and would have to wait until she could get help. LPN-A remained in the room until 11:41 a.m. At 11:37 a.m., social services (SS)-A entered the room. At 11:52 a.m., SS-A remained in the room with the door closed and NA-A entered the room and then exited the room. NA-B and NA-A both entered the room at 11:55 a.m., and LPN-A entered the room shortly after. At 12:10 p.m., all staff exited the room. On interview and observation on 4/23/25 12:39 p.m., R4 stated she needed to use the bed pan and they told me they needed more help. R4	F 725			

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F 725	Continued From page 78 stated it took them over an hour to finally get her on the bed pan. R4 stated she was really worried she was going to soil herself so she called the front desk for help but that didn't help either. R4 stated she was able to hold her bowel movement until they got her on the bedpan, but it was close. At 12:43 p.m., LPN-A entered the room and R4 complained of how she was laying in her bed with her feet touching the bottom footboard and stated she is not comfortable. LPN-A stated she can't move R4 alone and R4 asked if they had a male NA working today. LPN-A stated no and added we can't always have a male NA on duty. R4 then stated "see, this is what happens all the time." On observation and interview 4/23/25 at 1:21 p.m., R4 continued to have her feet touching the foot board with head of bed elevated at 60 degrees. R4 stated I am so uncomfortable, and someone needs to do something about it. R4 put on her call light. On observation and interview 4/23/25 at 1:34 p.m., NA-H and NA-A entered R4's room to boost R4 up in her bed. NA-H stated they called him from 2nd floor to assist. NA-H added it is just physics with putting her feet up and head down and then sliding her. NA-H stated he can boost R4 up in bed himself when doing this. On interview 4/23/25 at 1:35 p.m., NA-A stated it takes three staff to move R4 and she has to call another NA from another wing or floor to come and assist her and then find the nurse also. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated residents should not have to wait 30-45 minutes to be assisted onto a	F 725			

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F 725	Continued From page 79 bedpan or to be repositioned. The DON stated the staff need better ways to communicate and coordinate patient care activities. R21 On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room. R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on, and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help and R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated this is ridiculous, "you shouldn't have to, where are the aides?" LPN-A entered R21's shortly after and assisted with changing his wet pad. On 4/23/25 at 11:53 a.m., R21 placed call light on, and NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00, and NA-A stated she needed to help someone else and would be right back. R21 stated "all you are doing is wandering around."	F 725			

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F 725	Continued From page 80 On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he had been left lying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happened almost every day and gets nothing but excuses over and over. R21 stated again, "I laid in a wet pad for over 2 hours this morning" and the nurse had to change that because the NA never did come into my room and "I saw her wandering the halls." R21 stated they never toilet him and he just has to "go" in his pad. On interview 4/24/25 at 9:09 a.m., the DON stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. CALL LIGHT RESPONSE INTERVIEWS AND OBSERVATIONS: During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. R33 stated for example, there were signs around the building indicating staff were not supposed to be on their cell phones, but they were often seen on their cell phones. R33 provided another example on 4/20/25, at around 7:00 p.m., R31 was screaming because her call light wasn't working - she was screaming for help - she needed to be changed. After about a half hour and no one helping her, R33 walked to the dining room and saw the nursing assistant sitting	F 725			

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F 725	Continued From page 81 at the nurses station on her phone. R33 stated he told her to get off her phone and help R31 and slapped the sign about not being on cell phones in front of her. During observations during survey from 4/21/25, to 4/24/25, on both first and second floors, multiple staff, primarily NA's were observed on cell phones multiple times, both while at the nurses station and while in common areas on the units. During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. The DON's written response indicated, "Call lights answered promptly. Staff reported they went to assist as soon as able." There was no indication in the review/response that R8's call light log had been reviewed for the date and time of R8's complaint. During an interview on 4/24/25 at 1:36 p.m., R8's grievance was reviewed with the DON, including R8's call light log data from 4/1/25, to 4/24/25. R8 had two call light response times of 42 and 60 minutes on 4/6/25. The DON stated that was not acceptable and would expect call lights to be answered sooner than that. The DON believed she received wrong call light data for R8, otherwise would not have written on the grievance form that R8's call lights had been answered promptly. CALL-LIGHT RESPONSE REVIEW: Call light response times were reviewed for a one-month time frame from 3/23/25, to 4/22/25,	F 725			

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F 725	Continued From page 82 which indicated many call light response times greater than 20 minutes: FIRST FLOOR: R21: During an interview on 4/21/25 at 4:43 p.m., R21 stated it was not uncommon for his call light to be on for 30 minutes and no one answered it. When his call light wasn't answered, R21 stated he sometimes called the facility on his cell phone for help and half the time no one answered the phone. R21 stated he thought the NA's were drastically understaffed. R21 had 474 activations with call light response times of: > 20 minutes = 13 x > 30 minutes = 22 x > 40 minutes = 5 x > 50 minutes = 4 x > 60 minutes = 10 x R4: During an interview on 4/22/25 at 8:08 a.m., R4 stated she has had to wait hours for her call light to be answered. R4 had 76 activations with call light response times of: > 20 minutes = 8 x > 30 minutes = 1 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 11 x SECOND FLOOR: R16: During an interview on 4/21/25 at 3:34 p.m., R16 stated he waited a long time for his call light to be answered, depending on the shift. R16 stated about a week ago, around 9:00 p.m., he put his	F 725			

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F 725	Continued From page 83 call light on, and no one took care of him until the next morning. R16 had 66 call light activations with call light response times of: > 20 minutes = 5 x > 30 minutes = 7 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R37: During an interview on 4/22/25 at 9:14 a.m., R37 stated sometimes staff answered his call light in a few minutes and sometimes they didn't come at all. R37 stated, "What I'm scared about the most, is when my pain gets worse -- am I going to have to suffer?" R37 had 240 activations with call light response times of: > 20 minutes = 17 x > 30 minutes = 9 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R12: During an interview on 4/21/25 at 2:32 p.m., R12 stated he had his call light on for four hours one night when he had a bowel movement. R12 stated his call light was on for 45 minutes most of the time before anyone responded. R12 had 72 activations with call light response times of: > 20 minutes = 6 x > 30 minutes = 3 x > 40 minutes = 3 x > 50 minutes = 3 x > 60 minutes = 9 x	F 725			

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F 725	Continued From page 84 R38: During an interview on 4/21/25 at 5:36 p.m., R38 stated it took a long time for someone answer her call light -- sometimes up to 3 hours. R38 had 23 activations with call light response times of: > 20 minutes = 2 x > 30 minutes = 3 x > 40 minutes = 1 x > 50 minutes = 0 x > 60 minutes = 5 x R8 During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. Call lights response log for 4/1/25, to 4/24/25, were reviewed. R8 had 36 activations with call light response times of: > 20 minutes = 3 x > 30 minutes = 1 x > 40 minutes = 2 x (one occurred on 4/6/25) > 50 minutes = 1 x > 60 minutes = 2 x (one occurred on 4/6/25) During an interview on 4/24/25 at 10:52 a.m., the assistant director of nursing (ADON) whose office was on second floor, stated she had been in her role for almost a year. ADON stated resident call light response times often came up in conversation. ADON stated she could hear when a call light was not being answered in a timely manner due to the continued beeping sound outside of her office. The ADON stated sometimes she got up to see what was going on, or staff or residents brought it to her attention. The ADON stated she typically touched base with	F 725			

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F 725	Continued From page 85 residents when there were long call light response times to discuss circumstances. In addition, the ADON stated call light audits were done when a concern was identified by a resident. The ADON stated a manager conducted the audit by sitting in a residents room and activating the call light and waiting for staff to respond. The ADON stated she did not look at call light response time reports; that maybe the DON and/or administrator did. The ADON was informed by the surveyor that call light response time reports for multiple residents on second floor for the past month indicated many call lights were over 20, 30, 40, 50 and 60 minutes. The ADON stated she was not aware of that, and stated call lights should be answered within 10-15 minutes. The ADON stated licensed nursing staff on duty had accountability over the NA's to ensure they were doing their work in a timely manner. Further, the ADON stated staff cell phones were not permitted on the units - only when on break. During an interview on 4/24/25 at 12:21 p.m., the DON stated call lights response times were discussed at QAPI (quality assurance and performance improvement) meetings. The DON stated call light response times were discussed in terms of average call light response times rather than looking at and investigating outliers. The DON stated managers conducted call light audits where a manager went into a residents room and pressed the call light. The DON stated sometimes a call light could be long if staff went into the room and forgot to shut the light off. The DON stated it wasn't an issue of not having enough staff, adding they were adequately staffed for their census. The DON was informed by the surveyor of the call light response times noted on reports received from the administrator. The DON	F 725			

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F 725	Continued From page 86 stated, "That is not acceptable on any level." The DON stated she would expect licensed nursing staff on duty to hold NA's accountable for completing their work in a timely manner, but acknowledged staff nurses didn't have the time, and it could place them in an uncomfortable position. The DON stated the facility did not utilize walkie talkies to communicate with other staff across wings...adding that if a NA on one wing needed help, he/she would have to go look for someone to help. During an observation on 4/24/25 at 2:47 p.m., three NA's were standing in the common area on the first floor all on their cell phones. NA-A immediately put her phone away when observed. The other two unidentified NA's did not. The ADON was informed. During an interview on 4/24/25, at 2:50 p.m., (LPN)-C stated staff came to her about NA's being on their cell phones while on duty and stated she had told the ADON and DON, but nothing happened..."I can only do so much." Facility Resident Call System policy dated 3/5/25, indicated calls for assistance were answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. Call light response times were reviewed as part of the QAPI program.	F 725			
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726			5/30/25

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F 726	Continued From page 87 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure employed and agency nursing assistants (NA's) received appropriate orientation, training and supervision. In addition, the facility failed to ensure 2 of 5 nursing assistants (NA-A and NA-C) received and demonstrated required competency skills for resident cares. Further, NA-C had not completed all in-service trainings upon hire. This had potential to affect all 47 residents who resided in the facility.			F 726	R47 and R33 will meet with social service designee and staffing concerns will be recorded on a grievance form. R47 and R33 grievance resolution were investigated, and grievance resolution was completed on 5/21/2025. Nurse Aide A had completion of orientation on 5/21/2025 and Nurse Aide C will receive orientation and all assigned competencies on when Nurse Aide C returns from leave of absence. All current employees hired from survey		

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F 726	Continued From page 88 Findings include: R33's quarterly Minimum Data Set (MDS) assessment dated 1/27/25, indicated R33 was cognitively intact. R47's quarterly MDS assessment dated 2/17/25, indicated R47 was cognitively intact. During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. Reviewed binder provided by the administrator which was used for new employee and agency orientation. Review of the binder indicated one or two pages on various topics, primarily focused on topics licensed nursing staff would need to know/utilize, and little job-specific for non-licensed nursing staff (NA's). The topics included: pharmacy, oxygen, the electronic medical record (EMR) Point Click Care with a screen shot of how to locate the Kardex and care plan, infection control, emergency procedures, wounds, new admissions, risk management and assistance scoring. The administrator indicated new employee and agency orientation was conducted by the assistant director of nursing (ADON). Via email on 4/22/25, at 4:23 p.m., when asked if the binder was used for NA's too, the administrator replied, yes, but rarely did they have any agency NA's. Via email on 4/23/25, at 8:29 p.m. when asked to see certain NA orientation checklists, the administrator replied agency staff did not have a checklist; they only reviewed and signed the orientation binder. An undated document titled Agency Orientation -- provided by			F 726	exit until present, their employee files were reviewed for general orientation completion and competency and will be updated as needed. Existing employees will have competency performed annually according to the facility policy. Annual competencies include for nurses and nurse aides, handwashing, donning and doffing of PPE, Lift Mobility/Transfer Training, Medication Management, For Agency staff, they will have general orientation with competency performed as in example above before the beginning of their shift and a employee file created. The facility assessment was reviewed and no changes were warranted. Checklists were created for both agency and facility staff to ensure all areas have been completed. The facility continues to recruit employees through job postings and employee referrals with current incentives to attract licensed staff. On the spot interviews and immediate job offers are encouraged. The Administrator, Human Resource Director, DON, ADON will be in-serviced on Staffing, Sufficient and Competent Staff Policy and procedures that all staff must meet the specific competency requirement of their respective licensure and certification requirements defined by law. The VP of Clinical Services reviewed the facility General and Agency orientation and updates to both orientation presentations were implemented. This update included adding a list of presenters, agenda, the dementia video presentation, cultural competency, expanded information on the emergency		

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F 726	Continued From page 89 the administrator, listed printed name, signature and title of 13 registered nurses and NA's, but unable to determine when this training had occurred. A list of agency NA's for payroll cycle 4/14/25, through 4/27/25, provided by the director of nursing (DON) to identify agency staff working during survey week, identified 12 agency NA's having worked hours during that time period, working a total of 102.25 hours. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R47 stated agency NA's needed proper training; "That's my biggest concern." R47 stated agency NA's were not doing their work, didn't know what to do when they come here; were not properly trained. R47 stated agency NA's asked him what they were supposed to do and asked him where supplies were kept. R47 stated they didn't know how to use the [mechanical] lifts. Residents at the resident council meeting stated they could not always tell who was agency versus employed staff, adding not all staff wore name tags or often name tags were backwards. During an interview on 4/24/25 at 9:17 a.m., human resource director (HRD)-C stated he had been employed at the facility for one month. HRD-C stated a lot of money was going to agencies for staffing. HRD-C stated the ADON provided orientation for new employed and agency staff. HRD-C stated he was not able to find documentation of agency or employed staff orientation/training. During an interview on 4/24/25 at 10:52 a.m., the ADON stated she had been in her role since June	F 726	preparedness items and how the facility assessment is developed and renumbering of presentation slides. In addition, the HR Director and ADON were in-serviced on issuing name tags for agency staff to be worn during their tour of duty and to ensure facility staff are also compliant with this task.. Residents will also be informed of this deficiency, the facility response and ongoing auditing at the next resident council meeting tentatively scheduled for June 18, 2025. The Director of Nursing is responsible for compliance. Audits on facility and agency staff orientation completion along with assigned competencies before assigned to resident care will begin 3x a week for 4 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 726	Continued From page 90 2024. The ADON stated she was responsible for new employee staff orientation, including agency staff, and utilized an orientation binder for guidance. ADON stated there were no orientation checklists or other such documentation tools to ensure employed or agency NA's received orientation and training consistent with resident care requirements and expectations of the facility. There were no documentation to ensure NA's were shown where resident supplies were kept, no documentation to ensure NA's were competent in the use of the facility mechanical lifts, no documentation to ensure NA's were informed of expectations about checking resident preferences and transfer status (e.g., level of assistance needed) prior to providing care, nothing to ensure NA's were informed of providing fresh water to residents, of expected call light response times, or expectations about personal cell phone use. The ADON stated the only orientation NA's received regarding individualized resident care was how to access the Kardex (a quick reference guide that provided a summary of patient information) in the EMR which was one screen shot of how to access the Kardex. The ADON stated she did not ensure agency NA's had access to the Kardex, stating they should have the same access as employed NA's but did not follow up with agency NA's to ensure they had access and knew how to utilize the Kardex. The ADON stated licensed nursing staff on duty were accountable for ensuring NA's performed their job duties. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated she expected NA's to know about the individual resident care needs and how a resident transferred before caring for the resident, and expected NA's to use			F 726			

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F 726	Continued From page 91 the Kardex to determine this. The DON was informed of resident concerns regarding the perceived lack of orientation, training and oversight for NA's. The DON stated she expected licensed nursing staff on duty to hold NA's accountable for performing their job duties. NURSE AIDE TRAINING NA-A was hired 5/26/21. NA-A's employee file lacked skill competencies completed within the past year. NA-C was hired 2/4/25. NA-C's employee file contained undated competency exams related to HIPAA (The Health Insurance Portability and Accountability Act; federal stands to protect health information from disclosure without patient's consent), workplace emergencies, resident rights, abuse and neglect and elder justice, fire safety, and hazardous chemicals. NA-C's employee file lacked skill competencies. NA-C's Relias (platform which provides online training) transcript printed 4/24/25, indicated NA-C completed the following trainings: -Emergency Preparedness Requirements with completion date of 4/10/25. -Behavioral Management in the SNF (skilled nursing facility) with completion date of 4/8/25 and 4/10/25. -Cultural Awareness and Humility with completion date of 4/8/25. -Abuse, Neglect, and Exploitation with completion date of 4/8/25. -Basics of Tuberculosis with completion date of 4/8/25. -About Infection Control and Prevention with completion date of 4/8/25. -The Facts on COVID-19 (respiratory illness	F 726			

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F 726	Continued From page 92 caused by the SARS-CoV-2 virus, a type of coronavirus) with completion date of 4/8/25. During interview on 4/24/25 at 1:59 p.m., HRD-C stated new hires completed general onboarding through a PowerPoint (software to create and deliver presentations using slides, texts, images, and multimedia elements) presentation and completed skill competencies during shadow shifts on the floor. HR stated new hires completed some Relias training upon hire and had more Relias trainings during annual training. HR stated employees received annual competency training through a skills fair directed by the assistant director of nursing (ADON) and director of nursing (DON). During follow-up interview on 4/24/25 at 3:03 p.m., HRD-C reviewed NA-C's completed Relias trainings and was unsure if more training was required than what was completed. HRD-C expected Relias training to be completed within two weeks after orientation date. During interview on 4/24/25 at 3:22 p.m., the DON reviewed NA-C's Relias training transcript and stated NA-C was not signed up for all the required new hire Relias trainings. The DON was given opportunity to look for NA-C's new hire skill competencies. DON stated staff completed an annual skills fair which included hand washing, infection control, abuse, and other specific skills. The DON stated the last skills fair was August 2024, and had sign-in sheets for the staff. The DON stated they were not sure where the sign-in sheets were located. The DON stated skill competencies were important to ensure staff understood and were able to effectively perform their necessary job duties.	F 726			

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F 726	Continued From page 93 The facility assessment dated 9/20/24, indicated current strategies for recruitment and retention of nursing staff included competitive compensation and benefits by offering competitive salaries, comprehensive benefits, and incentives like bonuses or tuition reimbursement to attract and retain top talent. Replace agency with full-time facility employees. The facility utilized a comprehensive educational program with the goal of having the most competent and satisfied care givers. All new staff attended a classroom experience that covered the information all staff need to complete their jobs effectively. Completion of an extensive checklist (developed by the clinical leadership) in the care setting ensured the nursing staff had the opportunity to demonstrate knowledge and skill for required tasks. There was person centered care education via unit meetings, one to one with clinical managers or staff development. The facility provided annual education that covered required regulatory education as well as facility specific education which can occur in the classroom or online, depending on associate's preference, availability, and learning style. The agenda, power point, and checklist for General Orientation were available within the shared drive, located under Administration/General Orientation. The Facility Assessment indicated staff competencies included person-centered care, activities of daily living, disaster planning and procedures, infection control, vitals, caring for people with dementia, mental and psychosocial disorders, trauma, substance use disorder, and non-pharmacological management of responsive behaviors. The facility's Orientation Program for Newly Hired	F 726			

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F 726	Continued From page 94			F 726			
F 730 SS=C	Employees, Transfers, Volunteers policy dated 3/4/25, indicated the orientation program included a tour of the facility, instructions to be followed in an emergency, introduction to resident care procedures and administrative structure. The policy indicated orientation records included the date reviewed, participant's initials, subject matter reviewed, and other information deemed necessary or appropriate. Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 2 of 5 nursing assistants (NA-A, NA-B) whose employee files were reviewed. This had the potential to affect all 47 residents who resided at the facility. Findings include: Review of NA-A and NA-B employee files contained counseling forms with verbal and written warnings. Both files lacked documentation of an annual performance review in the last year. NA-A was hired on 5/26/21, and NA-B was hired on 12/6/23. During interview on 4/24/25 at 3:03 p.m., the			F 730	Nurse aide A and Nurse Aide B will have a performance review by the department director and/or supervisor on or by 5/28/2025. All current employees that are due for annual performance reviews will have those reviews completed by compliance date. Future employees will have a performance review after 90 days of employment and annually thereafter per facility policy. The Human Resource Director, DON, ADON, Dietary Manager and Administrator will be in-serviced on the Performance Evaluation Policy that indicates a performance review is conducted 90-day probationary period and at least annually thereafter.		5/30/25

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F 730	Continued From page 95 human resources manager (HR) stated were not sure of the process for performance reviews. HR further stated recently started role and planned to implement a process to ensure performance reviews were completed during employees' work anniversary month. During interview on 4/24/25 at 3:14 p.m., the director of nursing (DON) stated they referenced the performance review policy to know how often performance reviews were required. The DON stated they (NA-A and NA-b) held their role for approximately two years, and performance reviews were not completed in the past year. The DON stated performance reviews were important, so staff knew how well or not they performed their job duties and gave staff an opportunity to voice their concerns about education. Facility Job Descriptions and Performance Evaluations policy dated 9/2020, indicated performance evaluations measured the standards against job performance. The policy indicated the director of human resources and/or respective department director reviewed with each employee a copy of the employee's job description prior to or upon employment, or upon assignment of duties, to determine if the essential functions of the job can be performed, or if modification of the job position needs to be made. The policy lacked time frame for further performance reviews.	F 730	The Director of Nursing is responsible for compliance. Audits on annual performance evaluations will begin 2x week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		
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	F 761			5/30/25

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F 761	Continued From page 96 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe storage of medications when over the counter stock medications were left unlocked and unattended in an office. Findings include: On observation and interview on 4/21/25 at 3:31 p.m., through an open door, observed bottles/containers of over the counter (OTC) medications spread out on a table in an office located at the end of 1 West wing, a resident hallway. At the end of the hallway by the office was a vending machine for soda pop and snacks for staff and residents. There was no exit or entry located in this area. Medications included			F 761	Resident medications observed during the survey in the unlocked office were relocated to the medication room. All medication carts were audited and discontinued or expired medications were placed in the Med Safe for destruction. Future over the counter medications that are delivered to the facility will be stored in the medication room that is locked upon arrival per facility policy. Facility Health Unit Clerk/Supply Coordinator and licensed nurses will be in-serviced on the Storage Medication Policy with emphasis on #1 that drugs and biologicals used in the facility are stored in locked compartments.		

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F 761	Continued From page 97 vitamins, acetaminophen, probiotics, lidocaine patches and ibuprofen. Some medications were still in boxes, and some were unpackaged and on the table. Medical Records Director (MRD)-O was present in the room and stated she was also central supply and ordered supplies including OTC medications. MRD-O stated she was in the process of unpacking the medications to refill the medication closet on the nursing unit. MRD-O stated she locked the door when she left her office. On observation 4/21/25 at 6:30 p.m., the MRD office door was open and MRD-O was not in the office. At 6:34 p.m., MRD-O returned to her office and said she left it open as she just had to run to the second floor and wasn't gone long. On observation and interview on 4/22/25 at 12:37 p.m., MRD office door was closed, but not locked. At 2:23 p.m., MRD-O office door remained closed but unlocked. At 3:23 p.m., MRD office door was closed but remained unlocked. At 3:26 p.m., MRD-O returned to her office and opened the door without a key. MRD-O stated she was on a unit that was close by, so she did not lock the door. During an observation and interview on 4/22/25 at 3:24 p.m., during a tour with the administrator, the MRD office door was open. The OTC medications were still on the table and unattended. The administrator confirmed this was a potential safety issue and the medication should not be left unattended. On observation and interview 4/24/25 at 11:02 a.m., a tour of the 2nd floor medication room (only medication room in the building) was	F 761	Director of Nursing will be responsible for compliance. Audits on delivery of over-the-counter medication delivery and storage of these medications stored appropriately in medication room will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 761	Continued From page 98 completed with licensed practical nurse (LPN)-C. Multiple boxes of tube feeding solutions were present on the counter and multiple other non-medication supplies were stored on the shelves and counters. LPN-C stated they don't have a lot of room to store anything else in the medication room. On interview 4/24/25 at 12:03 p.m., the director of nursing (DON) stated medications should not be stored in a room that is not locked including over the counter stock medications. The DON stated she would expect MRD-O to lock the door when leaving with medications present even if she is gone for a short time. A policy on medication storage was requested and none received.	F 761			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by	F 801			5/30/25

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F 801	Continued From page 99 a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or	F 801			

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F 801	Continued From page 100 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to employ either a full-time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service, which had the potential to affect 44 of 44 residents who received food from the kitchen. Findings include: During interview on 4/21/25 at 2:39 p.m., the dietary manager (DM) stated she had a food safety certification and an MDH certification, but did not have her qualifications on hand. During interview on 4/22/25 at 12:16 p.m., DM	F 801	The Culinary Director registered for the Certified Dietary Management through the Association of Nutritional Food Professional course on 4/28/2025 and will begin course work via online through the University of Florida (Pathway I) 5/27/2025. This course is self-paced. The Culinary Director anticipated course completion is anticipated for 2026. The consultant registered dietitian will oversee the Culinary Director weekly to provide dietitian support for the dietary department until completion of the culinary director course. There were no ill effects experienced by the residents for this deficient practice. Future opportunities for		

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F 801	Continued From page 101 stated, the administrator told DM to bring her certifications in on Thursday, 4/24/25. DM stated the registered dietician (RD)-I worked every day. During interview on 4/23/25 at 7:53 a.m., RD-I stated he was the dietician for the facility, was contracted, and had been with the facility for 5 or 6 years and worked on Mondays. When asked about RD-I's FTE status, RD-I stated he had to look at his hours report and stated he worked 10 to 12 hours per week and again stated he usually only came in on Mondays. During interview on 4/23/25 at 2:38 p.m., DM came into the kitchen and stated the internet was poor and the HR director instructed her to email her qualifications and he would provide the qualifications to the surveyor. DM could not show or verify her certifications and qualifications and stated she tried to pull the certification up on her phone but the internet was bad. During interview on 4/23/25 at 2:18 p.m., human resources (HR)-C stated his role consisted of interviewing new staff, conducting background checks, and verifying licenses. HR-C stated personnel files were kept in his office and he tries to digitize them. HR-C further stated he had worked at the facility about a month and stated there were problems with employee files being incomplete and stated DM's personnel file was incomplete and stated DM had certifications and licenses but HR-C did not have them and expected DM's file be in the HR department. HR-C further stated did not know what DM's certifications were, and stated DM was a director or manager for a previous facility. HR-C verified there was nothing in smart links and verified DM did not have an employee file.			F 801	this position will be filled by a Certified Dietary Manager and/or qualified dietitian. The Culinary Director will be in-serviced on the Certified Dietary Manager Job Description on the section labeled Duties and Responsibilities with emphasis on the purpose of the role is to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state and local standards. In addition, the position requirements are, as a minimum, a bachelor's degree in nutrition, dietary management or related field from an accredited college or university, must be a certified dietary manager or comparable certification in the state. The Human Resource Director will be in-serviced on the Human Resource Job Description that instructs to check for all licenses/certifications required for the specific job role. The Administrator is responsible for compliance. Audits on weekly consultant dietitian recommendations, follow up item completion and course progress will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Compliance: 05/30/2025		

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F 801	Continued From page 102 During interview on 4/23/25 at 3:57 p.m., DM stated she had a food safety certificate, but did not have a certified dietary manager certificate. DM stated she was not a certified food service manager, but stated it is part of her course. DM stated she had a food safety certification from another nursing facility she worked at for 15 years. DM further stated she did not have an associate's degree or higher, was a manager at a facility for 15 years and stated she consulted with the dietician every day. DM did not provide any evidence of her certifications and qualifications. During interview on 4/23/25 at 4:03 p.m., the administrator stated a CDM was a certified dietary manager and added they had a certified dietician that superceded the CDM and verified their dietician was not full time. The administrator stated she knew the DM was a CDM and stated their dietician was a consultant. DM's personnel file was requested and the administrator stated HR-C noticed a lot of employees were without personnel files. A policy was requested for the dietician and dietary manager qualifications and verification of the dietician's qualifications or certifications. An unsigned and dated job description, Certified Dietary Director, indicated the purpose of the position was to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state and local standards. the job description further identified requirements for the position included: preferred, as a minimum, a bachelor's degree in nutrition, dietary management or related field from an accredited college or university, must be a certified dietary manager or	F 801			

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F 801	Continued From page 103 comparable certification in the state. The facility provided the dietary manager's (DM) resume on 4/24/25, at 11:04 a.m., that indicated DM was a kitchen manager from February 2019, to October 2023, at a senior living, and identified the following responsibilities: cooked, ordered food, cleaned the kitchen, and completed staff training and prep. Under a heading, Certifications and Licenses, indicated DM had ServSafe from June 2012 to present, was a Certified Dietary Manager from February 2018 to February 2028, had Food Handler Certification from September 2019 to present. Evidence of DM's qualifications including certifications was requested, on 4/24/25 at 12:59 p.m., however no additional information was provided.	F 801			
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure identified preferences for menu selection were honored for 1 of 1 resident (R16) reviewed for choices.	F 806			5/30/25
			R16 met with facility dietitian and a likes/dislikes review was completed, rice was removed from resident renal diet restriction and double portion meal order		

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F 806	Continued From page 104 Findings include: R16's 5-day Minimum Data Set (MDS assessment dated 2/15/25, indicated R16 had intact cognition with no behaviors and diagnoses included end stage renal disease, dependence on renal dialysis, diabetes, paroxysmal atrial fibrillation, and essential hypertension. R16 was independent with eating, required substantial assistance from staff for toileting, lower body dressing and transfers, and required moderate assistance for bed mobility. R16's Order Summary Report printed 4/23/25, indicated an order for renal diet, regular texture and thin liquids. Progress note dated 3/18/25, authored by registered dietician (RD) indicated "resident states that he has no questions or concerns regarding nutrition with the exception that he would like larger portion sizes ... Dietician provided education regarding weights and encouraged him to continue with regular portions, but resident was adamant that he wanted larger portions, Dietician notified manager of a preference for larger portions." Progress note dated 4/17/25, authored by RD indicated "RD spoke with dialysis RD who spoke with this resident [R16] regarding his diet and nutritional concerns. Resident and dialysis RD discussed switching to a regular diet, and both agreed this is acceptable. Dialysis RD states all labs look good with the exception of phosphorus, but that is d/t [due to] resident running out of Tums per his statement. Resident is able to return back to a renal diet at his request. DON	F 806	was obtained on 4/28/2025. R16's care plan was reviewed and updated as needed. All current residents' diet orders were reviewed, and resident meal preferences were reviewed and updated as needed. Future residents who admit to the facility and voice food dislikes, this information will be recorded in the resident meal order and meal ticket. The IDT team, Licensed nurses and dietary staff will be in-serviced on the Resident Food Preferences Policy with emphasis on #2 that nurses will document resident's food and eating preferences in the care plan, upon admission, the dietitian or nursing staff will identify food preferences and if a resident refuses or is unhappy with his/her diet, the staff will create a care plan that the resident is satisfied with. Dietary manager will begin on admission reviewing resident likes and dislikes and will introduce new residents to the current menu cycle and from the information gathered, the meal ticket and dietary care plan will be updated. . The Dietary Manager is responsible for compliance. Audits on resident diet orders, likes/dislikes documented, resident satisfaction with meal will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 806	Continued From page 105 and NP notified of resident diet order change to a regular diet." During an interview on 4/21/25 at 3:44 p.m., R16 stated he got white rice twice a day and he had requested multiple times to stop giving him rice with every meal. R16 stated "I don't eat the rice." R16 added he was not supposed to have bananas or milk which he received three times day. R16 stated he had never talked to the facility's RD. During observation and interview on 4/22/25 at 12:53 p.m., R16 was eating lunch, and his tray had a piece of ham, white rice, steam vegetables, a piece of cake, and apple juice. R16's meal card indicated renal diet, assorted juices (cran, apple or grape juice), regular protein-smaller portions, no potato, steamed rice, seasonal vegetables, strawberries and decaf coffee with creamer. R16 stated he was supposed to get strawberries but instead they gave a piece of cake rich in sugar. R16 added "last night they gave me white rice, and milk." During interview on 4/22/25 at 1:44 p.m., licensed practical nurse (LPN)-C stated for two days R16 received mashed potatoes and today he got rice. LPN-C stated for weeks R16 had complained about receiving rice white, he never eats the rice. LPN-C stated R16 told her for months he had complained and talked to the dietary staff about the rice and his diet. LPN-C stated during a RD's visit to the facility, she informed RD about R16's request to visit with him. LPN-C stated later that day, R16 told her RD never talked to him. LPN-C suggested to R16 to talk to the dialysis dietitian to discuss his concerns.	F 806			

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F 806	Continued From page 106 During interview on 4/23/25 at 1:01 p.m., RD stated the dietary manager stated the last dietary manager had a paper version of residents' food likes and dislikes, but he wasn't sure what the current dietary manager used. RD stated he met the resident in February 2025, and he didn't recall talking to R16 about his dislike for rice. RD stated on 4/17/25, the dialysis dietician contacted him and agreed to change R16's diet to a regular diet. During interview on 4/23/25 at 2:20 p.m., dietary manager (DM) stated she looked at all the trays returned to the kitchen and if residents didn't eat their meals, she talked to the residents to find out if they were not hungry, maybe they were sick, or didn't like the food. DM stated the resident's likes and dislikes were added to the residents' meal cards. DM stated she didn't recall talking to R16 or hearing bout his dislike of rice. R16's meal card dated 4/22/25, still indicated Renal diet and white rice. DM stated today she received an order, and she updated R16's meal card indicating a regular diet, double portions and no rice. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated we need to offer choices. DON stated she talked to the floor staff and dietary department to offer him (R16) choices. Not following R16's choices is a dignity and respect issue. We need to change his diet, document risk and benefits and educate the resident about his food choices. Facility Resident Food Preferences policy dated 12/9/21, indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The policy also indicated, if the resident refuses or is unhappy	F 806			

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F 806	Continued From page 107	F 806			
F 807 SS=D	with his diet, the staff will create a care plan that the resident is satisfied with. Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. In addition, 2 of 2 resident (R18 and R33) voiced concern of not receiving clean water mugs. Findings include: R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, and protein calorie malnutrition. R31's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was independent in her ability to transfer from bed to wheelchair and to self-propel her wheelchair. R31's physician order dated 1/7/25, indicated consistent carbohydrate diet regular texture, thin liquids consistency.	F 807			5/30/25
			R31, R18 and R33 met with social services and a grievance was created for water and clean mugs was recorded. The grievance was investigated, and resolution was discussed with identified residents. R31, R18, and R33's acceptance of plan were recorded. All current resident mugs were gathered, cleaned and their mugs were filled by facility nurse aides with ice and water on 4/25/2025. Residents will receive clean mugs with water and ice (unless restricted) daily and as needed. Licensed nurses, nurse aides and dietary staff were in-serviced on the Bedside Water Pitchers and Serving Drinking Water policy and procedure with emphasis that night shift staff will collect dirty mugs and provide fresh water and ice to the residents. The IDT team was also in-serviced on 5/22/2025 that any changes in facility operations must be reported to the resident council. The Director of Nursing and Dietary		

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F 807	Continued From page 108 R31's care plan dated 4/26/23, indicated the facility would encourage good nutrition and hydration in order to promote healthier skin. R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care. During an interview and observation on 4/22/25 at 8:47 a.m., no water mug or cup was visible in R31's room. R31 stated staff did not provide fresh water, that she had to get it herself. R31 stated she knew she should drink water throughout the day. Further, R31 stated they no longer had access to ice for their water, stating the facility just removed the ice machines. During an observation on 4/23/25 at 12:45 p.m., there was no water mug/cup visible in R31's room. Observations and interviews in the same hallway included: --R18: quarterly MDS assessment dated 2/9/25, indicated intact cognition, clear speech, could understand and be understood. Was independent with mobility via wheelchair. R18 stated he replenished his water mug with water from his bathroom sink; no one brought him fresh water. In addition, R18 stated he never received a clean water mug; he reused the same one. --R33: quarterly MDS assessment dated 1/27/25, indicated intact cognition, clear speech, could understand and be understood. R33 was independent with ambulation. R33 stated no one brought him fresh water - he refilled his cup himself. In addition, R33 stated he never received a clean water mug; he reused the same one. During observations on 4/21/25 through 4/23/25,	F 807	Manager are responsible for compliance. Audits on clean water mugs and water delivery and resident satisfaction will begin 2x week for 2 weeks, weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 807	Continued From page 109 while on second floor, did not observe staff pass water to resident rooms. During an interview on 4/23/25 at 1:11 p.m., dietary manager (DM)-J stated kitchen staff had nothing to do with water pass for residents, other than supplying the mugs. DM-J was not aware of a process to ensure residents received received a clean water mug and fresh water daily. During an interview on 4/23/25 at 1:14 p.m., licensed practical nurse (LPN)-C stated she had never seen nursing assistants (NA's) formally pass water to residents; had only seen staff refill a residents cup if requested. LPN-C stated there used to pitchers of ice water near the nurses station for nurses to use to fill water for residents, but it was removed this week - she did not know why. LPN-C stated she did not know how residents were supposed to get fresh water now. During an interview on 4/23/25 at 3:10 p.m., (NA)-A stated most of the residents on this floor (2nd floor) were independent and could get their own water; that staff did not go around with a cart and provide fresh water. NA-A stated there used to be a pitcher of water for residents to access but now that was gone. NA-A stated she did not know how residents were supposed to get fresh water now. During an interview on 4/24/25 at 10:46 a.m., assistant director of nursing (ADON), who's office was on the second floor, stated NA's were supposed to pass water on the day and evening shifts, was aware it was not happening consistently, but did not know why. During an interview on 4/24/25 at 12:50 p.m., the			F 807			

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F 807	Continued From page 110 director of nursing stated she expected staff to pass water daily and provide residents with a clean mug daily. Facility Bedside Water Containers policy dated 4/23/25, indicated the facility would provide residents with fresh drinking water at their bedside daily. The night shift would be responsible for collecting used water containers and replacing clean water containers, filled with fresh water and ice on a daily basis.	F 807			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen food items were labeled and dated, scoops were not	F 812			5/30/25
			Expired items in the resident common refrigerators were discarded. Expired items in the dietary kitchen refrigerator		

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F 812	Continued From page 111 stored in the dry bins, opened foods were properly wrapped or stored, outside food containers were cleaned. . In addition the facility failed to ensure resident meals brought from outside were labeled and dated in the 1 of 1 kitchenettes. This had the potential to affect all residents who consumed food from the kitchen. Findings include: See also F925 related to pest control. During the tour of the kitchen on 4/21/25 from 2:01 p.m., to 2:15 p.m., with the dietary manager (DM), observed the following: The kitchen refrigerator: A sponge cake that was opened, unlabeled and undated and the DM asked to have it labeled. A container of dried milk dated 1/11, DM verified was dated 1/11 and stated dried milk was good for a week and it wasn't kept because it could grow yeast inside the bag. The kitchen freezer: 1 box containing gluten free pasta shells was stored on the floor and packages of vegetables were located on top of the box and DM stated the box should not be stored on the floor. At 2:12 p.m., DM picked up the box and placed it on the shelf. 3 packages of waffles with 10 in each package were undated and without a label. 1 of the bags was opened. 1 opened bag of egg omelets that was undated and unlabeled. 1 more package of waffles was stored on another shelf and the DM stated they were bad and instructed staff to throw them out the previous week and stated they would go in the garbage.	F 812	and dry storage area were discarded. No ill effects were experienced by any of the residents for this deficient practice. The kitchen counters, cabinets, coffee machine, scoops, all plastic storage containers and storage areas were cleaned on or by 5/28/2025. Future items stored in the dietary kitchen refrigerator, dry storage area and resident common refrigerators will be dated and/or discarded per facility policy. Licensed Nurses, nurse aides and housekeeping staff will be in-served on the Food Brought in by Family Policy with emphasis on item #6 that foods stored will be labeled by nursing with the resident name and use by date and undated items must be discarded. The dietary department will be in-serviced on the Food Storage Policy instructing that indicated food would be stored in an area that is clean, dry and free from contaminants. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated. Scoops are not to be stored in food or ice containers but are kept covered in a protected area near the containers. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days. All foods should be covered, labeled and dated. All foods will be checked to ensure that foods including leftovers will be		

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F 812	Continued From page 112 1 bag of opened chicken sitting in a box. The DM stated the chicken bag should have been closed. 1 bag of chicken strips that were unlabeled and undated. Dry Storage: One 3.79 liter jug of molasses opened 10/9/23, had a brown substance on the outside of the jug. DM stated it was molasses and staff just didn't wipe it down and stated it should have been discarded. One 138 ounce jar of salsa that the DM stated contained dried salsa on the outside of the jar. DM verified the lid was not secured tightly. Five 16 ounce opened bags of Tostitos tortilla chips not tied closed. The DM stated the chips should be wrapped in plastic and took the bags off the shelf. A dry bin marked, "Sugar" contained two scoops in the bin. DM stated scoops should not be stored in the sugar. Additionally, the top of the lids of the sugar and flour contained flour and sugar on each and DM instructed kitchen staff to wipe down the lids and stated it was important to wipe down because of germs and food debris. During interview and observation on 4/21/25 at 2:37 p.m., the coffee machine contained debris on the under side of the machine. The DM stated it looked like coffee debris and stated it was dried up coffee and stated there was some white chunks she could not identify what it was and stated it looked like buildup from not being cleaned every day. During interview and observation on 4/21/25 at 2:44 p.m., the DM looked in the kitchenette refrigerator on the first floor that contained a salad in a Wendy's bag that was unlabeled and	F 812	consumed by their safe use by dates, or frozen where applicable, or discarded. All food will be stored off the floor in storage areas. Dietary manager will continue to train and begin to assign tasks to the dietary employees to ensure that the kitchen is clean at all times. The Dietary Supervisor will be responsible for compliance. Audits on proper food storage in dry, refrigerated and freezers, kitchen cleanliness and resident common refrigerator for properly dated items will begin 3x week for 4 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 812	Continued From page 113 undated and the DM removed the item from the refrigerator. During interview on 4/22/25 at 12:16 p.m., the DM stated she would be concerned with opened food items because they have pests in the kitchen and food was supposed to be closed right away. During interview on 4/22/25 at 2:14 p.m., the administrator stated it was a known fact that improperly stored food would attract something. Additionally, the administrator stated when food is delivered, it is placed on the floor in the cooler and the team puts the food away. Facility Foods Brought by Family/Visitors, dated 12/20/21, indicated food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility prepared food. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. Facility Food Storage, dated 7/13/23, indicated food would be stored in an area that is clean, dry and free from contaminants. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated. Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded			F 812			

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F 812	Continued From page 114	F 812			
F 880 SS=D	as per the 2013 Federal Food Code. All foods should be covered, labeled and dated. All foods will be checked to assure that foods including leftovers will be consumed by their safe use by dates, or frozen where applicable, or discarded. All foods will be stored off the floor. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880			5/30/25

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F 880	Continued From page 115 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1	F 880			
			R22 clinical chart was reviewed from survey exit until present and R22 did not experience any ill effects from this		

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F 880	Continued From page 116 resident (R22) reviewed for EBP. In addition, facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (22) observed for personal cares. Findings include: EBP R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. R22's Clinical Profile printed 4/23/25, indicated R22 was on enhanced barrier precautions (EBP). R22's Clinical Orders report printed 4/23/25, indicated orders for care of gastrostomy tube and wound care orders for his buttocks and left great toe. R22's care plan printed 4/23/25, indicated R22 had a risk for infection related to gastrostomy tube placement and directed staff to initiate appropriate isolation precautions. During observation on 4/21/25 at 4:10 p.m., an EBP sign was taped to R22's room door directing staff to wash their hand before entering the room, and to wear gloves and gown to provide personal cares. Also, a bin was located next to the door, containing personal protection equipment (PPE). During observation on 4/22/25 at 12:38 p.m., nursing assistants (NA)-E and NA-F were giving a			F 880	deficient practice. R22 ADL care plan was reviewed and updated as needed. Current residents who are in EBP and require assistance with peri-care, their charts and care plans were reviewed and updated as needed. Future residents who admit to the facility will have the proper PPE worn, hand hygiene performed in the correct sequence and EBP procedures followed by facility policy. Facility nurses and nurse aides will be in-serviced on the Handwashing/Hand Hygiene policy with emphasis on completing hand hygiene before and after care, body fluids and removing gloves, the Enhanced Barrier Precaution policy with emphasis on gowns and gloves are to be worn during care, changing linens and changing briefs and the Perineal Care policy with focus on item #8 cleansing process for male and female residents. Infection Preventionist is responsible for compliance. Audits on proper PPE worn during care and proper hand hygiene before, during and after peri-care will begin 2x week for 3 weeks, weekly x2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 880	Continued From page 117 sponge bath and providing pericare for R22 without using gowns. During interview on 4/22/25 at 12:45 p.m., NA-E stated she had worked at facility for 8 years and today she was oriented NA-F to the facility. NA-E stated she knew R22 was on EBP, but she forgot to put on a gown because the nurse was rushing her to complete cares for other residents. NA-E stated R22 was on precautions because he had an infection on his foot and had a tube feeding. NA-E stated the staff needed to wear gowns to prevent contamination. Glove Change During observation on 4/23/25 at 9:18 a.m., NA-H and NA-G put on PPE prior entering R22's room. NA-H provided most of the personal cares and NA-G primarily assisted with turning and repositioning R22. NA-G changed her gloves after each discrete area of the body as listed was washed; R22's face, upper body, genital area, buttocks and before dressing for a total of 5 glove changes. NA-H changed his gloves once while personal cares were given to R22. NA-H and NA-G did not wash their hands after removing each pair of dirty gloves and before putting on new gloves. During interview on 4/23/25 at 9:48 a.m., NA-H stated he needed to wash his hands before putting on clean gloves and added "I forgot." During interview on 4/23/25 at 9:51 a.m., NA-G stated, "I forgot I needed to wash my hands after removing my dirty gloves and put on clean gloves." NA-G she needed to wash her hands for infection	F 880			

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F 880	Continued From page 118 control issues. During interview on 4/23/25 at 2 p.m., licensed practical nurse (LPN)-C stated nursing assistants needed to wear proper PPE before providing cares for any resident on EBP. LPN-C stated we (nursing staff) need to wash their hands after removing dirty gloves and before putting on clean gloves to prevent infections. There are signs of the door, directing staff to wear PPE. Failure to follow precautions represented a risk to transmit infections. During interview on 4/23/25 at 3:02 p.m., director of nursing (DON) stated there were signs on the doors and carts by the resident's doors directing staff to wear PPE to prevent spread of infections. DON stated she expected nursing staff to follow infection control measures. Facility Enhanced Barrier Precautions policy dated 10/8/22, indicated EBP were utilized to prevent the spread of multi drug-resistant organisms (MDRO) to residents. The Policy also indicated EBP were indicated for residents with wounds and/or indwelling medical device regardless of MDRO colonization. Facility Using Gloves Personal Protective Equipment policy dated 4/24/25, indicated the objectives to use gloves were to prevent spread of infections, prevent wounds from contamination, to protect hands from potentially infectious material ... The policy directed staff to wash their hands after removing gloves.	F 880			
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2)	F 919			5/30/25

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F 919	Continued From page 119 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident call lights were functioning for 1 of 1 resident (R31) reviewed for call lights. Findings include: R31's facesheet received on 4/24/25, included diagnosis of left below the knee amputation. R31's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was frequently incontinent of bowel and bladder, used briefs for toileting and was dependent upon staff for toileting hygiene. R31's care plan with revised date of 3/27/25, indicated R31 was incontinent of bladder and bowel related to immobility and would remain free from skin breakdown due to incontinence and brief use. Care plan dated 10/29/24, indicated R31 was a total assist/one-person physical assist. During an interview on 4/21/25 at 4:53 p.m., R33 who resided in the same hallway as R31, stated	F 919	R31's call light was repaired on 5/20/2025. All resident rooms were checked for call light functionality. Any room with a malfunctioning call light was repaired or taken out of service. For future call light malfunction, the residents will be relocated to another room per facility policy. Facility staff will be in-serviced on the Answer Call-light Policy and Procedure, ensuring that maintenance is aware of the call light malfunction, checking on the residents more frequently and relocating residents as needed within the facility. Maintenance is responsible for compliance. Audits on call-light system electronic banner and nurse station screen notification, call light clip presence, is call light plugged in, and call light functioning will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure compliance. All audit results will be reviewed by the Administrator and the Administrator will present the audit results at QAPI for review and recommendation. The Maintenance Designee is responsible		

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F 919	Continued From page 120 that on 4/20/25, at about 7:00 p.m., R31 was hollering for help because she needed to be changed, and her call light did not work. R33 stated after 30 minutes, he walked to the dining room to inform staff. R33 stated that was not the first time R31 had hollered out for help. During an interview and observation on 4/22/25 at 8:34 a.m., R31 stated her call light did not work. Both R31 and surveyor attempted to activate the call light by pressing the red button on the end of the white call cord. The small red light on the call station located on the wall at the head of the bed did not illuminate to indicate the call light had been activated, nor did her room number appear on the electronic scrolling sign in the hallway. R31 could not recall when she first noticed her call light not working, but had been given a tap bell to use. A metal tap bell was observed on her overbed table. R31 stated staff did not always hear the bell and stated she had to call out for help sometimes. During an interview and observation on 4/22/25 at 3:24 p.m., together with the administrator, entered R31's room and attempted to activate the call light by pressing the red button on the end of the white call card. The small red light did not illuminate on the call station located on the wall at the head of the bed, nor did R31's room number appear on the electronic scrolling sign in the hallway. Using her cell phone, the administrator immediately informed maintenance. The administrator did not know why this had not been addressed sooner and expected call lights to be functioning at all times. Facility Call System, Resident policy dated 3/6/25, indicated each resident was provided a means to	F 919	for compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 05/30/2025		

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F 919	Continued From page 121 call staff directly for assistance; the call system would remain functional at all times. The call system would be routinely maintained and tested by the maintenance department. Calls for assistance would be answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance would be addressed immediately.	F 919			
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to implement interventions to maintain an effective pest control program to eliminate mice in the facility. This had the potential to affect 47 of 47 residents who resided at the facility. Findings include: See also F812 related to food storage. A Paffy's pest control inspection report dated 4/22/25 at 2:45 p.m., indicated the facility staff reported seeing mice activity with droppings in the kitchen, but no rodents were found. Additionally, the facility provided the following inspection reports: 1/9/25, a comment indicated nothing was entered on the pest log. 1/23/25, a comment indicated nothing had been entered on the pest log, however the kitchen had	F 925	R31 uncovered items were stored properly and R31's room was thoroughly cleaned and inspected for mice on 5/20/2025. R27's room was thoroughly cleaned and inspected for mice on 5/20/2025. On 5/22/2025 Paffey's Pest control inspected the entire building and pest control visit schedule was increased to weekly. Areas of concern were noted, and several patches and baits were placed to block rodent entry and exit. Weekly pest control services will continue until the building shows no signs of rodent activity for a 2-week sustained period, at which point we will transition back to bi-weekly visits to maintain prevention. Facility staff were in-serviced on the Pest Control policy to report all sightings of pest within the facility and to record sightings in the pest control log. A deep room cleaning schedule was also created and re-implemented on 5/21/2025. In		5/30/25

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F 925	Continued From page 122 seen activity and exterior bait stations had varying degrees of activity. 2/7/25, a comment indicated the logbook was checked and nothing was added to the logbook, minor activity was found in the kitchen. 2/20/25, a comment indicated nothing was added to the logbook and minor activity was found in the kitchen. 3/6/25, a comment indicated nothing new was entered to the logbook, however kitchen staff reported seeing a mouse run into a wall void and light activity was found upon an exterior inspection. 3/20/25, a comment indicated nothing was entered to the logbook and no activity was found in the facility. 4/3/25, a comment indicated in unit 210 activity was not found other than old green mouse droppings. The kitchen was inspected, and kitchen staff reported seeing a mouse run under the steam table 2 days prior and RTU was moved near the back door since they opened that door a lot. 4/17/25, a comment indicated no issues were reported and moderate activity was identified on an exterior inspection on the east side and light activity was identified on a bait station across from staff's office. A report log provided by the facility, Pest Sighting Report Facility Deficiency Report indicated mice sightings in various locations in the facility on 3/12/24, 3/21/24, 4/19/24, 4/24/24, 5/3/24, 5/9/24, 5/15/24, 6/3/24, 6/11/24, 6/13/24, 6/17/24, 6/16/24, 6/20/24, 6/22/24, 6/23/24, 6/24/25, 7/23/24, 7/29/24, 8/5/24, 8/11/24, 8/13/24, 8/14/24, 8/19/24, 8/20/24, 9/3/24, 9/9/24, 9/10/24, 9/17/24, 9/22/24, 9/23/24, 9/25/24, 10/24/24, and on 10/30/24. No other mouse sightings were			F 925	addition, the residents will be educated on the Pest Control Policy and that pest concerns can be reported directly to facility staff. Residents will be educated at the next resident council of the updated pest control company plan to eradicate this concern. The kitchen staff will be assigned specific tasks to ensure kitchen is clean and a sign will be placed on the kitchen door that indicates that staff must keep door closed at all times. Maintenance is responsible for compliance. Audits on pest control reports, pest citing's log, kitchen door not propped open and deep cleaning of facility rooms will begin 2x week for 3 weeks, weekly x 4 weeks then monthly. Compliance: 05/30/2025		

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F 925	Continued From page 123 logged after 10/30/24. During interview and observation 4/21/25 between 2:16 p.m., and 2:31 p.m., a Plunkett's pest trap was in the kitchen on the floor. At 2:17 p.m., on the way to the dumpster located through the door that went to the outside from the kitchen, the dietary manager (DM) was going to prop the door open and stated they propped the door open to bring the trash outside and leave the door open to come back inside. The dumpster was uncovered, and the DM stated they kept the dumpster covers opened because the nurses also disposed of trash. The dumpster contained bags in the bottom of the bin and briefs were visible in the bags. At 2:21 p.m., a Plunkett's pest trap was in the dry storage room and next to the trap were several black particles. The DM stated, "it looks like mouse turds" and further stated it would be mopped that evening. The DM further stated there were three traps in the dry storage area. DM stated she had been at the facility 5 months and had not seen mice in the kitchen. At 2:25 p.m., a 3.79-liter jug of molasses was located on the shelf in the kitchen and the DM verified there was molasses around the outside of the container and stated staff didn't wipe it down. At 2:26 p.m., a 138-ounce jar of salsa was in the dry storage that the DM verified had dried salsa on the outside of the jar and the lid had not been securely closed. At 2:28 p.m., five 16-ounce opened and unsecured bags of Tostitos tortilla chips were in the dry storage and DM stated the bags should have been wrapped in plastic and took the bags off the shelf. At 2:31 p.m., the sugar and flour storage bins contained sugar and flour on top of the lids and was verified by the DM who instructed staff to wipe down the lids. At 2:37 p.m., the underside of the coffee machine	F 925			

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F 925	Continued From page 124 contained brown flaky material the DM stated was dried coffee along with some white chunks the DM could not identify and stated it was a build up from not being cleaned. During observation on 4/22/25 at 7:52 a.m., the last table on the first floor towards the East hall had a whitish chalky material on the table. During observation on 4/22/25 between 7:53 a.m. and 7:56 a.m., the table on the first floor by the window and closest to the West Hall and the table across from the table by the window had crumbs on the table and on the floor next to the table. During observation on 4/22/25 at 7:59 a.m., the food cart was going towards the west hall on the first floor. During interview and observation on 4/22/25 at 8:00 a.m., housekeeping (H)-A stated tables were wiped down in the a.m., and in the afternoon before housekeeping left at 2:30 p.m. H-A stated the nursing assistants were supposed to wipe down the tables at night and stated housekeeping did not vacuum at night because housekeeping didn't work at night and observed the tables and floor and stated the crumbs were cookies on the tables and floor and wiped down the tables. During interview on 4/22/25 at 8:04 a.m., nursing assistant (NA)-I stated no residents eat in the dining area on the first floor for breakfast and stated they were just passing meal trays at this time and no residents had eaten in the dining area. During observation on 4/22/25 at 8:23 a.m., meal trays were being passed out on the East hallway.	F 925			

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F 925	Continued From page 125 During observation on 4/22/25 at 8:52 a.m., staff took a meal out of room 122E and did not wipe down the table. A plastic lid with a white cream substance was located on the floor in room 122E with the cream substance also on the floor. During interview and observation on 4/22/25 at 12:16 p.m., the DM stated pest control was coming today. The area around the Plunkett's trap in the dry storage area contained little black particles and stated they swept and mopped the floor last night and stated they had a pest problem and verified the particles were mouse droppings and stated food items needed to be closed and secured. The DM further stated the aides were responsible for wiping down the dining room tables and stated propping the door open can be a problem for pests and further stated the cook will open the door if it was smoky in the kitchen or hot. The dumpster outside was uncovered with several garbage bags and the DM verified it was opened and stated she thought it should be closed but stated that was maintenance's responsibility and verified the dumpster contained food items and several garbage bags. During interview on 4/22/25 at 12:59 p.m., maintenance (M)-A stated for mouse prevention they utilized mouse traps, but the mice didn't seem to want food and traveled through the registers. He further stated it would be important for food to be in containers. Mice were more prevalent in the fall and spring and the doors should not be propped open. M-A further stated the dumpster should be closed and were approximately 25 feet from the kitchen door. M-A and M-B denied seeing mice.	F 925			

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F 925	Continued From page 126 During interview on 4/22/25 at 1:47 p.m., licensed practical nurse (LPN)-C stated she found a dead baby mouse in a room two weeks ago and was busy and forgot to log it in the pest control book. During interview and observation on 4/22/25 at 2:06 p.m., Paffy's pest control staff (PPC)-N stated there were droppings in the kitchen, but no rodents in the traps. PPC-N stated they used mouse poison and metal traps or bait stations. PPC-N stated the mice eat the poison and they had several traps in the property and about a year prior there had been ground movement which created a huge influx of mice, and the administrator called this week due to droppings. PPC-N stated food, and warmth could attract mice and added propping doors open was the worse thing in the world and kitchens loved to leave the doors open which invited critters and stated mice lived in a 10-foot radius if they had warmth, food, and water. The door to the outside on the second floor where residents went to smoke contained a gap on the bottom and the door opened automatically to a small room with another door that went to the outside of the building. Both doors opened and closed automatically, the door to the outside did not have a gap. During interview on 4/22/25 at 2:14 p.m., the administrator stated the kitchen got hot and has directed staff to shut the door and further stated the dumpster had been uncovered since she had been at the facility and added 99% of their staff were short making it difficult to shut. The administrator stated housekeepers left at 2:30 p.m., and added that was probably why food was on the tables and floors in the a.m. and the aides	F 925			

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

PRINTED: 05/31/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025	
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116			
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F 925	Continued From page 127 were supposed to clean the tables after dinner. The administrator stated Paffy's used to come twice a week and then went down to once a week and a few months ago went down to every other week because there was no activity and no complaints from staff or residents and stated the mice that are here were only coming out at night and added it was a known fact that anywhere food was not stored properly would attract something and stated the kitchen door should always be shut and if the door was propped open should be fast. The administrator further stated if residents kept food in the room they talked to residents and asked families to bring in sealable containers to keep goodies to avoid mice from going into rooms and stated anyone going into the rooms could monitor this. If no family, the facility would purchase them for the resident. The administrator stated she was not aware of mice sightings and stated Paffy's started coming to the facility every other week in January. During further interview on 4/22/25 on 2:15 p.m., the administrator stated if there was of an uptick in sightings of mice, the pest control agency was contacted immediately to come to the facility. A logbook was established for staff and residents to report sighting and were instructed to report each time a mouse was sighted to ensure appropriate follow up. (The last entry in this logbook was 10/30/24. The administrator was informed of a dead mouse sighting by a nurse two weeks ago and stated, "That's the first I'm hearing this." During an interview and observation on 4/22/25 at 3:24 p.m., together with the administrator, toured the facility for upkeep/maintenance. In R31's room, observed multiple candies and snacks on R31's overbed table and a loaf of bread on the			F 925			

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F 925	Continued From page 128 dresser. These items were not in covered containers. Observed many items on the floor around the perimeter of the room and in the closet. Across the hall in R27's room, concern was expressed for the amount of clutter on the floor and bed which could potentially attract and conceal mice. The administrator stated she was well aware of R27's room and stated staff went through the mounds of clothing and items on the floor to ensure there were no mice. During an observation on 4/23/25 at 8:44 a.m. and again at 3:00 p.m., R31's snacks and bread were still not in covered containers. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R16 stated LPN-C had been doing morning medication rounds in his room and said, "Oh my gosh, there is dead mouse on the floor." R16 said that was about two weeks ago. During observation and interview on 4/23/25 at 2:37 p.m., the door to the outside from the kitchen was propped open with a plastic pink wet floor sign. At 2:40 p.m., the door remained propped open approximately seven inches. At 2:43 p.m., the door remained propped open. At 2:46 p.m., the door was still opened. At 2:48 p.m., the door remained open. At 2:49 p.m., a staff person opened the door and stepped over the pink wet floor caution sign and went out the door which was still propped open. The DM verified the door was propped open and stated they needed water and were going back and forth so she monitored the door to make sure nobody came in. At 2:50 p.m., the door remained propped open. During an interview on 4/24/25 at 1:44 p.m., the	F 925			

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F 925	Continued From page 129 director of nursing (DON) was informed of the dead mouse finding and stated the facility had not had a mouse sighting in over 90 days or longer but would put a plan in place. Facility Pest Control policy dated 9/6/23, indicated on-going measures are taken to prevent, contain and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice and rats. General measures to decrease pests include elimination of cracks and crevices, proper lighting and ventilation, use of screen on windows and doors, and the use of self-closing doors. All food stored in the dietary area is kept in a designated area in securely covered containers, is off the floor and away from walls. All food items kept in resident rooms are stored in covered containers, with the exception of uncut fruits such as bananas and oranges, a contract with a pest control company will be elected to assure regular inspection and application of chemical pesticides. Staff will report all sightings of pest to the maintenance and or environmental services director for pest control intervention.	F 925			

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F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Notice of Medicare Non Coverage (NOMNC) and advanced beneficiary notice (ABN) was provided at least 2 days before the end of a Medicare covered part A stay for 1 of 3 residents (R8) whose Medicare Covered part A stay was ending. Findings include: The Entrance Conference Worksheet, Beneficiary Notice-Residents Discharged Within the Last Six Months, directed staff to complete the worksheet and identify a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months and identify whether a resident discharged home, or remained in the facility. The form indicated R8 remained in the facility. During interview on 4/21/25 at 5:07 p.m., social worker (SW)-A stated she starts the ABNs and was the back			

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

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F 582	Continued From Page 1 up person for the assistant director of nursing (ADON) and the ABN forms were uploaded in the resident's chart. During interview on 4/21/25 at 5:11 p.m., the ADON stated she completed beneficiary notices most of the time, otherwise SW-A completed them and once completed are uploaded into documents the same day. R8's NOMNC form indicated R8's services would end on 1/30/25. R8 signed the NOMNC on 1/30/25. During interview on 4/22/25 at 3:08 p.m., the business office manager (BOM) stated R8 started on Medicare on 1/20/25, and R8's payer change went back to Medicaid on 1/31/25. During interview on 4/22/25 at 3:17 p.m., the ADON stated R8's last covered day of Medicare was on 1/30/25. The ADON stated the ABN form was used to inform residents of services not covered and the resident's responsibility for service coverage. During interview on 4/22/25 at 3:50 p.m., the administrator dropped off R8's ABN form signed on 1/30/25, and stated the form had not been scanned. During interview on 4/23/25 at 9:04 a.m., the administrator verified R8 had Medicare for insurance and stated notices should be provided 48 hours prior to resident's signing and verified the forms were signed the same day services ended. A policy was requested with regard to the NOMNC and ABN forms and when an ABN is completed along with advanced notice to residents when Medicare is ending but not received.			
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-			

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F 623	Continued From Page 2 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notice of transfer was sent to the resident and/or resident representative for 2 of 2 residents (R7 and R41) reviewed for hospitalization. Findings include:			

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F 623	Continued From Page 3 R7's face sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity, noninfective gastroenteritis and colitis (inflammation of the digestive tracts not caused by bacteria or virus) and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated 2/14/25, indicated R7 was cognitively intact, had clear speech, could understand and be understood. R7's activities of daily living section was not completed. A nursing progress note on 4/17/25 at 2:25 p.m., indicated R7 was complaining of abdominal pain, nausea and diarrhea. The provider evaluated the patient and resident was sent to emergency department at 1:10 p.m. with emergency medical services (EMS). A nursing progress note on 4/21/25 at 5:13 p.m., included R7 was readmitted today from hospital by EMS. R7 is able to make her needs known. On 4/22/25 at 8:37 a.m., during interview, R7 stated she never got anything in writing from the facility when she was transferred to the hospital. R7 stated "I was just told I was going there". A Minnesota Notice of Bed-Hold policy undated, but signed by R7 on 4/17/25, indicated R7 wanted to have her bed held during the time of her absence. The electronic medical record (EMR) did not include a notice of transfer was given to the resident or family member in writing. R41's face sheet printed 4/24/25, included diagnoses of malignant neoplasm of right female breast, and multiple fractures of pelvis. R41's quarterly MDS dated 4/10/25, indicated severe cognitive impairment with inattention behavior and disorganized thinking continuously present but no behaviors. A nurse progress note 4/20/25 at 4:48 p.m., indicated R41 was sent to the hospital around 3:40 p.m. due to pain and inability to swallow oral pills. A Minnesota Notice of Bed-Hold Policy included telephone contact made with family member 4/21/25, and requested bed be held during the time of leave of absence. R41's EMR did not include a notice of transfer was given to R41 and or family member. On interview 4/23/25 at 2:06 p.m., licensed practical nurse (LPN)-A stated they have the patient or family member sign the bed hold, and get an order from the provider to transfer to the hospital. LPN-A indicated she isn't aware of a transfer notice that is given in writing to the resident or family member. On interview 4/23/25 at 2:10 p.m., registered nurse (RN)-A stated she asks the patient or gets verbal			

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F 623	Continued From Page 4 permission for a bed hold, gets a provider order for transfer but does not give a notice of transfer in writing to either the patient or the family. On interview 4/23/25 at 2:24 p.m., LPN-B stated the facility does not have a transfer notice in writing given to the resident or the family but they let them know verbally the reason for the transfer. On interview 4/24/25 at 9:00 a.m., the director of nursing (DON) confirmed they do not give a notice of transfer for resident's transferred to the hospital in writing to the family or the resident. The DON indicated she was not familiar with a requirement for a transfer notice and the facility currently does not have one. Facility Transfer or Discharge, Preparing a Resident form, dated 1/25/23, included: Nurse services is responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment...assisting with transportation as applicable (calling for an ambulance); completing discharge note in the medical record..			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 22, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Highland Chateau Health & Rehabilitation Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed					TITLE		(X6) DATE 05/23/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The building was constructed at two different times. The original building was constructed in 1963 and was determined to be of Type II (222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II (222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000			

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K 000	Continued From page 2	K 000			
	The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 49 at the time of the survey.				
K 225 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.1.3.2.3, and 7.2.2.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2025 between 8:00 AM and 10:30 AM, it was revealed by observation that there was combustible storage under the stairwell of the	K 225		5/30/25	
			Per observation, the facility did not maintain stairwells per NFPA 101, Life Safety Code sections 19.2.2.3, 7.1.3.2.3, and 7.2.2.5.3. The facility removed the combustible material that was under the lobby stairwell on 4/22/25. All other stairwells were audited and no combustible material was noted to be in those stairwells. Maintenance Tech has been in-serviced on this regulation and ensuring no combustible materials have been stored in		

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(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 225	Continued From page 3 Lobby Stairwell. An interview with the Administrator verified this deficient finding at the time of discovery.	K 225	stairwells. Audits will be conducted 2x week for 1 month and then monthly x 3 to ensure compliance. Maintenance Tech will be responsible for completing the audits. Results will be given to Administrator for review and any deficiencies will be brought to QA for review. Compliance Date: May 28, 2025		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363			5/30/25

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K 363	Continued From page 4 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2025 between 8:00 AM and 10:30 AM, it was revealed by observation that the door to the storage room did not have a closer on it allowing to to self-close. An interview with the Administrator verified this deficient finding at the time of discovery.			K 363	Per observation, the facility did not have self closures on storage room doors in accordance with Life Safety Code 19.3.6.3.5. The facility audited all doors for self closures and determined all required doors not noted on inspection had proper closures. The facility will add closures to the storage room doors noted in the inspection. Audits will be conducted monthly x 3 months to ensure all doors are in working order with proper closures working effectively. Maintenance Tech will be in-serviced on this regulation. Maintenance Tech or designee will be responsible for inspecting door closures. Results will be given to Administrator for review and any deficiencies will be brought to QA for review. Compliance Date: May 30, 2025		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric			K 511			5/30/25

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K 511	Continued From page 5 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), Life Safety Code, sections 300.15 and 314.25. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2025 between 8:00 AM and 10:30 AM, it was revealed by observation that the outlet in the Maintenance Office didn't have a cover on it exposing electrical wires. An interview with the Administrator verified this deficient finding at the time of discovery.	K 511	The facility did not maintain the electrical system per NFPA 101, Life Safety Code, section 9.1.2, and NFPA 70, Life Safety Code 300.15 and 314.25. Per observation, the outlet in the Maintenance Office did not have a cover on it exposing electrical wires. The facility has audited all electrical outlets for proper covers and noted that there were no further issues. Maintenance Tech will be in-serviced on expectations of proper covers on all electrical outlets. The outlet noted in the deficiency was fixed on 4/28/25. Audits will be conducted monthly to ensure all outlets have proper covers. Audits will be done monthly x 6 months. Maintenance Tech or designee will be responsible for conducting the audits. Results will be given to Administrator for review and any deficiencies will be brought to QA for review. Compliance Date: May 30, 2025		
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712			5/30/25

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K 712	Continued From page 6 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2025 between 8:00 AM and 10:30 AM, it was revealed by a review of available documentation that the facility had not performed a fire drill on the 3rd shift of the 1st quarter for 2025. An interview with the Administrator verified this deficient finding at the time of discovery.			K 712	The facility did not document and conduct fire drills per NFPA 101 Life Safety Code 19.2.2.3, 7.1.3.2.3, and 7.2.2.5.3. -Documentation presented for review identified that the facility did not complete a fire drill on the 3rd shift of the 1st quarter of 2025. The facility has recreated a new fire drill schedule to follow that follows the time stamps per Life Safety Code. Maintenance Tech was in-serviced on the proper way to fill out the fire drill forms as well as proper timing of fire drills. Audits will be conducted monthly to ensure that the proper schedule and paperwork is followed for all fire drills for all shifts per quarter. Maintenance Tech or designee will be responsible for conducting fire drills. Audits of fire drills will be conducted monthly x 6 months to ensure drills are being conducted as scheduled. Results will be given to Administrator for review and any deficiencies will be brought to QA		

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

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K 712	Continued From page 7	K 712	for review. Compliance Date: May 30, 2025		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

Administrator
Highland Chateau Health And Rehabilitation Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: 3J2L11

Dear Administrator:

The above facility was surveyed on April 21, 2025 through April 24, 2025 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, Regional Operations Supervisor
Mankato District Office
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.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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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 4/21/25, to 4/24/25, 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/22/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. NO citations were issued: H50282723C (MN00112237) and (MN0011288) H50283167C (MN00108511) H50283169C (MN00105782) H50283171C (MN00103840) The following complaint was reviewed with a deficiency cited at 1805: H50283168C (MN00108191) The following complaint was reviewed with a deficiency cited at 1730: H50283170C (MN00108094) 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	2 000			

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265			5/30/25

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2 265	Continued From page 3 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification to a family member for change of condition and hospitalization for 1 of 1 resident (R22) reviewed for change in condition. Findings include, R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. A review of R22's progress notes contained the following information: - Progress noted dated 2/4/25, indicated R22 was coughing more than usual, and blood was coming out of his mouth. R22 had bitten his lower lip.	2 265	Corrected		

Minnesota Department of Health

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2 265	Continued From page 4 Progress note indicated the nurse practitioner was updated and gave an order for cough medication as needed. - Progress note dated 2/5/25, indicated change in health condition. Progress note indicated the nurse practitioner was updated and ordered to send R22 to the hospital for further evaluation. - Progress notes lacked documentation regarding R22's family being notified about the change in condition, new orders, and/or transfer to the hospital. During interview on 4/21/25 at 5:23 p.m., family member (FM)-A indicated R22 was sent to the hospital in February, and she was not notified. FM-A learned R22 was sent to the hospital when she received a call from a hospital doctor who called her to discuss treatment options for R22. FM-A stated R22 had been at the hospital for one hour and forty-five minutes. FM-A called the facility and asked why she was not notified about R22's change of condition and transfer to the hospital. FM-A stated the facility stated they didn't have time. During interview on 4/23/25 at 11:10 a.m., the director of nursing (DON) stated the family or responsible party should be notified about change in condition as soon as we know, and before sending the resident to the hospital. The DON verified the facility didn't notify FM-A about his change of condition or transfer. A facility policy about notification of change in condition and transfer to a hospital was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure timely	2 265			

Minnesota Department of Health

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2 265	Continued From page 5 notification to the family or legal representative. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the quality assurance performance improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 2 of 5 nursing assistants (NA-A, NA-B) whose employee files were reviewed. This	2 285	Corrected		5/30/25

Minnesota Department of Health

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2 285	Continued From page 6 had the potential to affect all 47 residents who resided at the facility. Findings include: Review of NA-A and NA-B employee files contained counseling forms with verbal and written warnings. Both files lacked documentation of an annual performance review in the last year. NA-A was hired on 5/26/21, and NA-B was hired on 12/6/23. During interview on 4/24/25 at 3:03 p.m., the human resources manager (HR) stated were not sure of the process for performance reviews. HR further stated recently started role and planned to implement a process to ensure performance reviews were completed during employees' work anniversary month. During interview on 4/24/25 at 3:14 p.m., the director of nursing (DON) stated they referenced the performance review policy to know how often performance reviews were required. The DON stated they (NA-A and NA-b) held their role for approximately two years, and performance reviews were not completed in the past year. The DON stated performance reviews were important, so staff knew how well or not they performed their job duties and gave staff an opportunity to voice their concerns about education. Facility Job Descriptions and Performance Evaluations policy dated 9/2020, indicated performance evaluations measured the standards against job performance. The policy indicated the director of human resources and/or respective department director reviewed with each employee a copy of the employee's job description prior to or upon employment, or upon assignment of	2 285			

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2 285	Continued From page 7 duties, to determine if the essential functions of the job can be performed, or if modification of the job position needs to be made. The policy lacked time frame for further performance reviews. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to staff performance review. The administrator, DON, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285			
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure employed and agency nursing assistants (NA's) received appropriate orientation, training and supervision. In addition, the facility failed to ensure 2 of 5 nursing assistants (NA-A and NA-C) received and demonstrated required competency skills for	2 300	Corrected		5/30/25

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2 300	Continued From page 8 resident cares. Further, NA-C had not completed all in-service trainings upon hire. This had potential to affect all 47 residents who resided in the facility. Findings include: R33's quarterly Minimum Data Set (MDS) assessment dated 1/27/25, indicated R33 was cognitively intact. R47's quarterly MDS assessment dated 2/17/25, indicated R47 was cognitively intact. During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. Reviewed binder provided by the administrator which was used for new employee and agency orientation. Review of the binder indicated one or two pages on various topics, primarily focused on topics licensed nursing staff would need to know/utilize, and little job-specific for non-licensed nursing staff (NA's). The topics included: pharmacy, oxygen, the electronic medical record (EMR) Point Click Care with a screen shot of how to locate the Kardex and care plan, infection control, emergency procedures, wounds, new admissions, risk management and assistance scoring. The administrator indicated new employee and agency orientation was conducted by the assistant director of nursing (ADON). Via email on 4/22/25, at 4:23 p.m., when asked if the binder was used for NA's too, the administrator replied, yes, but rarely did they have any agency NA's. Via email on 4/23/25, at 8:29 p.m. when asked to see certain NA orientation	2 300			

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2 300	Continued From page 9 checklists, the administrator replied agency staff did not have a checklist; they only reviewed and signed the orientation binder. An undated documented titled Agency Orientation listed names of some nursing staff, but unable to determine when this training had occurred. A list of agency NA's for payroll cycle 4/14/25, through 4/27/25, provided by the director of nursing (DON) to identify agency staff working during survey week, identified 12 agency NA's having worked hours during that time period, working a total of 102.25 hours. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R47 stated agency NA's needed proper training; "That's my biggest concern." R47 stated agency NA's were not doing their work, didn't know what to do when they come here; were not properly trained. R47 stated agency NA's asked him what they were supposed to do and asked him where supplies were kept. R47 stated they didn't know how to use the [mechanical] lifts. Residents at the resident council meeting stated they could not always tell who was agency versus employed staff, adding not all staff wore name tags or often name tags were backwards. During an interview on 4/24/25 at 9:17 a.m., human resource director (HRD)-C stated he had been employed at the facility for one month. HRD-C stated a lot of money was going to agencies for staffing. HRD-C stated the ADON provided orientation for new employed and agency staff. HRD-C stated he was not able to find documentation of agency or employed staff orientation/training. During an interview on 4/24/25 at 10:52 a.m., the	2 300			

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2 300	Continued From page 10 ADON stated she had been in her role since June 2024. The ADON stated she was responsible for new employee staff orientation, including agency staff, and utilized an orientation binder for guidance. ADON stated there were no orientation checklists or other such documentation tools to ensure employed or agency NA's received orientation and training consistent with resident care requirements and expectations of the facility. There were no documentation to ensure NA's were shown where resident supplies were kept, no documentation to ensure NA's were competent in the use of the facility mechanical lifts, no documentation to ensure NA's were informed of expectations about checking resident preferences and transfer status (e.g., level of assistance needed) prior to providing care, nothing to ensure NA's were informed of providing fresh water to residents, of expected call light response times, or expectations about personal cell phone use. The ADON stated the only orientation NA's received regarding individualized resident care was how to access the Kardex (a quick reference guide that provided a summary of patient information) in the EMR which was one screen shot of how to access the Kardex. The ADON stated she did not ensure agency NA's had access to the Kardex, stating they should have the same access as employed NA's but did not follow up with agency NA's to ensure they had access, knew how to utilize the Kardex. The ADON stated licensed nursing staff on duty were accountable for ensuring NA's performed their job duties. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated she expected NA's to know about the individual resident care needs and how a resident transferred before caring for the resident, and expected NA's to use	2 300			

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2 300	Continued From page 11 the Kardex to determine this. The DON was informed of resident concerns regarding the perceived lack of orientation, training and oversight for NA's. The DON stated she expected licensed nursing staff on duty to hold NA's accountable for performing their job duties. NURSE AIDE TRAINING NA-A was hired 5/26/21. NA-A's employee file lacked skill competencies completed within the past year. NA-C was hired 2/4/25. NA-C's employee file contained undated competency exams related to HIPAA (The Health Insurance Portability and Accountability Act; federal stands to protect health information from disclosure without patient's consent), workplace emergencies, resident rights, abuse and neglect and elder justice, fire safety, and hazardous chemicals. NA-C's employee file lacked skill competencies. NA-C's Relias (platform which provides online training) transcript printed 4/24/25, indicated NA-C completed the following trainings: -Emergency Preparedness Requirements with completion date of 4/10/25. -Behavioral Management in the SNF (skilled nursing facility) with completion date of 4/8/25 and 4/10/25. -Cultural Awareness and Humility with completion date of 4/8/25. -Abuse, Neglect, and Exploitation with completion date of 4/8/25. -Basics of Tuberculosis with completion date of 4/8/25. -About Infection Control and Prevention with completion date of 4/8/25. -The Facts on COVID-19 (respiratory illness	2 300			

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2 300	Continued From page 12 caused by the SARS-CoV-2 virus, a type of coronavirus) with completion date of 4/8/25. During interview on 4/24/25 at 1:59 p.m., HRD-C stated new hires completed general onboarding through a PowerPoint (software to create and deliver presentations using slides, texts, images, and multimedia elements) presentation and completed skill competencies during shadow shifts on the floor. HR stated new hires completed some Relias training upon hire and had more Relias trainings during annual training. HR stated employees received annual competency training through a skills fair directed by the assistant director of nursing (ADON) and director of nursing (DON). During follow-up interview on 4/24/25 at 3:03 p.m., HRD-C reviewed NA-C's completed Relias trainings and was unsure if more training was required than what was completed. HRD-C expected Relias training to be completed within two weeks after orientation date. During interview on 4/24/25 at 3:22 p.m., the DON reviewed NA-C's Relias training transcript and stated NA-C was not signed up for all the required new hire Relias trainings. The DON was given opportunity to look for NA-C's new hire skill competencies. DON stated staff completed an annual skills fair which included hand washing, infection control, abuse, and other specific skills. The DON stated the last skills fair was August 2024, and had sign-in sheets for the staff. The DON stated they were not sure where the sign-in sheets were located. The DON stated skill competencies were important to ensure staff understood and were able to effectively perform their necessary job duties.	2 300			

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2 300	Continued From page 13 The facility assessment dated 9/20/24, indicated current strategies for recruitment and retention of nursing staff included competitive compensation and benefits by offering competitive salaries, comprehensive benefits, and incentives like bonuses or tuition reimbursement to attract and retain top talent. Replace agency with full-time facility employees. The facility utilized a comprehensive educational program with the goal of having the most competent and satisfied care givers. All new staff attended a classroom experience that covered the information all staff need to complete their jobs effectively. Completion of an extensive checklist (developed by the clinical leadership) in the care setting ensured the nursing staff had the opportunity to demonstrate knowledge and skill for required tasks. There was person centered care education via unit meetings, one to one with clinical managers or staff development. The facility provided annual education that covered required regulatory education as well as facility specific education which can occur in the classroom or online, depending on associate's preference, availability, and learning style. The agenda, power point, and checklist for General Orientation were available within the shared drive, located under Administration/General Orientation. The Facility Assessment indicated staff competencies included person-centered care, activities of daily living, disaster planning and procedures, infection control, vitals, caring for people with dementia, mental and psychosocial disorders, trauma, substance use disorder, and non-pharmacological management of responsive behaviors. The facility's Orientation Program for Newly Hired Employees, Transfers, Volunteers policy dated 3/4/25, indicated the orientation program included	2 300			

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2 300	Continued From page 14 a tour of the facility, instructions to be followed in an emergency, introduction to resident care procedures and administrative structure. The policy indicated orientation records included the date reviewed, participant's initials, subject matter reviewed, and other information deemed necessary or appropriate. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing (DON) or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's quality assurance performance improvement (QAPI) committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300			
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a	2 302			5/30/25

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2 302	Continued From page 15 segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided a description of the Alzheimer's disease or related disorder training in a written or electronic form. Further, the facility failed to ensure the assistant director of nursing (ADON), nursing assistant (NA)-J, and NA-C were provided the required training for care of residents with Alzheimer's disease. Findings include: Review of the facility Matrix identified three residents with Alzheimer's dementia. A facility nursing schedule indicated nursing	2 302	Corrected		

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2 302	Continued From page 16 assistant (NA)-C worked the day shift on 4/22/25, 4/23/25, and 4/24/25. Dementia training and competencies were requested on 4/21/25 at 7:43 p.m., via email for the following staff, nursing assistant (NA)-C, NA-J, the director of nursing (DON), and the administrator. Dementia training and competencies were requested on 4/23/25 at 9:40 a.m., via email for the following staff, licensed practical nurse (LPN)-A, LPN-C, the assistant director of nursing (ADON). A form, Alzheimer's Disease and Dementia Competency Exam, dated 6/17/24, was completed, however lacked information the assistant director of nursing (ADON) completed any training. The ADON's Relias transcript printed on 4/23/25 at 10:37 a.m., lacked information the ADON hired on 6/17/24, received dementia training. No additional training records were provided. A form, New Hire Report, indicated nursing assistant (NA)-J was hired on 4/11/25. A form, Alzheimer's Disease and Dementia Competency Exam, undated, was completed, however lacked information nursing assistant (NA)-J completed any training. No additional training records were provided. A form, New Hire Report, indicated NA-C was hired on 2/4/25. A form, Alzheimer's Disease and Dementia Competency Exam, undated, was completed,	2 302			

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2 302	Continued From page 17 however lacked information NA-C completed any training. No additional training records were provided. During interview on 4/23/25 at 8:12 a.m., NA-C stated she had not had dementia training. During interview on 4/23/25 at 8:39 a.m., the administrator stated she was a certified dementia practitioner and all staff received training since the beginning of the year and further stated staff didn't work on the floor until they received general orientation and Alzheimer's training was a part of general orientation. The administrator stated she was not aware of having to provide consumers a description of their training program. The administrator viewed the resident handbook and the facility website, but did not locate information provided to consumers. Requested evidence of employee dementia training. During interview on 4/23/25 at 2:18 p.m., human resources director (HRD) stated personal files were kept in his office and stated he worked at the facility approximately a month and stated employee files were incomplete. A follow up email from the administrator on 4/23/25 at 9:54 a.m., indicated corporate was going to create a link on their website on 4/23/25, to include the consumer information. A form, Care Providers of Minnesota, SNF/NF Staff Training Requirements 2025, provided 4/23/25 at 9:47 a.m., indicated skilled nursing facilities (SNFs) and nursing facilities (NFs) must have a system to deliver appropriate staff training and maintain documentation of such training. Lack of documented staff training is often referenced in SNF/NF deficiencies issued by the	2 302			

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2 302	Continued From page 18 CMS and or the Minnesota Department of Health. Further, for facilities serving clients with Alzheimer's disease or related disorders, staff training must include an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem-solving with challenging behaviors and communication skills. The facility must provide to consumers in written or electronic form a description of the training program, including the categories of employees trained, the frequency of training, and the basic topics covered in the training (required for facilities who provide dementia services per Minnesota Statute 144.6503). This could be a notice in your admissions packet or a sign stating that this information is available upon request. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, DON, or designee could develop a system to ensure staff are educated as required, and develop a monitoring system to ensure compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302			

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2 385	Continued From page 19	2 385	Corrected		5/30/25
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays for 4 of 4 residents (R16, R47, R32, R42) who attended the resident council meeting, who verbally confirmed mail was not delivered on Saturdays. This had the potential to affect all 47 residents residing in the facility. Findings include: During an interview on 4/23/25 at 10:05 a.m., R16, R47, R32, R42 stated they had never seen mail delivered on Saturdays. R32 stated the business office manager was not there on Saturdays, and she usually delivered it. R16's annual Minimum Data Set (MDS) assessment dated 2/15/25, indicated intact cognition. R47's quarterly MDS assessment dated 2/17/25, indicated intact cognition. R32's quarterly MDS assessment dated 2/4/25, indicated intact cognition.				

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2 385	Continued From page 20 R42's quarterly MDS assessment dated 4/1/25, indicated intact cognition. During an interview on 4/23/25 at 3:52 p.m., business office manager (BOM)-D stated she delivered mail to residents during the week, but no one was assigned to deliver mail on Saturdays. During an interview on 4/24/25 at 12:21 p.m., the director of nursing (DON) stated mail was not delivered on Saturdays since BOM-D, who delivered mail during the week did not work on Saturdays. Facility Mail and Electronic Communication policy dated 4/23/25, indicated mail and packages would be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents have reasonable access to personal mail, including Saturdays. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) received personal mail, including Saturdays. The results of audits could be reviewed by the facility's quality assurance performance improvement (QAPI) committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 385			

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2 550	Continued From page 21	2 550	Corrected	5/30/25	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 2 residents (R16) reviewed for MDS accuracy. Findings include: R16's annual MDS assessment dated 2/15/25, indicated R16 had limited range of motion of upper extremities and was cognitively intact with diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation. Section N0415 indicated R16 was taking an antidepressant, an antibiotic but didn't indicate taking an anticoagulant. A section of the RAI labeled, "Section N-Medications", outlined directions for coding the subsequent sections including N0415: High-risk Drug Classes. High-risk drug classes included antipsychotics, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic or none of the above. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated the MDSs were completed by a person at the corporate office. DON stated she was the MDS coordinator prior to				

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2 550	Continued From page 22 assuming her current position as DON and was knowledgeable of the RAI process. The DON verified R16 received an anticoagulant medication during the MDS review period but was not coded. DON stated we [facility] will have to redo the assessments or make a correction. DON stated the MDS was the base for payment and care planning and needed to be accurate. Facility MDS Error Correction policy dated 12/9/21, indicated: If an error is discovered after the encoding period and the record in error is an OBRA assessment, determine if the error is major or minor. a. A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to the QIES ASAP system. b. A major error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors: (1) correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; AND (2) perform a new significant change in status (if this has occurred) OR a new significant correction to a prior assessment with a new observation period and assessment reference date. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could assure policies are up to date, staff training has been completed, implemented and monitored to assure quarterly and annual minimum data set (MDS) assessments are completed accurately and timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			

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2 560	Continued From page 23	2 560			
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and maintained for 2 of 2 residents reviewed, (R7) who was assessed for facility acquired pressure ulcers and (R4) for respiratory cares. Findings include: R7's face sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated 2/14/25, indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated "not assessed". Risk of pressure ulcers (PU) was answered "no" and R7 had no unhealed pressure ulcers.	2 560	Corrected		5/30/25

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2 560	Continued From page 24 A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care, dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-personal physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown. On interview 4/23/25, at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been a high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K indicated she does wound rounds weekly and R7 is always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K indicated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back. NP-K added she requested a heel protector boots for both feet also. On 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-B indicated R7 has a plan of care to reposition every 2 hours. LPN-B stated they were getting R7 up once a day but since she returned from the hospital, they don't have order	2 560			

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2 560	Continued From page 25 to get her out of bed. LPN-B stated it takes 2 staff to turn R7 which has not changed since her admission in February. On 4/23/25 at 2:24 p.m., LPN-A indicated R7 should be repositioned every 2 hours and believes that is part of her plan of care. R4's face sheet printed 4/24/25, indicated R4 had diagnosis including morbid (severe) obesity, chronic pain, reduced mobility, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R4's admission MDS assessment dated 2/13/25, indicated R4 had intact cognition, no behaviors including refusal of care. Special treatments included non-invasive mechanical ventilator. Oxygen was not checked as being used. Activities of daily living section was not completed and included "not assessed". On observation 4/22/25 at 8:24 a.m., an oxygen concentrator was present in R4's room. R4 had a nasal cannula in her nose and oxygen concentrator was set at 2 liters oxygen flow. There was a non-invasive mechanical ventilator present in the room but was not on the resident at this time. R4's plan of care dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfer included total assist using 600 pound full body lift with 4 persons to transfer. The care plan did not include R7 was risk or had a potential for impairment of the respiratory system.	2 560			

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2 560	Continued From page 26 Physician orders dated 1/9/25, included Noninvasive Ventilator (NIV) Trilogy PC/AVAPS PC01 > or = to 52 mm HG, target tidal volume 550 with rate at 14 IPAP min: 10IPAP max: 30 EPAP 08 and full face mask every shift. The physician orders did not include an order for oxygen. On interview 4/24/25 at 10:17 a.m., LPN-A stated R4 has been on oxygen since she came here in January 2025. LPN-A indicated R4 had a plan of care addressing R4's respiratory issues that included the NIV, oxygen and inhalers R4 uses. LPN-A upon review of R4's medical record and stated there was not an order for oxygen and there was not a plan of care addressing R4's respiratory issues which she should have. On interview 4/24/25 at 12:03 p.m., the director of nursing (DON) confirmed R7 did not have a plan of care to prevent skin breakdown but stated she should have one. The DON confirmed R4 did not have a respiratory plan of care and indicated she would expect one with R7's current medical conditions and using NIV and oxygen. Facility Care Plans, Comprehensive Person-Centered policy dated 1/20/25, included: -The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including: (1)services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be	2 560			

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2 560	Continued From page 27 provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident ' s stated goals upon admission and desired outcomes; d. builds on the resident ' s strengths; and e. reflects currently recognized standards of practice for problem areas and condition -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. b. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could direct staff to revise the resident's care plan to include appropriate interventions for monitoring non pressure related skin conditions and respiratory cares. A monitoring program could be established in order to assure on going and effective care plan interventions based on audits and observations. The results of audits could be reviewed by the facility's quality assurance performance improvement (QAPI) committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560			

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2 570	Continued From page 28	2 570	Corrected		5/30/25
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care conference was conducted for 3 of 3 residents (R31, R3 and R36) reviewed for care planning. Findings include: R3's quarterly MDS assessment dated 2/20/25, indicated R3 had moderate cognitive impairments, needed set up for eating, required substantial assistance with dressing and was dependent for oral hygiene, toileting, personal hygiene, bed mobility and transfers. MDS indicated diagnoses of lumbar spinal stenosis, heart failure, hypertension, renal insufficiency, diabetes, and depression. R3's electronic medical record (EMR) report of care conferences indicated resident had care conferences on 6/19/24 and 5/14/24.				

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2 570	Continued From page 29 During interview on 4/23/25 at 12:11 p.m., family member (FM)-B indicated a care conference (CC) was scheduled in March 2025 for R3. FM-B stated he was not available and requested to change the CC to be moved to the following week. FM-B talked to social services (SS)-A who informed him the CC couldn't be scheduled the following week but was going to call him later to re-schedule the CC. FM-B stated SS-A never followed up and the CC was never rescheduled. During interview on 4/24/25 at 10:21 a.m., SS-A stated R3 conference was scheduled on 3/13/25, but it was canceled because family was unable to attend. SS-A stated R3's family asked if the CC could be rescheduled the following week, but the CC schedule for the following week was full. SS-A stated she had not talked to the R3's son again and had not scheduled a new CC. SS-A stated she needed to prioritize CC and if it's urgent a new CC would be re-scheduled. During interview on 4/24/25 at 2:47 p.m., director of nursing DON stated we (facility) needed to accommodate CCs to facilitate residents and family participation. R36's admission MDS assessment dated 3/20/25, indicated R36 was admitted to the facility on 3/12/25, was cognitively intact, and had no behaviors or delusions. MDS indicated resident was on a pain management program, received pain medications as needed, had a surgical wound, had oxygen, and received occupational and physical therapy services. R36's Clinical Profile dated 4/23/25, identified an admission date of 3/12/25, with diagnosis of infection and inflammatory reaction due to unspecified internal joint prosthesis.	2 570			

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2 570	Continued From page 30 During review of R36's Care Conference Summary section of the electronic medical record (EMR), R36's MR lacked evidence of any care conference since 3/12/25, despite MDS data submitted on 3/20/25. R36's EMR included a progress note titled "care conference", dated 4/4/25, and authored by SS-A indicated R36 wished to discharge to a sober house once he meets his goal ... care conference will be scheduled quarterly and as needed. During interview on 4/21/25 at 7:03 p.m., R36 stated he didn't remember having a care conference, not like other places. R36 stated "I talk to the therapists during the therapy sessions and maybe I talked to the SW." R36 added he did not meet as a group with SS, therapist, and a nurse to talk about his care plan or rehabilitation goals. During interview on 4/23/28 at 2:28 p.m., SS-A stated she scheduled the initial, quarterly, significant changes and discharge care conferences. SS-A indicated initial care conferences are scheduled 48 to 72 hours after admission and during the initial care conference residents receive a copy of their baseline care plan. SS-A stated the progress note dated 4/2/25, was a late entry and added maybe she was out that week, maybe we didn't have the care conference. SS-A stated R36 did not meet with the interdisciplinary team which includes a nurse, therapist, and SS. During interview on 4/24/25 at 10:13 a.m., director of nursing (DON) stated initial care conferences were scheduled 48 to 72 hours after a resident was admitted to the facility. The	2 570			

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2 570	Continued From page 31 residents meet with the Interdisciplinary Team (IDT) which included SS, therapies, recreational therapist, nursing, dietary manager, resident, and family. DON stated when a care conference was canceled or missed, a new care conference should be rescheduled as soon as possible. R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, protein calorie malnutrition, and depression. R31's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was able to transfer from bed to wheelchair independently and self-propel wheelchair throughout the facility. R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care. During an interview on 4/22/25 at 9:42 a.m., R31 stated she did not recall having had a care conference. A care conference was explained to her, and she still did not recall having had one. During an interview on 4/23/25 at 12:19 p.m., social services (SS)-A stated care conferences were conducted quarterly, as needed, or at family or resident request. SS-A provided two care conference notes for R31 titled Social Services Care Conference - one dated 6/5/24, and one dated 4/18/25. Both notes indicated R31 was in attendance as well as members of the IDT (interdisciplinary team). During an interview on 4/24/25 at 12:06 p.m., SS-A stated when a resident was due for a care	2 570			

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2 570	Continued From page 32 conference, she asked the resident if he/she wanted her to schedule one. SS-A stated sometimes R31 stated she did not want a care conference in which case a care conference was not conducted. Further, SS-A stated when a resident declined their care conference, the IDT team did not always meet without the resident or resident representative to review various areas such as nursing, dietary, activities and/or therapy. During an interview at 4/24/25 at 12:45 p.m., the director of nursing (DON) stated SS-A spoke to her about this and stated SS-A misunderstood the requirement about frequency of care conferences. The DON stated SS-A thought care conferences should be conducted every 92 days IF needed, or IF the resident wanted one. The DON stated she expected care conferences to be conducted every 92 days, regardless if the resident attended. Facility Resident Care Conference/Care Plan Review policy dated 6/27/22, indicated the purpose of the care conference was to develop a plan of care and to ensure that the resident goals and preferences were discussed and established. The overall care conference goal process would aid in better resident care outcomes for our long-term, and safe discharge to the community for our short-term residents. Once a conference date and time was established, an email invite would be sent to the IDT team members, including therapy alerting of this meeting. During conferences, the following items would be discussed: resident diagnosis, review of the comprehensive care plan, therapy course, and any other care areas (wound, medication therapy, psychotropic therapy, diet, appointments, etc.) along with the code status and POLST (Physician Orders for Life Sustaining Treatment). If the	2 570			

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2 570	Continued From page 33 resident refused to meet, this would be noted in the resident chart. Quarterly care conferences would include a review of the care plan by the IDT team prior to the conference to ensure focuses, goals and interventions are accurate. In addition, the resident orders should be reviewed and updated as needed for accuracy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary and include participation of resident and/or residents legal or chosen representative. The results of the monitoring could be reviewed by the facility's quality assurance performance improvement (QAPI) committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800			5/30/25

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2 800	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide sufficient staffing and/or oversight of non-licensed nursing staff to ensure 7 of 7 residents (R16, R37, R12, R38, R8, R4, R21) received care and assistance as needed and in a timely manner. These deficient practices had the potential to affect all 47 residents who resided in the facility. Findings include: Refer to F677: The facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Refer to F690: The facility failed to have comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 residents (R21) reviewed for bladder incontinence. Refer to F726: The facility failed to ensure agency nursing assistants (NA's) received appropriate orientation, training and supervision. Refer to F807: The facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. RECORD REVIEW: R4's face sheet received on 4/24/25, indicated R4 had diagnoses including morbid (severe) obesity, chronic pain, reduced mobility.	2 800	Corrected		

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2 800	Continued From page 35 R4's admission minimum data set (MDS) assessment dated 2/13/25, indicated R4 had intact cognition. R4's care plan dated 1/14/25, included functional performance requiring total assist of two persons for bed mobility, dressing and personal hygiene. Transfers required total assist using 600 pound full-body lift with 4 persons to transfer. R8's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. R8's significant change MDS assessment dated 1/23/25, indicated intact cognition, clear speech, could understand and be understood. R8 was dependent upon staff for toileting and most ADL's. R8 was always incontinent of urine and occasionally incontinent of bowel. R8's care plan dated 3/27/25, indicated R8 required extensive physical assist for most ADL's. R12's face sheet received on 4/24/25, included diagnosis of stroke affecting his non-dominate left side. R12's quarterly MDS assessment dated 3/11/25, indicated intact cognition, clear speech, he could understand and be understood. R12 required supervision with toileting transfers, and was dependent upon staff for toileting hygiene. R12 was frequently incontinent of bowel and bladder. R12's care plan dated 3/28/25, indicated R12 required extensive physical assist for most ADL's. R16's annual MDS assessment dated 2/15/25,	2 800			

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2 800	Continued From page 36 indicated R16 was cognitively intact, had clear speech, could understand and be understood. R16 required partial to substantial staff assist with dressing and substantial assist with toileting; was occasionally incontinent of urine and always incontinent of bowel. Diagnoses including renal insufficiency, amputation, diabetes, heart failure and atrial fibrillation. R16's care plan dated 4/25/25, indicated R16 required extensive assistance with dressing, bed mobility, toileting and transfers. R16's care plan also indicated risk for skin impairment and directed staff to apply barrier cream after each incontinent episode. R21's face sheet received on 4/24/25, included diagnoses of orthopedic aftercare for left hip replacement, pressure ulcer of right heel stage 3, and pressure ulcer of right buttocks stage 2. R21's admission MDS assessment dated 3/30/25 indicated R21 was cognitively intact, had clear speech, could understand and be understood. No behaviors or delirium; was always incontinent of bowel and bladder and required assistance of staff for toileting. R21's care plan dated 3/24/25 and updated 4/16/26 did not include a plan for bowel and bladder incontinence. R31's face sheet received on 4/24/25, included diagnosis of left below the knee amputation. R31's quarterly MDS assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was frequently incontinent of bowel and bladder, used briefs for toileting and was	2 800			

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2 800	Continued From page 37 dependent upon staff for toileting hygiene. R31's care plan with revised date of 3/27/25, indicated R31 was incontinent of bladder and bowel related to immobility and would remain free from skin breakdown due to incontinence and brief use. Care plan dated 10/29/24, indicated R31 was a total assist/one-person physical assist. R33's face sheet received on 4/24/25, included chronic venous hypertension of bilateral lower legs (persistent high blood pressure in veins of legs). R33's quarterly MDS assessment dated 1/27/25, was cognitively intact, had clear speech, could understand and be understood. R33 was independent with activities of daily living R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. R37's quarterly MDS assessment dated 2/26/25, indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most activities of daily living (ADL's) and could walk short distances with the aid of a walker. R37 was occasionally incontinent of bladder and bowel. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's care plan dated 9/24/24, indicated R37 received hospice care, would be comfortable and would not have an interruption in normal activities due to pain. R37's care plan with revised date of 3/27/25, indicated R37 required one-person	2 800			

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2 800	Continued From page 38 physical assist for most ADL's. R38's face sheet received on 4/24/25, included diagnosis of stroke affecting her non-dominate left side. R38's significant change MDS assessment dated 3/7/25, indicated intact cognition, clear speech, could understand and be understood. R38 was dependent upon staff assist for most ADL's including toileting. R38 was always incontinent of bowel and bladder. R38's care plan with revised date of 3/27/25, indicated R38 required extensive physical assist for most ADL's. RESIDENT OBSERVATIONS: R4 On observation 4/23/25 at 11:30 a.m., nursing assistant (NA)-A entered R4's room and R4 told her she needed the bed pan and NA-A stated she needed to get more help. At 11:32 a.m. NA-B entered R4's room and R4 told her she needed to use the bed pan NA-B informed her she needed to get more assistance and left the room. R4 called the front desk of the facility stating she needed help and to send someone as "I don't want anyone to have to clean up my mess". At 11:36 a.m. licensed practical nurse (LPN)-A went into R4's room but was not able to locate NA-A or NA-B and told R4 she couldn't get her on the bed pan alone and would have to wait until she could get help. LPN-A remained in the room until 11:41 a.m. At 11:37 a.m., social services (SS)-A entered the room. At 11:52 a.m., SS-A remained in the room with the door closed and NA-A entered the room and then exited the room. NA-B and NA-A both entered the room at 11:55	2 800			

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2 800	Continued From page 39 a.m., and LPN-A entered the room shortly after. At 12:10 p.m., all staff exited the room. On interview and observation on 4/23/25 12:39 p.m., R4 stated she needed to use the bed pan and they told me they needed more help. R4 stated it took them over an hour to finally get her on the bed pan. R4 stated she was really worried she was going to soil herself so she called the front desk for help but that didn't help either. R4 stated she was able to hold her bowel movement until they got her on the bedpan, but it was close. At 12:43 p.m., LPN-A entered the room and R4 complained of how she was laying in her bed with her feet touching the bottom footboard and stated she is not comfortable. LPN-A stated she can't move R4 alone and R4 asked if they had a male NA working today. LPN-A stated no and added we can't always have a male NA on duty. R4 then stated "see, this is what happens all the time." On observation and interview 4/23/25 at 1:21 p.m., R4 continued to have her feet touching the foot board with head of bed elevated at 60 degrees. R4 stated I am so uncomfortable, and someone needs to do something about it. R4 put on her call light. On observation and interview 4/23/25 at 1:34 p.m., NA-H and NA-A entered R4's room to boost R4 up in her bed. NA-H stated they called him from 2nd floor to assist. NA-H added it is just physics with putting her feet up and head down and then sliding her. NA-H stated he can boost R4 up in bed himself when doing this. On interview 4/23/25 at 1:35 p.m., NA-A stated it takes three staff to move R4 and she has to call another NA from another wing or floor to come	2 800			

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2 800	Continued From page 40 and assist her and then find the nurse also. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated residents should not have to wait 30-45 minutes to be assisted onto a bedpan or to be repositioned. The DON stated the staff need better ways to communicate and coordinate patient care activities. R21 On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room. R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on, and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help and R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated this is ridiculous, "you shouldn't have to, where are the aides?" LPN-A entered R21's shortly after and assisted with changing his wet pad. On 4/23/25 at 11:53 a.m., R21 placed call light on, and NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00, and	2 800			

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2 800	Continued From page 41 NA-A stated she needed to help someone else and would be right back. R21 stated "all you are doing is wandering around." On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he had been left lying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happened almost every day and gets nothing but excuses over and over. R21 stated again, "I laid in a wet pad for over 2 hours this morning" and the nurse had to change that because the NA never did come into my room and "I saw her wandering the halls." R21 stated they never toilet him and he just has to "go" in his pad. On interview 4/24/25 at 9:09 a.m., the DON stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. CALL LIGHT RESPONSE INTERVIEWS AND OBSERVATIONS: During an interview on 4/21/25 at 4:53 p.m., R33 stated agency staff had no get up and go. R33 stated there were no standards; no one holding them accountable to make sure they were doing their job. R33 stated for example, there were signs around the building indicating staff were not supposed to be on their cell phones, but they were often seen on their cell phones. R33 provided another example on 4/20/25, at around 7:00 p.m., R31 was screaming because her call light wasn't working - she was screaming for help	2 800			

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2 800	Continued From page 42 - she needed to be changed. After about a half hour and no one helping her, R33 walked to the dining room and saw the nursing assistant sitting at the nurses station on her phone. R33 stated he told her to get off her phone and help R31 and slapped the sign about not being on cell phones in front of her. During observations during survey from 4/21/25, to 4/24/25, on both first and second floors, multiple staff, primarily NA's were observed on cell phones multiple times, both while at the nurses station and while in common areas on the units. During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. The DON's written response indicated, "Call lights answered promptly. Staff reported they went to assist as soon as able." There was no indication in the review/response that R8's call light log had been reviewed for the date and time of R8's complaint. During an interview on 4/24/25 at 1:36 p.m., R8's grievance was reviewed with the DON, including R8's call light log data from 4/1/25, to 4/24/25. R8 had two call light response times of 42 and 60 minutes on 4/6/25. The DON stated that was not acceptable and would expect call lights to be answered sooner than that. The DON believed she received wrong call light data for R8, otherwise would not have written on the grievance form that R8's call lights had been answered promptly. CALL-LIGHT RESPONSE REVIEW:	2 800			

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2 800	Continued From page 43 Call light response times were reviewed for a one-month time frame from 3/23/25, to 4/22/25, which indicated many call light response times greater than 20 minutes: FIRST FLOOR: R21: During an interview on 4/21/25 at 4:43 p.m., R21 stated it was not uncommon for his call light to be on for 30 minutes and no one answered it. When his call light wasn't answered, R21 stated he sometimes called the facility on his cell phone for help and half the time no one answered the phone. R21 stated he thought the NA's were drastically understaffed. R21 had 474 activations with call light response times of: > 20 minutes = 13 x > 30 minutes = 22 x > 40 minutes = 5 x > 50 minutes = 4 x > 60 minutes = 10 x R4: During an interview on 4/22/25 at 8:08 a.m., R4 stated she has had to wait hours for her call light to be answered. R4 had 76 activations with call light response times of: > 20 minutes = 8 x > 30 minutes = 1 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 11 x SECOND FLOOR: R16: During an interview on 4/21/25 at 3:34 p.m., R16 stated he waited a long time for his call light to be answered, depending on the shift. R16 stated	2 800			

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2 800	Continued From page 44 about a week ago, around 9:00 p.m., he put his call light on, and no one took care of him until the next morning. R16 had 66 call light activations with call light response times of: > 20 minutes = 5 x > 30 minutes = 7 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R37: During an interview on 4/22/25 at 9:14 a.m., R37 stated sometimes staff answered his call light in a few minutes and sometimes they didn't come at all. R37 stated, "What I'm scared about the most, is when my pain gets worse -- am I going to have to suffer?" R37 had 240 activations with call light response times of: > 20 minutes = 17 x > 30 minutes = 9 x > 40 minutes = 1 x > 50 minutes = 1 x > 60 minutes = 7 x R12: During an interview on 4/21/25 at 2:32 p.m., R12 stated he had his call light on for four hours one night when he had a bowel movement. R12 stated his call light was on for 45 minutes most of the time before anyone responded. R12 had 72 activations with call light response times of: > 20 minutes = 6 x > 30 minutes = 3 x > 40 minutes = 3 x > 50 minutes = 3 x > 60 minutes = 9 x	2 800			

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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
2 800	Continued From page 45 R38: During an interview on 4/21/25 at 5:36 p.m., R38 stated it took a long time for someone answer her call light -- sometimes up to 3 hours. R38 had 23 activations with call light response times of: > 20 minutes = 2 x > 30 minutes = 3 x > 40 minutes = 1 x > 50 minutes = 0 x > 60 minutes = 5 x R8 During document review, a written grievance filed by R8 on 4/6/25, indicated he had turned his call light on at noon and someone came in and turned the light off saying they would get to him. No one came for 3.5 hours. Call lights response log for 4/1/25, to 4/24/25, were reviewed. R8 had 36 activations with call light response times of: > 20 minutes = 3 x > 30 minutes = 1 x > 40 minutes = 2 x (one occurred on 4/6/25) > 50 minutes = 1 x > 60 minutes = 2 x (one occurred on 4/6/25) During an interview on 4/24/25 at 10:52 a.m., the assistant director of nursing (ADON) whose office was on second floor, stated she had been in her role for almost a year. ADON stated resident call light response times often came up in conversation. ADON stated she could hear when a call light was not being answered in a timely manner due to the continued beeping sound outside of her office. The ADON stated sometimes she got up to see what was going on, or staff or residents brought it to her attention. The ADON stated she typically touched base with residents when there were long call light	2 800			

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2 800	Continued From page 46 response times to discuss circumstances. In addition, the ADON stated call light audits were done when a concern was identified by a resident. The ADON stated a manager conducted the audit by sitting in a residents room and activating the call light and waiting for staff to respond. The ADON stated she did not look at call light response time reports; that maybe the DON and/or administrator did. The ADON was informed by the surveyor that call light response time reports for multiple residents on second floor for the past month indicated many call lights were over 20, 30, 40, 50 and 60 minutes. The ADON stated she was not aware of that, and stated call lights should be answered within 10-15 minutes. The ADON stated licensed nursing staff on duty had accountability over the NA's to ensure they were doing their work in a timely manner. Further, the ADON stated staff cell phones were not permitted on the units - only when on break. During an interview on 4/24/25 at 12:21 p.m., the DON stated call lights response times were discussed at QAPI (quality assurance and performance improvement) meetings. The DON stated call light response times were discussed in terms of average call light response times rather than looking at and investigating outliers. The DON stated managers conducted call light audits where a manager went into a residents room and pressed the call light. The DON stated sometimes a call light could be long if staff went into the room and forgot to shut the light off. The DON stated it wasn't an issue of not having enough staff, adding they were adequately staffed for their census. The DON was informed by the surveyor of the call light response times noted on reports received from the administrator. The DON stated, "That is not acceptable on any level." The DON stated she would expect licensed nursing	2 800			

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2 800	Continued From page 47 staff on duty to hold NA's accountable for completing their work in a timely manner, but acknowledged staff nurses didn't have the time, and it could place them in an uncomfortable position. The DON stated the facility did not utilize walkie talkies to communicate with other staff across wings...adding that if a NA on one wing needed help, he/she would have to go look for someone to help. During an observation on 4/24/25 at 2:47 p.m., three NA's were standing in the common area on the first floor all on their cell phones. NA-A immediately put her phone away when observed. The other two unidentified NA's did not. The ADON was informed. During an interview on 4/24/25, at 2:50 p.m., (LPN)-C stated staff came to her about NA's being on their cell phones while on duty and stated she had told the ADON and DON, but nothing happened..."I can only do so much." Facility Resident Call System policy dated 3/5/25, indicated calls for assistance were answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. Call light response times were reviewed as part of the QAPI program. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with care needs. The facility could educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with	2 800			

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2 800	Continued From page 48 adequate staffing. The facility could report the findings of audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800			
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.]	2 840			5/30/25

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2 840	Continued From page 49 Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a comprehensive incontinence care plan and provide timely assistance with toileting for 1 of 1 resident (R21) reviewed for bladder incontinence. Findings include R21's face sheet printed 4/24/25, included diagnoses of orthopedic aftercare (hip replacement), mixed incontinence, pressure ulcer of right buttock and muscle weakness. R21's admission Minimum Data Set (MDS) assessment dated 3/30/25, identified R21 was cognitively intact and did not have rejection/refusal of care behaviors. The MDS identified R21 required substantial to maximum assistance for lower body dressing and footwear. R21 requires supervision or touching assistance for toilets transfers. The MDS indicated R21 was always incontinent of urine and bowel. MDS	2 840	Corrected		

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2 840	Continued From page 50 identified no toileting program had been or is currently being attempted. A Care Area Assessment (CAA) dated 3/30/25 included R21 is always incontinent of bowel and bladder. R21 requires assist with transfers needed with toileting tasks. Several skin alterations noted including surgical incision and pressure ulcers present. Will address in care plan. R21's plan of care did not include an incontinence care plan. R21's current functional performance plan of care last updated 4/16/25, included limited to assist of one person for personal hygiene and toilet use. Transfers included extensive assist of one person physical assist. On review of R21's medical record, no bladder/bowel incontinence assessment was found. On observation 4/23/25 at 9:05 a.m., R21 placed call light on. At approximately 9:10 a.m., nursing assistant (NA)-A entered the room and R21 requested to be changed as his pad was wet. NA-A stated she would be back soon. On observation on 4/23/25 at 10:44 a.m., R21 placed his call light on and licensed practical nurse (LPN)-A was in the hallway. R21 was yelling at the nurse that he has been sitting in a wet pad for hours and no one comes and answers his call light. R21 stated the NA said she would be back hours ago. LPN-A stated she would get him some help. R21 stated he has been sitting in wet stuff for over 2 hours and that is ridiculous and was going to contact state senators to stop all funding for the facility. LPN-A stated she would help him shortly and R21 stated	2 840			

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2 840	Continued From page 51 this is ridiculous, "you shouldn't have to, where are the aides?" LPN-A entered R21's shortly after and assisted with changing his wet pad. On observation 4/23/25 at 11:53 a.m., R21 placed call light on while NA-A was walking past his room. R21 told NA-A he needed to get dressed before lunch and NA-A still in the hallway, stated she would be there soon. NA-A continued to walk down the hallway towards the nurses station and then back towards R21's room. R21 again stated he needed to get dressed and has an appointment at 1:00 p.m., and NA-A stated she needed to help someone else and would be right back from the hallway. R21 stated "all you are doing is wandering around." On interview and observation on 4/23/25 at 11:59 a.m., R21 stated he was left laying in a wet pad for 2 hours this morning and that just isn't right. R21 was in a hospital gown in his bed. R21 stated this happens almost every day and gets nothing but excuses over and over. R21 stated again "I layed in a wet pad for over 2 hours this morning" and added the nurse had to change the pad because the NA never did come into his room and he saw her wandering the halls. R21 stated they never toilet him and he just has to "go" in his pad. On observation on 4/23/25 at 12:12 p.m., NA-A entered R21's room and closed the door. On interview 4/23/25 at 12:43 p.m., LPN-A indicated R21 was upset this morning and she did change his wet pad. LPN-A stated R21 is incontinent of urine and requires assist of one to change his pad. LPN-A stated she was not aware R21 had been waiting for assistance for over 2 hours until R21 told her.	2 840			

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2 840	Continued From page 52 On interview 4/23/25 at 1:30 p.m., NA-A indicated R21 had his call light on multiple times this morning but she was assisting other residents at the times he was requesting assistance. NA-A indicated she informed him she would assist him as soon as she could. NA-A stated she was the only NA down this hallway. On interview 4/24/25 at 9:09 a.m., the director of nursing (DON) stated staff should go into the room once a call light is activated and should not have conversations with them from the hallway. The DON stated residents should not have to wait over an hour to get assistance for toileting or dressing and should never lay in a wet pad for two hours. Facility Urinary Continence and Incontinence - Assessment and Management policy, last reviewed 10/18/22 included: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. 4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include the following: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.); b. Associated pain or discomfort (dysuria); and c. Type of incontinence 8. The staff and physician will identify individuals	2 840			

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2 840	Continued From page 53 with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis). 16. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including: a. tapering, stopping, or changing medications that may be causing or exacerbating incontinence; b. managing pain and/or providing adaptive equipment to help mobilize individuals suffering from arthritis, contractures, neurological impairments, etc.; c. incorporating environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) to facilitate toileting; d. treating underlying conditions that may impair continence (e.g., delirium causing urinary incontinence related to acute confusion); and e. implementing a fluid and/or bowel management program to meet assessed needs. 18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. b. Toileting programs will start with a 3- to 5-day toileting assistance trial. c. If the individual requires assistance from more than one person to transfer to the toilet, staff will address his or her mobility problems before attempting a toileting assistance trial.	2 840			

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2 840	Continued From page 54 d. Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption. e. Prompted voiding is not helpful at night (e.g., between the hours of 10 p.m. and 5 a.m.) and has been shown to disrupt sleep. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment and services. The DON or designee could develop a system to conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of audits could be reviewed by the facility's quality assurance performance improvement (QAPI) committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840			
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine	2 860	Corrected		5/30/25

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2 860	Continued From page 55 personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R22) reviewed for activities of daily living (ADLs) who was dependent on staff for his care. Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia (paralysis of arms and legs), essential hypertension, and seizure disorders. R22's care plan printed 4/24/25, indicated R22 had a self-care deficit with bathing, dressing and feeding. This care plan directed staff to assist R22 with activities of daily living (ADL). A care plan titled Current Functional Performance identified R22 needed total assist with personal hygiene. During observation on 4/21/25 at 4:10 p.m., resident was sleeping in bed. R22's fingernails were about half an inch long and had black debris underneath his fingernails. During observation and interview on 4/21/25 at 4:13 p.m., nursing assistant (NA)-D verified R22's fingernails were long and had black debris underneath his fingernails. NA-D stated he usually worked overnight shifts and didn't know when or who trims R22's nails. During interview on 4/21/25 at 12:38 p.m., family member (FM)-A stated she visited R22 on 4/13/25, and observed his fingernails were long and dirty. FM-A stated on 4/13/25 she left a voice	2 860			

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2 860	Continued From page 56 mail for who she believed was the charge nurse. FM-A stated she left a voice mail to request R22's nails be cleaned and trimmed. During interview on 4/22/25 at 12:38 p.m., NA-E verified R22's nails were long. NA-E stated she gave a sponge bath to R22 this morning and planned to trim his nails before the end of her shift. During observation on 4/23/25 at 8:24 a.m., R22's fingernails were long and had black debris underneath them. During interview on 4/23/25 at 1:55 p.m., licensed practical nurse (LPN)-C stated residents nails are checked on their bath day and trimmed as needed. LPN-C stated R22 is a diabetic, therefore nurses are responsible to trim his nails. During interview on 4/23/25 at 2:56 p.m., director of nursing (DON) stated she expected the facility's residents' nails will be cut on bath days or on a weekly basis. DON added. if a resident had contractures there was a risk to produce skin alterations, and was an infection and dignity issue. Facility Care of Fingernails/Toenails policy dated 4/24/25, indicated the purpose was to clean the nail bed, to keep nails trimmed, and to prevent infections. Activities of Daily Living SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nail care for dependent residents. The director of nursing or designee could re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent	2 860			

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2 860	Continued From page 57 implementation of these policies, with results of those audits being brought to the facility's quality assurance performance improvement (QAPI) committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860			
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly transcribe and implement physician orders for a resident requiring edema and surgical incision monitoring for 1 of 1 resident (R36) reviewed for edema and skin conditions. Findings include, R36's Clinical Profile dated 4/23/25, identified an admission date of 3/12/25. R36's Clinical Diagnoses report printed 4/23/25, indicated diagnoses of infection and inflammatory reaction due to unspecified internal joint prosthesis, presence of right artificial knee joint,	2 875	Corrected		5/30/25

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2 875	Continued From page 58 acute on chronic diastolic heart failure, cellulitis of right lower extremity, and acute and chronic respiratory failure. R36's admission Minimum Data Set (MDS) assessment dated 3/20/25, indicated R36 was admitted to the facility on 3/12/25. R36 was cognitively intact, had no behaviors or delusions. MDS indicated resident was on pain management, received medications for pain as needed, received intravenous antibiotics, had a surgical wound, used oxygen, and received occupational and physical therapy services. R36's Clinical Orders report printed 4/23/25, included the following orders: - Below the knee Ted hose stocking for compression. On in the morning, off at night. Order dated 3/12/25, no end date. - Dressing change with gauze, ABD (large, highly absorbent sterile gauze pad used for managing heavily draining wounds) and Ace wrap. Keep incision dry. Let steri-strips fall off on their own. As needed (PRN). Order dated 3/12/25 at 10 p.m., and discontinued on 3/12/25 at 9:25 p.m. R36's medication administration record (MAR) and treatment administration record TAR) for March 2025 indicated: - "Leave wound dressing in place for two weeks or until orthopedic follow-up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance". Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. It was documented as done between 3/12/25 and 3/31/25. - "Daily dressing change with gauze, tape, and Ace wrap for compression. Keep incision dry, one time a day". Order starting date 3/20/25, and ending date 3/26/25. Documented as done.	2 875			

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2 875	Continued From page 59 - "Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN". Order starting date 3/26/25, no ending date. No dressing changes were documented. - March's MAR or TAR did not included the order for Ted stockings. R36's medication administration record (MAR) and treatment administration record TAR) for April 2025 indicated: - "Leave wound dressing in place for two weeks or until orthopedic follow up appointment. Call surgeon if significant cloudy, blood or malodorous drainage, redness or warmth around incision. Every shift for wound maintenance". Order starting date 3/12/25 at 10 p.m. and was discontinued on 4/15/25. Documented as done. - "Dressing change with gauze, ABD and Ace wrap. Keep incision dry. Let Steri strips fall off on their own. PRN." Order starting date 3/26/25, no ending date. No dressing changes were documented. - "Below the knee Ted hose stockings for compression. On in the morning, off at night". Space for documentation was crossed out. No documentation was done. R36's care plan titled Wound Management Post-Surgical dated 3/12/25, indicated the wound will be free of signs or symptoms of infections. The care plan also indicated "Administer antibiotic therapy as prescribed. Wound dressing to remain intact until ortho visit. Do not get dressing wet." No reviews or updates to the care plan were done since 3/12/25. R36's edema and order for ted stockings was not addressed in his care plan.	2 875			

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2 875	Continued From page 60 During interview on 4/21/25 at 7:16 p.m., R36 stated he was at the facility after his 7th right knee surgery. R36 was not wearing ted stockings. R36's left shin skin color was darker with some red and dry spots, but the skin was intact. R36 stated "A few weeks ago I removed my ted stockings and pulled off some of the skin. It's healed now." R36 had a gauze present below his right knee. R36 stated he had problems with edema and was supposed to wear ted stockings during the day and remove them at night before going to bed. R36 stated the staff did not put on the ted stockings or remove them. R36 added "never done it for me. I do it by myself." During interview on 4/22/25 at 12:33 p.m., R36 was not wearing ted stockings and had a dressing present below his left knee. R36 stated he probably scratched a little scab and the area was draining so he put a gauze over the affected area. R36 stated he kept some gauze and dressings in his room, and he took care of his wounds. R36 stated he was admitted to the facility on 3/12/25, and had a surgical dressing on for 2 weeks. R36 stated on 3/26/25, the surgeon removed the surgical dressing and for a week "or so" the nurses changed my dressings every day. R36 added "after that week I had taken care of my wounds." During observation and interview on 4/22/25 at 2:47 p.m., R36's lower leg was swollen and red. R36 stated his right leg didn't hurt, but compared to his left leg, it felt warmer. R36 was not wearing ted stockings. During interview on 4/23/25 at 8:41 a.m., the assistant director of nursing (ADON) verified R36 had orders for ted stockings and wound care. ADON stated the orders can be seen under	2 875			

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2 875	Continued From page 61 physician orders but not under the Point Click Care (PCC) TAR or MAR used every shift by the nurses. During interview on 4/23/25 at 1:37 p.m., LPN-C stated she didn't know R36 had ted stockings or current wound care orders. LPN-C stated this morning the ADON asked her to investigate. LPN-C stated the ted stocking order was transcribed on 3/12/25, but was not properly processed and the nurses couldn't see the order as a daily assignment. LPN-C stated the only way to know was to look at the physician orders. LPN-C verified R36's order for PRN (as needed) wound care. LPN-C stated the order for wound care dated 3/26/25 was transcribed, but was not appropriately processed and was not included in the nurses' daily assignments. LPN-C stated "Yesterday, I put a dressing on his [R36] knee because he had a small wound and he is taking antibiotics." During interview on 4/23/25 at 2:50 p.m., director of nursing (DON) stated the ted stockings and wound care orders were not properly carried over PCC for nurses to follow orders. DON stated the mistake was done by the nurse transcribing the orders. DON stated R36 had a history of infection on the right leg and edema. DON stated not putting the ted stockings on to help with the fluid built up, not doing dressing changes and assessing his wounds could be a risk for infection and decline in condition for R36. Facility Comprehensive Person-Centered Care Plans dated 1/20/25, indicated a comprehensive, person centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.	2 875			

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2 875	Continued From page 62 The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occurring. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. The results of those audits could be brought to the facility's quality assurance performance improvement (QAPI) committee for review to determine compliance or the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to	2 900			5/30/25

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2 900	Continued From page 63 promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to prevent the development of new pressure ulcers for 1 of 3 residents (R7) who were reviewed for pressure ulcers. Findings include: R7's Face Sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS) assessment dated 2/14/25, indicated R7 was cognitively intact, had no behaviors, had a Foley catheter present and was always incontinent of stool. Activities of daily living assessment indicated "not assessed". Risk of pressure ulcers (PU) was "no" and R7 had no unhealed pressure ulcers. A Care Area Assessment (CAA) dated 2/14/25 included a risk for wound care plan will be initiated. A PU/injury will not be addressed in the plan of care. Diagnosis and condition putting patient at increase risk includes diabetes and chronic end stage renal liver, heart disease, depression and pain. Meds affecting potential skin injury include antipsychotics and antidepressants. In addition R7 has come cognitive loss and is incontinent. Needs special	2 900	Corrected		

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2 900	Continued From page 64 mattress or seat cushion. A Braden Scale (risk assessment tool for patient's risk of developing pressure injuries) completed for R7 on 2/14/25, indicated a score of 13 which indicates moderate risk of PU. Repeat Braden Scales were completed 4/9/25 and 4/21/25, and both indicated moderate risk for PU. R7's plan of care dated 2/21/25, indicated wound management as a problem. Interventions included notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. A current functional performance included bed mobility, dressing, toilet use were independent/one-person physical assist, with transfers of a total assist of two persons using full body lift. R7's plan of care did not include a risk for skin breakdown or interventions to prevent skin breakdown. Weekly bath audit forms included: 2/13/25: R7 had an open area above the coccyx (fissure) and an open area on the right breast due to dampness. 2/27/25: No new alterations in skin noted during this observation. 3/7/25: No new alternation in skin noted during this observation. 3/9/25: No new alternation in skin noted during this observation. 3/13/25: No new alternation in skin noted during this observation. 3/20/25: No new alternation in skin noted during this observation. 3/27/25: No new alternation in skin noted during this observation. 4/3/25: No new alternation in skin noted during this observation. Resident refused shower/bath.	2 900			

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2 900	Continued From page 65 Resident said will take shower/bath at another time. An Integrated Wound Care note from 3/12/25, included R7 is being seen for evaluation and treatment recommendations for a fissure (small tear in thin tissue) to the gluteal fold (fold of the buttock horizontal crease) and open lesion to the right breast. She is incontinent of urine and bowel and her mobility is limited by her body habitus (shape and size), weakness and recent surgery to repair a fracture of the right tibia. R7's Braden score is 12 high risk for pressure injury. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol. Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 3/19/25 and 3/26/25, included a Braden score of 12 which is high risk for pressure injury and requires assistance with bed mobility. Recommendations included pressure relief/off loading to include facility pressure ulcer prevention protocol, pressure redistribution mattress, heel offloading and turn and reposition per facility protocol. Other orders included incontinence care and optimize nutrition. An Integrated Wound Care note dated 4/4/25, included R7 is incontinent of urine and bowel and her mobility is limited by her body habitus, weakness and recent surgery to repair a fracture of the right tibia. Her Braden score is 12 which is high risk for pressure injury. New wound was noted on this visit which is an unstageable pressure ulcer to left heel. Treatment orders were placed. Plan of care was discussed with	2 900			

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2 900	Continued From page 66 facility staff and the patient. Heel unstageable ulcer was 100% eschar (hardened, dry, black or brown crust caused by dead tissue) and measured 1.5 x 0.7 x 0 centimeter (cm). Treatment recommendation included paint pressure ulcer on heel with Betadine (antiseptic medicine use to treat skin infections) every day. Wound evaluation dated 4/16/25, included abrasion measuring 4.5 cm x 1.7 cm., new wound, in house acquired. Granulation (indicates wound healing) 100% of wound with light serous (serum, the clear watery part of liquid in the body) exudate (body fluid) present. Foam dressing applied. An Integrated Wound Care note dated 4/23/25 included unstageable pressure ulcer left heel was 1.3 x 0.9 x 0 cm with 100% eschar present. Progress improving. No drainage present. Pressure ulcer left gluteus (group of muscles that make up area commonly known as the buttocks) - stage 3 (wound that affects the top two layers of skin, as well as fatty tissues) measured 0.8 x 0.5 x 0.1 cm with scant serosanguinous (serous fluid and blood) drainage. 30% granulation with 70% slough (dead tissue yellow or white appearance) present. Periwound (skin around the wound) is fragile. Wound treatment to left heel included cleanse wound and surrounding area with saline. Do not dry the wound surface. Spread Iodosorb (substance that helps clean and heel wounds) in 1/8-1/4" thickness over wound bed and cover with super absorbent pad. Change three times a week and as needed. Plan is to address factors affecting wound healing include incontinence care as needed, turn and reposition, offload pressure per facility protocol, air mattress and heel offloading.	2 900			

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2 900	Continued From page 67 On interview and observation 4/22/25 at 8:09 a.m., R7 was lying on her back in her bed with head of bed at 20 degrees. R7 stated she got back from the hospital yesterday and has been having problems with abdominal pain and loose stools. R7 stated her Foley catheter was removed over a month ago. R7 stated she does have some wounds on her bottom and one on her heel. R7 stated she has one wound on her bottom since she came in that she has had off and on for a long time. The other wound on her bottom is new as is the heel wound in the past month. R7 stated she isn't able to move or position herself in the bed and requires assistance to reposition. R7 stated prior to her going to the hospital she was getting up in her chair at least once a day. R7 had a heel protector on her left leg. On interview 4/23/25 at 10:30 a.m., nurse practitioner (NP)-K stated R7 has been at high risk for pressure ulcer development since she started seeing her at the facility in March 2025. NP-K stated it was hard to determine if the 2 new pressure ulcers were preventable or not. NP-K added she does wound rounds weekly and R7 is always laying on her back which is concerning. NP-K stated R7 requires assistance to reposition and is not able to turn herself. NP-K stated she made recommendations to the facility to have her on a repositioning program at least every 2 hours and to keep her off her back and has educated the resident of this also. NP-K added she had seen on past visits the staff were placing a pillow under R7's lower legs in attempt to float her heels but the heels were often times resting on the pillow. NP-K added she recommended heel protector boots for both of her heels after her left heel ulcer was discovered.	2 900			

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2 900	Continued From page 68 On observation and interview 4/23/25 at 10:35 a.m., NP-K, registered nurse (RN)-G, also identified as assistant director of nursing (ADON), and nursing assistant (NA)-A entered the room to complete wound evaluation, care and treatment. See above 4/23/25 Integrated Wound note above for wound descriptions. NP-K educated R7 and all staff in the room on importance of offloading and staying off her back. Also recommended heel protector for the right heel as one wasn't present and the heel was resting on a pillow. R7 did have a heel protector on her left heel. Continuous observation started on 4/23/25 at 10:38 a.m. for R7: 10:38 a.m., NA-A positioned R7 on her left side using a pillow. 10:56 a.m., no change in position. R7 is dozing off and on. 11:08 a.m., no change in position. 11:26 a.m., no change in position. No staff into her room. 11:45 a.m., no change in position. 12:07 p.m., no change in position. No staff into her room. 12:19 p.m., no change in position. 12:29 p.m., NA-A into room with lunch tray. NA-A raised the head of the bed but did not reposition R7. Pillow remains tucked behind R7 positioned slightly on her left side. 12:33 p.m., P7 is awake and eating lunch. R7 states she has not been repositioned since after the wound care this morning. 12:55 p.m., remains in the same position and continues to eat her lunch. 1:06 p.m., no change in position and R7 continues to eat her lunch. NA-A went into room but did not reposition R7 and said she would come back in a bit to get her tray. 1:09 p.m., NA-A into room with trash bags. Did	2 900			

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2 900	Continued From page 69 not reposition R7. 1:26 p.m., R7 remains in the same position. NA-A indicated when she took R7's lunch tray into the room she pulled the pillow down slightly behind R7's back but did not reposition her. NA-A indicated R7 should be repositioned every 2 hours per the plan of care. NA-A entered the room and checked to ensure R7's pad was dry and repositioned R7 on her opposite side with pillow placed behind her back. NA-A lowered the head of the bed to approximately 20 degrees. R7 did have heel protector on her left heel, but right heel was resting on the bed with no pillow or heel protector present. NA-A stated she used the pillow under R7's right heel to use behind her back for positioning. Another pillow was present on a chair in the room but did not have a pillow case on it. On interview 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-A stated R7 should be repositioned every 2-3 hours. On interview 4/23/25 at 2:22 p.m., licensed practical nurse (LPN)-B indicated R7 has a plan of care to reposition every 2 hours. LPN-B stated they were getting R7 up once a day but since she returned from the hospital, they don't have order to get her out of bed. LPN-B stated it takes 2 staff to turn R7, which has not changed since her admission in February. On interview 4/23/25 at 2:24 p.m., LPN-A indicated R7 should be repositioned every 2 hours and believes that is part of her plan of care. LPN-A stated R7 came in with one wound on her coccyx area but the heel and other coccyx area is new since being at the facility. LPN-A stated R7 requires assist of 2 to reposition.	2 900			

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2 900	Continued From page 70 On interview 4/24/25 at 9:50 a.m., NA-I stated R7 should be repositioned every 2 hours. NA-I stated R7 is cooperative with repositioning and requires assist of 1 to complete. On interview 4/24/25 at 9:03 a.m., the director of nursing (DON) confirmed there was no plan of care related to prevention of skin breakdown and would expect if R7 has a pressure ulcer injury, repositioning should occur ever 1-2 hours unless the resident refuses. The DON stated if a resident refuses it should be care planned that the risks and benefits were explained. The DON confirmed R7 should have a heel protectors on both feet. Facility Prevention of Pressure Injuries policy dated 9/29/21, included: - Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. -Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident ' s risk factors, and prior to discharge. 2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; and	2 900			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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2 900	Continued From page 71 c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. - Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident 's risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of	2 900			

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2 900	Continued From page 72 pressure ulcers. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of those audits could be brought to the facility's quality assurance performance improvement (QAPI) committee for review to determine compliance or the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube care for 1 of 1 resident (R22) reviewed for tube feeding.	2 930	Corrected	5/30/25	

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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2 930	Continued From page 73 Findings include: R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction (stroke), quadriplegia, essential hypertension, moderate protein-calorie malnutrition, and seizure disorders. R22's Clinical orders printed 4/23/25, indicated Jevity 1.5 feeding at 65 milliliters (ml) per hour for 22 hours daily. R22's care plan dated 10/25/24, indicated R22 required a tube feeding and was NPO (nothing per mouth). Care plan indicated R22 will be free of aspiration through the review date and maintain adequate nutritional and hydration status. R22's care plan indicated R22's head of bed (HOB) needed to be elevated 45 degrees during and thirty minutes after tube feeding. R22's medical record indicated three hospitalizations within the last 12 months. On 2/5/25, R22 was hospitalized with a diagnosis of influenza A, pneumonia and sepsis. On 12/12/ 24, R22 was hospitalized with a diagnosis of acquired community pneumonia. On 10/12/24, R22 was hospitalized with a diagnosis of sepsis of unknown source with suspected pulmonary versus oropharyngeal source. During observation on 4/21/25, at 4:10 p.m., R22 was laying in bed in supine position and the head of the bed was not elevated. A tube feeding pump was infusing Jevity 1.5 at 65 ml per hour.	2 930			

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2 930	Continued From page 74 During interview on 4/21/25 at 4:13 p.m., NA-D entered R22's room and stated "the bed is flat, and it shouldn't be flat. The HOB should be elevated at least 30 degrees. We don't want him to aspirate." NA-D approached and elevated R22's HOB to about 45 degrees. During interview on 4/23/25 at 2:04 p.m., licensed practical nurse (LPN)-C stated R22's HOB should be elevated at least 30 degrees during TF infusion to prevent aspiration. During interview on 4/23/25 at 3:05 p.m., director of nursing (DON) stated the HOB of a resident receiving a tube feeding infusion had to be up at least 30 degrees to prevent aspiration. Facility Safety Precautions Enteral Feedings policy dated 4/24/25, indicated "Always elevate the head of the bed (HOB) at least 30° - 45° during tube feeding and at least 1 hour after." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and to ensure the safe administration of enteral nutrition according to professional standards of practice. Nursing staff could be educated as necessary to the importance of safe administration of enteral feeding to avoid complications and/or infections. The DON or designee could audit nursing staff assigned to residents effected and take that information to the quality assurance performance improvement(QAPI) to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930			

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2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide water, consistent with the resident needs and preferences, and sufficient to maintain hydration for 1 of 1 resident (R31) reviewed for hydration. In addition, 2 of 2 resident (R18 and R33) voiced concern of not receiving clean water mugs. Findings include: R31's face sheet received on 4/24/25, included diagnoses of left below the knee amputation, diabetes, and protein calorie malnutrition. R31's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R31 was cognitively intact, had clear speech, could understand and be understood. R31 was independent in her ability to transfer from bed to wheelchair and to self-propel her wheelchair. R31's physician order dated 1/7/25, indicated consistent carbohydrate diet regular texture, thin liquids consistency. R31's care plan dated 4/26/23, indicated the facility would encourage good nutrition and hydration in order to promote healthier skin. R31's care plan with revised date of 1/7/25, indicated R31's preferences would be considered when providing care.	2 940	Corrected		5/30/25

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2 940	Continued From page 76 During an interview and observation on 4/22/25 at 8:47 a.m., no water mug or cup was visible in R31's room. R31 stated staff did not provide fresh water, that she had to get it herself. R31 stated she knew she should drink water throughout the day. Further, R31 stated they no longer had access to ice for their water, stating the facility just removed the ice machines. During an observation on 4/23/25 at 12:45 p.m., there was no water mug/cup visible in R31's room. Observations and interviews in the same hallway included: --R18: quarterly MDS assessment dated 2/9/25, indicated intact cognition, clear speech, could understand and be understood. Was independent with mobility via wheelchair. R18 stated he replenished his water mug with water from his bathroom sink; no one brought him fresh water. In addition, R18 stated he never received a clean water mug; he reused the same one. --R33: quarterly MDS assessment dated 1/27/25, indicated intact cognition, clear speech, could understand and be understood. R33 was independent with ambulation. R33 stated no one brought him fresh water - he refilled his cup himself. In addition, R33 stated he never received a clean water mug; he reused the same one. During observations on 4/21/25 through 4/23/25, while on second floor, did not observe staff pass water to resident rooms. During an interview on 4/23/25 at 1:11 p.m., dietary manager (DM)-J stated kitchen staff had nothing to do with water pass for residents, other than supplying the mugs. DM-J was not aware of	2 940			

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2 940	Continued From page 77 a process to ensure residents received received a clean water mug and fresh water daily. During an interview on 4/23/25 at 1:14 p.m., licensed practical nurse (LPN)-C stated she had never seen nursing assistants (NA's) formally pass water to residents; had only seen staff refill a residents cup if requested. LPN-C stated there used to be pitchers of ice water near the nurses station for nurses to use to fill water for residents, but it was removed this week - she did not know why. LPN-C stated she did not know how residents were supposed to get fresh water now. During an interview on 4/23/25 at 3:10 p.m., (NA)-A stated most of the residents on this floor (2nd floor) were independent and could get their own water; that staff did not go around with a cart and provide fresh water. NA-A stated there used to be a pitcher of water for residents to access but now that was gone. NA-A stated she did not know how residents were supposed to get fresh water now. During an interview on 4/24/25 at 10:46 a.m., assistant director of nursing (ADON), who's office was on the second floor, stated NA's were supposed to pass water on the day and evening shifts, was aware it was not happening consistently, but did not know why. During an interview on 4/24/25 at 12:50 p.m., the director of nursing stated she expected staff to pass water daily and provide residents with a clean mug daily. Facility Bedside Water Containers policy dated 4/23/25, indicated the facility would provide residents with fresh drinking water at their bedside daily. The night shift would be	2 940			

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2 965	Continued From page 79 review, the facility failed to ensure identified preferences for menu selection were honored for 1 of 1 resident (R16) reviewed for choices. Findings include: R16's 5-day Minimum Data Set (MDS assessment dated 2/15/25, indicated R16 had intact cognition with no behaviors and diagnoses included end stage renal disease, dependence on renal dialysis, diabetes, paroxysmal atrial fibrillation, and essential hypertension. R16 was independent with eating, required substantial assistance from staff for toileting, lower body dressing and transfers, and required moderate assistance for bed mobility. R16's Order Summary Report printed 4/23/25, indicated an order for renal diet, regular texture and thin liquids. Progress note dated 3/18/25, authored by registered dietician (RD) indicated "resident states that he has no questions or concerns regarding nutrition with the exception that he would like larger portion sizes ... Dietician provided education regarding weights and encouraged him to continue with regular portions, but resident was adamant that he wanted larger portions, Dietician notified manager of a preference for larger portions." Progress note dated 4/17/25, authored by RD indicated "RD spoke with dialysis RD who spoke with this resident [R16] regarding his diet and nutritional concerns. Resident and dialysis RD discussed switching to a regular diet, and both agreed this is acceptable. Dialysis RD states all labs look good with the exception of phosphorus, but that is d/t [due to] resident running out of	2 965			

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2 965	Continued From page 80 Tums per his statement. Resident is able to return back to a renal diet at his request. DON and NP notified of resident diet order change to a regular diet." During an interview on 4/21/25 at 3:44 p.m., R16 stated he got white rice twice a day and he had requested multiple times to stop giving him rice with every meal. R16 stated "I don't eat the rice." R16 added he was not supposed to have bananas or milk which he received three times day. R16 stated he had never talked to the facility's RD. During observation and interview on 4/22/25 at 12:53 p.m., R16 was eating lunch, and his tray had a piece of ham, white rice, steam vegetables, a piece of cake, and apple juice. R16's meal card indicated renal diet, assorted juices (cran, apple or grape juice), regular protein-smaller portions, no potato, steamed rice, seasonal vegetables, strawberries and decaf coffee with creamer. R16 stated he was supposed to get strawberries but instead they gave a piece of cake rich in sugar. R16 added "last night they gave me white rice, and milk." During interview on 4/22/25 at 1:44 p.m., licensed practical nurse (LPN)-C stated for two days R16 received mashed potatoes and today he got rice. LPN-C stated for weeks R16 had complained about receiving rice white, he never eats the rice. LPN-C stated R16 told her for months he had complained and talked to the dietary staff about the rice and his diet. LPN-C stated during a RD's visit to the facility, she informed RD about R16's request to visit with him. LPN-C stated later that day, R16 told her RD never talked to him. LPN-C suggested to R16 to talk to the dialysis dietitian to discuss his concerns.	2 965			

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2 965	Continued From page 81 During interview on 4/23/25 at 1:01 p.m., RD stated the dietary manager stated the last dietary manager had a paper version of residents' food likes and dislikes, but he wasn't sure what the current dietary manager used. RD stated he met the resident in February 2025, and he didn't recall talking to R16 about his dislike for rice. RD stated on 4/17/25, the dialysis dietician contacted him and agreed to change R16's diet to a regular diet. During interview on 4/23/25 at 2:20 p.m., dietary manager (DM) stated she looked at all the trays returned to the kitchen and if residents didn't eat their meals, she talked to the residents to find out if they were not hungry, maybe they were sick, or didn't like the food. DM stated the resident's likes and dislikes were added to the residents' meal cards. DM stated she didn't recall talking to R16 or hearing bout his dislike of rice. R16's meal card dated 4/22/25, still indicated Renal diet and white rice. DM stated today she received an order, and she updated R16's meal card indicating a regular diet, double portions and no rice. During interview on 4/24/25 at 2:59 p.m., director of nursing (DON) stated we need to offer choices. DON stated she talked to the floor staff and dietary department to offer him (R16) choices. Not following R16's choices is a dignity and respect issue. We need to change his diet, document risk and benefits and educate the resident about his food choices. Facility Resident Food Preferences policy dated 12/9/21, indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The policy also indicated, if the resident refuses or is unhappy	2 965			

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2 965	Continued From page 82 with his diet, the staff will create a care plan that the resident is satisfied with. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or registered dietitian could review and revise policies and procedures related to implementation of dietary recommendations and educate staff. The DON or designee, could conduct audits to ensure compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965			
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to employ either a full-time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service, which had the potential to affect 44 of 44 residents who received food	2 980	Corrected		5/30/25

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2 980	Continued From page 83 from the kitchen. Findings include: During interview on 4/21/25 at 2:39 p.m., the dietary manager (DM) stated she had a food safety certification and an MDH certification, but did not have her qualifications on hand. During interview on 4/22/25 at 12:16 p.m., DM stated, the administrator told DM to bring her certifications in on Thursday, 4/24/25. DM stated the registered dietician (RD)-I worked every day. During interview on 4/23/25 at 7:53 a.m., RD-I stated he was the dietician for the facility, was contracted, and had been with the facility for 5 or 6 years and worked on Mondays. When asked about RD-I's FTE status, RD-I stated he had to look at his hours report and stated he worked 10 to 12 hours per week and again stated he usually only came in on Mondays. During interview on 4/23/25 at 2:38 p.m., DM came into the kitchen and stated the internet was poor and the HR director instructed her to email her qualifications and he would provide the qualifications to the surveyor. DM could not show or verify her certifications and qualifications and stated she tried to pull the certification up on her phone but the internet was bad. During interview on 4/23/25 at 2:18 p.m., human resources (HR)-C stated his role consisted of interviewing new staff, conducting background checks, and verifying licenses. HR-C stated personnel files were kept in his office and he tries to digitize them. HR-C further stated he had worked at the facility about a month and stated there were problems with employee files being	2 980			

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2 980	Continued From page 84 incomplete and stated DM's personnel file was incomplete and stated DM had certifications and licenses but HR-C did not have them and expected DM's file be in the HR department. HR-C further stated did not know what DM's certifications were, and stated DM was a director or manager for a previous facility. HR-C verified there was nothing in smart links and verified DM did not have an employee file. During interview on 4/23/25 at 3:57 p.m., DM stated she had a food safety certificate, but did not have a certified dietary manager certificate. DM stated she was not a certified food service manager, but stated it is part of her course. DM stated she had a food safety certification from another nursing facility she worked at for 15 years. DM further stated she did not have an associate's degree or higher, was a manager at a facility for 15 years and stated she consulted with the dietician every day. DM did not provide any evidence of her certifications and qualifications. During interview on 4/23/25 at 4:03 p.m., the administrator stated a CDM was a certified dietary manager and added they had a certified dietician that superceded the CDM and verified their dietician was not full time. The administrator stated she knew the DM was a CDM and stated their dietician was a consultant. DM's personnel file was requested and the administrator stated HR-C noticed a lot of employees were without personnel files. A policy was requested for the dietician and dietary manager qualifications and verification of the dietician's qualifications or certifications. An unsigned and dated job description, Certified Dietary Director, indicated the purpose of the position was to plan, organize, develop and direct	2 980			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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2 980	Continued From page 85 the operations of the food and nutrition services department in accordance with current federal, state and local standards. the job description further identified requirements for the position included: preferred, as a minimum, a bachelor's degree in nutrition, dietary management or related field from an accredited college or university, must be a certified dietary manager or comparable certification in the state. The facility provided the dietary manager's (DM) resume on 4/24/25, at 11:04 a.m., that indicated DM was a kitchen manager from February 2019, to October 2023, at a senior living, and identified the following responsibilities: cooked, ordered food, cleaned the kitchen, and completed staff training and prep. Under a heading, Certifications and Licenses, indicated DM had ServSafe from June 2012 to present, was a Certified Dietary Manager from February 2018 to February 2028, had Food Handler Certification from September 2019 to present. Evidence of DM's qualifications including certifications was requested, on 4/24/25 at 12:59 p.m., however no additional information was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The administrator or designee could educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980			

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21090	Continued From page 86	21090	Corrected		5/30/25
21090	MN Rule 4658.0650 Subp. 3 Food Supplies; Food Containers Subp. 3. Food containers. Food, whether raw or prepared, if removed from the container or package in which it was obtained, must be stored in a clean, covered container. The container need not be covered during necessary periods of preparation or service. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen food items were labeled and dated, scoops were not stored in the dry bins, opened foods were properly wrapped or stored, outside food containers were cleaned. . In addition the facility failed to ensure resident meals brought from outside were labeled and dated in the 1 of 1 kitchenettes. This had the potential to affect all residents who consumed food from the kitchen. Findings include: See also F925 related to pest control. During the tour of the kitchen on 4/21/25 from 2:01 p.m., to 2:15 p.m., with the dietary manager (DM), observed the following: The kitchen refrigerator: A sponge cake that was opened, unlabeled and undated and the DM asked to have it labeled. A container of dried milk dated 1/11, DM verified was dated 1/11 and stated dried milk was good for a week and it wasn't kept because it could grow yeast inside the bag. The kitchen freezer:	21090			

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21090	Continued From page 87 1 box containing gluten free pasta shells was stored on the floor and packages of vegetables were located on top of the box and DM stated the box should not be stored on the floor. At 2:12 p.m., DM picked up the box and placed it on the shelf. 3 packages of waffles with 10 in each package were undated and without a label. 1 of the bags was opened. 1 opened bag of egg omelets that was undated and unlabeled. 1 more package of waffles was stored on another shelf and the DM stated they were bad and instructed staff to throw them out the previous week and stated they would go in the garbage. 1 bag of opened chicken sitting in a box. The DM stated the chicken bag should have been closed. 1 bag of chicken strips that were unlabeled and undated. Dry Storage: One 3.79 liter jug of molasses opened 10/9/23, had a brown substance on the outside of the jug. DM stated it was molasses and staff just didn't wipe it down and stated it should have been discarded. One 138 ounce jar of salsa that the DM stated contained dried salsa on the outside of the jar. DM verified the lid was not secured tightly. Five 16 ounce opened bags of Tostitos tortilla chips not tied closed. The DM stated the chips should be wrapped in plastic and took the bags off the shelf. A dry bin marked, "Sugar" contained two scoops in the bin. DM stated scoops should not be stored in the sugar. Additionally, the top of the lids of the sugar and flour contained flour and sugar on each and DM instructed kitchen staff to wipe down the lids and stated it was important to wipe down because of germs and food debris.	21090			

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21090	Continued From page 88 During interview and observation on 4/21/25 at 2:37 p.m., the coffee machine contained debris on the under side of the machine. The DM stated it looked like coffee debris and stated it was dried up coffee and stated there was some white chunks she could not identify what it was and stated it looked like buildup from not being cleaned every day. During interview and observation on 4/21/25 at 2:44 p.m., the DM looked in the kitchenette refrigerator on the first floor that contained a salad in a Wendy's bag that was unlabeled and undated and the DM removed the item from the refrigerator. During interview on 4/22/25 at 12:16 p.m., the DM stated she would be concerned with opened food items because they have pests in the kitchen and food was supposed to be closed right away. During interview on 4/22/25 at 2:14 p.m., the administrator stated it was a known fact that improperly stored food would attract something. Additionally, the administrator stated when food is delivered, it is placed on the floor in the cooler and the team puts the food away. Facility Foods Brought by Family/Visitors, dated 12/20/21, indicated food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility prepared food. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. Facility Food Storage, dated 7/13/23, indicated	21090			

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21090	Continued From page 89 food would be stored in an area that is clean, dry and free from contaminants. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated. Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code. All foods should be covered, labeled and dated. All foods will be checked to assure that foods including leftovers will be consumed by their safe use by dates, or frozen where applicable, or discarded. All foods will be stored off the floor. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored, secured, closed, 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.	21090			

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21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R22) reviewed for EBP. In addition, facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (22) observed for personal cares. Findings include: EBP R22's quarterly Minimum Data Set (MDS) assessment dated 2/16/25, indicated R22 was severely cognitively impaired, had no behaviors and did not refuse personal cares. R22's MDS indicated diagnoses of cerebral infarction, quadriplegia, essential hypertension, and seizure disorders. R22's Clinical Profile printed 4/23/25, indicated R22 was on enhanced barrier precautions (EBP). R22's Clinical Orders report printed 4/23/25, indicated orders for care of gastrostomy tube and wound care orders for his buttocks and left great toe.	21385	Corrected	5/30/25	

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21385	Continued From page 91 R22's care plan printed 4/23/25, indicated R22 had a risk for infection related to gastrostomy tube placement and directed staff to initiate appropriate isolation precautions. During observation on 4/21/25 at 4:10 p.m., an EBP sign was taped to R22's room door directing staff to wash their hand before entering the room, and to wear gloves and gown to provide personal cares. Also, a bin was located next to the door, containing personal protection equipment (PPE). During observation on 4/22/25 at 12:38 p.m., nursing assistants (NA)-E and NA-F were giving a sponge bath and providing pericare for R22 without using gowns. During interview on 4/22/25 at 12:45 p.m., NA-E stated she had worked at facility for 8 years and today she was oriented NA-F to the facility. NA-E stated she knew R22 was on EBP, but she forgot to put on a gown because the nurse was rushing her to complete cares for other residents. NA-E stated R22 was on precautions because he had an infection on his foot and had a tube feeding. NA-E stated the staff needed to wear gowns to prevent contamination. Glove Change During observation on 4/23/25 at 9:18 a.m., NA-H and NA-G put on PPE prior entering R22's room. NA-H provided most of the personal cares and NA-G primarily assisted with turning and repositioning R22. NA-G changed her gloves after each discrete area of the body as listed was washed; R22's face, upper body, genital area, buttocks and before dressing for a total of 5 glove changes. NA-H changed his gloves once while	21385			

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21385	Continued From page 92 personal cares were given to R22. NA-H and NA-G did not wash their hands after removing each pair of dirty gloves and before putting on new gloves. During interview on 4/23/25 at 9:48 a.m., NA-H stated he needed to wash his hands before putting on clean gloves and added "I forgot." During interview on 4/23/25 at 9:51 a.m., NA-G stated, "I forgot I needed to wash my hands after removing my dirty gloves and put on clean gloves." NA-G she needed to wash her hands for infection control issues. During interview on 4/23/25 at 2 p.m., licensed practical nurse (LPN)-C stated nursing assistants needed to wear proper PPE before providing cares for any resident on EBP. LPN-C stated we (nursing staff) need to wash their hands after removing dirty gloves and before putting on clean gloves to prevent infections. There are signs of the door, directing staff to wear PPE. Failure to follow precautions represented a risk to transmit infections. During interview on 4/23/25 at 3:02 p.m., director of nursing (DON) stated there were signs on the doors and carts by the resident's doors directing staff to wear PPE to prevent spread of infections. DON stated she expected nursing staff to follow infection control measures. Facility Enhanced Barrier Precautions policy dated 10/8/22, indicated EBP were utilized to prevent the spread of multi drug-resistant organisms (MDRO) to residents. The Policy also indicated EBP were indicated for residents with wounds and/or indwelling medical device	21385			

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21385	Continued From page 93 regardless of MDRO colonization. Facility Using Gloves Personal Protective Equipment policy dated 4/24/25, indicated the objectives to use gloves were to prevent spread of infections, prevent wounds from contamination, to protect hands from potentially infectious material ... The policy directed staff to wash their hands after removing gloves. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards, use of gloves and when to use EBP are properly implemented. The DON or designee could educate all appropriate staff on the policies/procedures and could develop monitoring systems to ensure ongoing compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21385			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426			5/30/25

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21426	Continued From page 94 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing assistant (NA)-C, had a TB symptom screen upon hire, and failed to ensure residents (R22, R8) were screened for TB upon admission. Additionally, the facility failed to ensure a chest x-ray was obtained for R41 who refused to have a two step mantoux. Further, the facility failed to ensure R41's tuberculin skin test (TST) result was documented. Findings include: A form, Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health care Settings Licensed by MDH, dated 3/17/25, indicated human resources was responsible for maintaining TB screening records and residents were screened at the time of admission. The form identified a heading, TB Screening of Health Care Personnel, prompted staff to identify whether baseline TB screening of all health care personnel was performed at the time of hire as required and a "no" response	21426	Corrected		

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21426	Continued From page 95 prompted staff to contact Minnesota Department of Health (MDH) TB prevention and control program for guidance. NA-C's provided TB documents lacked information NA-C was screened for TB. The facility provided NA-C's chest x-ray which lacked information a TB screen was completed. During interview on 4/23/25 at 2:27 p.m., the human resources director (HRD)-C stated NA-C had a chest x-ray, but did not have a TB symptom screen and was also one of the employees who did not have a personnel file and verified the chest x ray form lacked information a TB screen was completed and added normally the symptom screen form is attached with a two step mantoux and not on a chest x-ray form. R22: R22's immunization form indicated a two step mantoux was administered on 8/8/24, and 8/22/24 and both were negative. R22's medical record was reviewed and lacked information a TB screen was completed. R8: R8's immunization form indicated a two step mantoux was administered on 4/4/23, and 4/19/23, and both were negative. R8's medical record was reviewed and lacked information a TB screen was completed. R1: R1's progress notes dated 8/14/24, indicated R1	21426			

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21426	Continued From page 96 refused the tuberculin injection. R1's progress notes dated 8/16/24, indicated R1 refused the tuberculin injection. R1's progress notes dated 8/28/24 at 8:41 p.m., indicated the tuberculin injection was not available. R1's progress notes dated 8/30/24 at 8:34 p.m., indicated R1 refused the tuberculin test when first admitted and there was no test to read. No other documentation regarding follow up on refusals and further intervention was documented. R1's immunizations form was reviewed and lacked evidence a tuberculin test was ever administered. R41: R41's physician orders dated 1/3/25, indicated tuberculin PPD 5 unit per 0.1 milliliter (ML) inject 0.1 ml intradermally. R41's physician orders dated 1/5/25, directed staff to read R41's TST and record the results under the immunization tab in the electronic medical record (electronic medical record). R41's medication administration record (MAR) and treatment administration record (TAR) dated January 2025, indicated R41 received a TST on 1/3/25. Further, on 1/5/25, the TST was documented on the MAR and TAR the TST was read, but did not indicate whether the TST was negative, or positive. R41's immunization form was reviewed in the EMR and lacked information regarding the results	21426			

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21426	Continued From page 97 of R41's TST. R41's progress notes were reviewed and lacked information of the results of the TST. During interview on 4/23/25 at 1:04 p.m., the assistant director of nurse (ADON) and Director of Nursing (DON) stated staff were screened for TB upon hire and residents were screened for TB upon admission. Further the tuberculin skin test (TST) was documented under immunizations or in the nursing notes and if a resident could not have a TST or refused, staff would obtain an order to complete a chest x-ray or when completing baseline labs a quantiferon and would document if a resident refused and the reasoning in a progress note. The ADON viewed R1's medication administration record and could not locate a TST was completed and the DON directed the ADON to check under the miscellaneous tab to see if a chest x ray was completed. The DON verified R1 did not have an x ray in the chart. The ADON viewed R41's chart and verified the results of the TST was not identified on the MAR and TAR and further did not locate documentation of the results of the TST and verified results were supposed to be documented in the immunization form, but were not. The ADON viewed R22 and R8's EMR and verified there was no TB symptom screen completed. The ADON stated TB screenings were important in order to prevent outbreaks of TB and was important to obtain a chest x-ray because they still needed to rule out the possibility of TB. During interview on 4/24/25 at 10:45 a.m., the DON stated she had not had time to look for an x-ray for R1, and expected symptoms screens be completed within 24 hours.	21426			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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21426	Continued From page 98 The administrator sent an email on 4/24/25 at 10:54 a.m., that indicated TB was documented in the immunization tab and if a resident refused a chest x-ray would request a blood draw and refusals would also be documented in the immunization tab. Facility Tuberculosis, Screening Residents policy dated 10/4/21, indicated all residents would be screened for tuberculosis infection and disease (TB). The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB. If the IGRA or TST is positive, the nursing staff will contact the physician to obtain orders for a chest x-ray and the physician will assess the resident prior to admission for possible active TB. The policy lacked information regarding recording results of the TST. Facility Tuberculosis, Employee Screening policy dated 5/1/24, indicated all employees were screened for latent TB infection and active TB disease using a tuberculin skin test or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis policies and procedures to ensure compliance. The director of nursing (DON) or designee could review the assessment process for residents and staff to be sure the documentation of the TB tests are completed per guidelines. The DON or designee could audit for screening and TB testing for residents and staff. The results of these audits could be reviewed by the quality assurance committee to ensure compliance.	21426			

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21426	Continued From page 99	21426	Corrected		5/30/25
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe storage of medications when over the counter stock medications were left unlocked and unattended in an office. Findings include: On observation and interview on 4/21/25 at 3:31 p.m., through an open door, observed bottles/containers of over the counter (OTC) medications spread out on a table in an office located at the end of 1 West wing, a resident hallway. At the end of the hallway by the office was a vending machine for soda pop and snacks for staff and residents. There was no exit or entry located in this area. Medications included vitamins, acetaminophen, probiotics, lidocaine patches and ibuprofen. Some medications were still in boxes, and some were unpackaged and on the table. Medical Records Director (MRD)-O was present in the room and stated she was also central supply and ordered supplies including OTC medications. MRD-O stated she was in the process of unpacking the medications to refill the				

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21610	Continued From page 100 medication closet on the nursing unit. MRD-O stated she locked the door when she left her office. On observation 4/21/25 at 6:30 p.m., the MRD office door was open and MRD-O was not in the office. At 6:34 p.m., MRD-O returned to her office and said she left it open as she just had to run to the second floor and wasn't gone long. On observation and interview on 4/22/25 at 12:37 p.m., MRD office door was closed, but not locked. At 2:23 p.m., MRD-O office door remained closed but unlocked. At 3:23 p.m., MRD office door was closed but remained unlocked. At 3:26 p.m., MRD-O returned to her office and opened the door without a key. MRD-O stated she was on a unit that was close by, so she did not lock the door. During an observation and interview on 4/22/25 at 3:24 p.m., during a tour with the administrator, the MRD office door was open. The OTC medications were still on the table and unattended. The administrator confirmed this was a potential safety issue and the medication should not be left unattended. On observation and interview 4/24/25 at 11:02 a.m., a tour of the 2nd floor medication room (only medication room in the building) was completed with licensed practical nurse (LPN)-C. Multiple boxes of tube feeding solutions were present on the counter and multiple other non-medication supplies were stored on the shelves and counters. LPN-C stated they don't have a lot of room to store anything else in the medication room. On interview 4/24/25 at 12:03 p.m., the director of	21610			

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21610	Continued From page 101 nursing (DON) stated medications should not be stored in a room that is not locked including over the counter stock medications. The DON stated she would expect MRD-O to lock the door when leaving with medications present even if she is gone for a short time. A policy on medication storage was requested and none received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Staff could be educated as necessary to the importance of medication storage and securing of medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610			
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21665	Corrected		5/30/25

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21665	Continued From page 102 review, the facility was unaware of and failed to comprehensively assess a resident for safe vaping practices for 1 of 1 resident (R37) reviewed for accidents. Findings include: R37's face sheet received on 4/24/25, included diagnoses of malignant cancer of the bladder, chronic pain due to cancer, anxiety, and insomnia. R37's quarterly Minimum Data Set (MDS) assessment dated 2/26/25, indicated R37 had moderately impaired cognition, clear speech, could understand and be understood. R37 was dependent on staff for some activities of daily living and could walk short distances with the aid of a walker. R37 had pain almost constantly which interfered with sleep and day to day activities. R37's physician orders did not indicate use of medical marijuana or vaping THC (tetrahydrocannabinol). R37's care plan did not indicate use of medical marijuana or vaping THC. Smoking assessments dated 8/21/24, 11/25/24, and 2/24/25, indicated R37 was a non-smoker. Vaping was listed as an option on the electronic assessment tool but had not been checked. Consequently, an assessment for safe vaping had not been conducted. During an interview on 4/23/25 at 11:05 a.m., with R37 and family member (FM)-L, while lying in bed, R37 started vaping with a pen; smoking coming out of his mouth as he exhaled. R37	21665			

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21665	Continued From page 103 stated it was weed (marijuana). FM-L stated R37 was on a cannabis program and had a medical marijuana card. FM-L brought the supplies to the facility and R37 stated he vaped multiple times daily. During an interview on 4/23/25 at 4:26 p.m., the director of nursing (DON) and assistant director of nursing (ADON) stated they were not aware of any residents who vaped. The DON stated she knew R37 had a medical marijuana card due to cancer pain. The DON stated, "We all knew he was using it" (marijuana) but did not know how he ingested it. The DON stated when R37 was admitted (in August 2024), he was given a locked box to store his marijuana supplies, but she never looked at the supplies nor asked how he planned to ingest it. The DON stated she was instructed not to put marijuana use on R37's care plan, and stated the facility did not do anything with the marijuana or supplies -- it was up to the resident and family to manage it. Nursing progress note dated 4/23/25 at 4:50 p.m., was written as follows by the DON: Writer was informed that resident was vaping medical cannabis in his bed while talking with a surveyor. Resident was admitted with a medical cannabis card and the terms of use were initially explained. Writer approached resident after learning about resident vaping in his bed and asked to speak with him about facility medical cannabis policy. Writer explained to resident that he is not allowed to vape the cannabis within the facility or on facility grounds. Writer encouraged resident to use manual wheelchair and leave facility property if he feels like he needs to use the medication. Resident voiced understanding and stated he would not use the cannabis within the facility nor on facility grounds. Writer left resident with facility	21665			

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21665	Continued From page 104 policy. In an email request on 4/23/25, at 7:38 p.m., the DON was asked if R37's provider was aware of R37 vaping marijuana, and if so, provide that documentation. Documentation was not received. During an interview on 4/24/25 at 12:16 p.m., the DON stated she talked to R37 late yesterday afternoon (4/23/25), about the facility policy on vaping. In addition, the DON informed R37's provider last night via email of R37's marijuana use and did not know if the provider was aware. The DON stated, we won't know if R37 continued to vape in his room, stating we are hands off; the supplies are in his locked box. The DON stated the facility would have to monitor R37 for vaping in his room. A note in R37's electronic medical record indicated the facility should have been aware R37 was vaping THC in his room. The note was documented by physician assistant certified (PA-C)-M and indicated date of service of 4/17/25, and included R37 had a primary hospice diagnosis of malignant neoplasm of the bladder with metastases. Within this note were three other dates: --10/17/24, indicated R37 seemed to be heavily under the influence of THC and was holding his vape pen in his hand and noted to be quite comfortable. --11/7/24, indicated R37 was resting, and FM-L via telephone stated it [vaping THC] helped relieve R37's anxiety and gave him a break from everything. "It helps a lot with his pain, too." --12/4/24, indicated R37's THC continued to help. Facility Medical Cannabis policy dated 7/28/23, indicated:	21665			

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21665	Continued From page 105 1. The resident's physician must support the resident's use of medical cannabis. 2. The resident and/or the resident's representative must provide documentation of confirmation that the resident is on the State Medical Cannabis Patient Registry. 3. Confirmation of the resident's certified qualifying medical condition. 4. Confirmation that any individual who intended to assist the resident with administration of the medical cannabis was identified as a Registered Designated Caregiver. 5. If the resident's supply of medical cannabis was to be stored within the facility, it must be stored in a locked secured storage. The facility would provide the resident with a lockable container and secure it within the room if requested. 6. If the resident intended to administer the medical cannabis independently, the resident would be assessed for safe self-administration of medication by the interdisciplinary team. This assessment would be maintained within the resident's medical record. 7. Vaporizing medical cannabis or smoking dried cannabis flower was not allowed within the facility or on facility grounds. Only liquid (oral suspensions, tincture, sublingual spray), pills/capsules, or topicals (balms or oils), or gummies or chews were permitted. 8. Documentation - The use of medical cannabis would not be documented in the resident's medication administration record. However, the resident's plan of care would be updated to reflect that he/she was authorized to use medical cannabis and had been educated on and met the facility's restriction for use of medical cannabis as outlined by this policy. Facility Residents Smoking Policy with reviewed	21665			

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21665	Continued From page 106 date of 1/20/22, indicated: Prior to, and upon admission, residents would be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking was only permitted in designated resident smoking areas, which were located outside of the building. Electronic cigarettes would be permitted outside in designated areas only. Otherwise, smoking was not allowed inside the facility under any circumstances. The resident would be evaluated on admission to determine if he or she was a smoker or non-smoker. If a smoker, the evaluation would include method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); ability to smoke safely with or without supervision (per a completed Smoking Observation). The staff would consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely would be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) would be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues . SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review policies and procedures for comprehensive resident assessment of safe vaping practices. The DON or designee could educate staff on policy and procedures and conduct monitoring for compliance. The facility could report those findings to the quality	21665			

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21665	Continued From page 107 assurance performance improvement (QAPI) committee for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665			
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to implement interventions to maintain an effective pest control program to eliminate mice in the facility. This had the potential to affect 47 of 47 residents who resided at the facility. Findings include: See also F812 related to food storage. A Paffy's pest control inspection report dated 4/22/25 at 2:45 p.m., indicated the facility staff reported seeing mice activity with droppings in the kitchen, but no rodents were found. Additionally, the facility provided the following inspection reports:	21730	Corrected		5/30/25

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21730	Continued From page 108 1/9/25, a comment indicated nothing was entered on the pest log. 1/23/25, a comment indicated nothing had been entered on the pest log, however the kitchen had seen activity and exterior bait stations had varying degrees of activity. 2/7/25, a comment indicated the logbook was checked and nothing was added to the logbook, minor activity was found in the kitchen. 2/20/25, a comment indicated nothing was added to the logbook and minor activity was found in the kitchen. 3/6/25, a comment indicated nothing new was entered to the logbook, however kitchen staff reported seeing a mouse run into a wall void and light activity was found upon an exterior inspection. 3/20/25, a comment indicated nothing was entered to the logbook and no activity was found in the facility. 4/3/25, a comment indicated in unit 210 activity was not found other than old green mouse droppings. The kitchen was inspected, and kitchen staff reported seeing a mouse run under the steam table 2 days prior and RTU was moved near the back door since they opened that door a lot. 4/17/25, a comment indicated no issues were reported and moderate activity was identified on an exterior inspection on the east side and light activity was identified on a bait station across from staff's office. A report log provided by the facility, Pest Sighting Report Facility Deficiency Report indicated mice sightings in various locations in the facility on 3/12/24, 3/21/24, 4/19/24, 4/24/24, 5/3/24, 5/9/24, 5/15/24, 6/3/24, 6/11/24, 6/13/24, 6/17/24, 6/16/24, 6/20/24, 6/22/24, 6/23/24, 6/24/25, 7/23/24, 7/29/24, 8/5/24, 8/11/24, 8/13/24,	21730			

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21730	Continued From page 109 8/14/24, 8/19/24, 8/20/24, 9/3/24, 9/9/24, 9/10/24, 9/17/24, 9/22/24, 9/23/24, 9/25/24, 10/24/24, and on 10/30/24. No other mouse sightings were logged after 10/30/24. During interview and observation 4/21/25 between 2:16 p.m., and 2:31 p.m., a Plunkett's pest trap was in the kitchen on the floor. At 2:17 p.m., on the way to the dumpster located through the door that went to the outside from the kitchen, the dietary manager (DM) was going to prop the door open and stated they propped the door open to bring the trash outside and leave the door open to come back inside. The dumpster was uncovered, and the DM stated they kept the dumpster covers opened because the nurses also disposed of trash. The dumpster contained bags in the bottom of the bin and briefs were visible in the bags. At 2:21 p.m., a Plunkett's pest trap was in the dry storage room and next to the trap were several black particles. The DM stated, "it looks like mouse turds" and further stated it would be mopped that evening. The DM further stated there were three traps in the dry storage area. DM stated she had been at the facility 5 months and had not seen mice in the kitchen. At 2:25 p.m., a 3.79-liter jug of molasses was located on the shelf in the kitchen and the DM verified there was molasses around the outside of the container and stated staff didn't wipe it down. At 2:26 p.m., a 138-ounce jar of salsa was in the dry storage that the DM verified had dried salsa on the outside of the jar and the lid had not been securely closed. At 2:28 p.m., five 16-ounce opened and unsecured bags of Tostitos tortilla chips were in the dry storage and DM stated the bags should have been wrapped in plastic and took the bags off the shelf. At 2:31 p.m., the sugar and flour storage bins contained sugar and flour on top of the lids and was verified by the DM	21730			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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21730	Continued From page 110 who instructed staff to wipe down the lids. At 2:37 p.m., the underside of the coffee machine contained brown flaky material the DM stated was dried coffee along with some white chunks the DM could not identify and stated it was a build up from not being cleaned. During observation on 4/22/25 at 7:52 a.m., the last table on the first floor towards the East hall had a whitish chalky material on the table. During observation on 4/22/25 between 7:53 a.m. and 7:56 a.m., the table on the first floor by the window and closest to the West Hall and the table across from the table by the window had crumbs on the table and on the floor next to the table. During observation on 4/22/25 at 7:59 a.m., the food cart was going towards the west hall on the first floor. During interview and observation on 4/22/25 at 8:00 a.m., housekeeping (H)-A stated tables were wiped down in the a.m., and in the afternoon before housekeeping left at 2:30 p.m. H-A stated the nursing assistants were supposed to wipe down the tables at night and stated housekeeping did not vacuum at night because housekeeping didn't work at night and observed the tables and floor and stated the crumbs were cookies on the tables and floor and wiped down the tables. During interview on 4/22/25 at 8:04 a.m., nursing assistant (NA)-I stated no residents eat in the dining area on the first floor for breakfast and stated they were just passing meal trays at this time and no residents had eaten in the dining area. During observation on 4/22/25 at 8:23 a.m., meal	21730			

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21730	Continued From page 111 trays were being passed out on the East hallway. During observation on 4/22/25 at 8:52 a.m., staff took a meal out of room 122E and did not wipe down the table. A plastic lid with a white cream substance was located on the floor in room 122E with the cream substance also on the floor. During interview and observation on 4/22/25 at 12:16 p.m., the DM stated pest control was coming today. The area around the Plunkett's trap in the dry storage area contained little black particles and stated they swept and mopped the floor last night and stated they had a pest problem and verified the particles were mouse droppings and stated food items needed to be closed and secured. The DM further stated the aides were responsible for wiping down the dining room tables and stated propping the door open can be a problem for pests and further stated the cook will open the door if it was smoky in the kitchen or hot. The dumpster outside was uncovered with several garbage bags and the DM verified it was opened and stated she thought it should be closed but stated that was maintenance's responsibility and verified the dumpster contained food items and several garbage bags. During interview on 4/22/25 at 12:59 p.m., maintenance (M)-A stated for mouse prevention they utilized mouse traps, but the mice didn't seem to want food and traveled through the registers. He further stated it would be important for food to be in containers. Mice were more prevalent in the fall and spring and the doors should not be propped open. M-A further stated the dumpster should be closed and were approximately 25 feet from the kitchen door. M-A and M-B denied seeing mice.	21730			

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21730	Continued From page 112 During interview on 4/22/25 at 1:47 p.m., licensed practical nurse (LPN)-C stated she found a dead baby mouse in a room two weeks ago and was busy and forgot to log it in the pest control book. During interview and observation on 4/22/25 at 2:06 p.m., Paffy's pest control staff (PPC)-N stated there were droppings in the kitchen, but no rodents in the traps. PPC-N stated they used mouse poison and metal traps or bait stations. PPC-N stated the mice eat the poison and they had several traps in the property and about a year prior there had been ground movement which created a huge influx of mice, and the administrator called this week due to droppings. PPC-N stated food, and warmth could attract mice and added propping doors open was the worse thing in the world and kitchens loved to leave the doors open which invited critters and stated mice lived in a 10-foot radius if they had warmth, food, and water. The door to the outside on the second floor where residents went to smoke contained a gap on the bottom and the door opened automatically to a small room with another door that went to the outside of the building. Both doors opened and closed automatically, the door to the outside did not have a gap. During interview on 4/22/25 at 2:14 p.m., the administrator stated the kitchen got hot and has directed staff to shut the door and further stated the dumpster had been uncovered since she had been at the facility and added 99% of their staff were short making it difficult to shut. The administrator stated housekeepers left at 2:30 p.m., and added that was probably why food was on the tables and floors in the a.m. and the aides were supposed to clean the tables after dinner.	21730			

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21730	Continued From page 113 The administrator stated Paffy's used to come twice a week and then went down to once a week and a few months ago went down to every other week because there was no activity and no complaints from staff or residents and stated the mice that are here were only coming out at night and added it was a known fact that anywhere food was not stored properly would attract something and stated the kitchen door should always be shut and if the door was propped open should be fast. The administrator further stated if residents kept food in the room they talked to residents and asked families to bring in sealable containers to keep goodies to avoid mice from going into rooms and stated anyone going into the rooms could monitor this. If no family, the facility would purchase them for the resident. The administrator stated she was not aware of mice sightings and stated Paffy's started coming to the facility every other week in January. During further interview on 4/22/25 on 2:15 p.m., the administrator stated if there was of an uptick in sightings of mice, the pest control agency was contacted immediately to come to the facility. A logbook was established for staff and residents to report sighting and were instructed to report each time a mouse was sighted to ensure appropriate follow up. (The last entry in this logbook was 10/30/24. The administrator was informed of a dead mouse sighting by a nurse two weeks ago and stated, "That's the first I'm hearing this." During an interview and observation on 4/22/25 at 3:24 p.m., together with the administrator, toured the facility for upkeep/maintenance. In R31's room, observed multiple candies and snacks on R31's overbed table and a loaf of bread on the dresser. These items were not in covered containers. Observed many items on the floor	21730			

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21730	Continued From page 114 around the perimeter of the room and in the closet. Across the hall in R27's room, concern was expressed for the amount of clutter on the floor and bed which could potentially attract and conceal mice. The administrator stated she was well aware of R27's room and stated staff went through the mounds of clothing and items on the floor to ensure there were no mice. During an observation on 4/23/25 at 8:44 a.m. and again at 3:00 p.m., R31's snacks and bread were still not in covered containers. During an interview on 4/23/25 at 10:05 a.m., at resident council meeting, R16 stated LPN-C had been doing morning medication rounds in his room and said, "Oh my gosh, there is dead mouse on the floor." R16 said that was about two weeks ago. During observation and interview on 4/23/25 at 2:37 p.m., the door to the outside from the kitchen was propped open with a plastic pink wet floor sign. At 2:40 p.m., the door remained propped open approximately seven inches. At 2:43 p.m., the door remained propped open. At 2:46 p.m., the door was still opened. At 2:48 p.m., the door remained open. At 2:49 p.m., a staff person opened the door and stepped over the pink wet floor caution sign and went out the door which was still propped open. The DM verified the door was propped open and stated they needed water and were going back and forth so she monitored the door to make sure nobody came in. At 2:50 p.m., the door remained propped open. During an interview on 4/24/25 at 1:44 p.m., the director of nursing (DON) was informed of the dead mouse finding and stated the facility had not	21730			

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21730	Continued From page 115 had a mouse sighting in over 90 days or longer but would put a plan in place. Facility Pest Control policy dated 9/6/23, indicated on-going measures are taken to prevent, contain and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice and rats. General measures to decrease pests include elimination of cracks and crevices, proper lighting and ventilation, use of screen on windows and doors, and the use of self-closing doors. All food stored in the dietary area is kept in a designated area in securely covered containers, is off the floor and away from walls. All food items kept in resident rooms are stored in covered containers, with the exception of uncut fruits such as bananas and oranges, a contract with a pest control company will be elected to assure regular inspection and application of chemical pesticides. Staff will report all sightings of pest to the maintenance and or environmental services director for pest control intervention. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure a preventative pest/rodent control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest/rodent control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730			

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21805	Continued From page 116	21805	Corrected		5/30/25
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a dignified experience for 2 of 2 residents (R30 and R1) who did not have clothing to wear and were spoken to in an undignified manner by staff. Findings include: R30's face sheet printed 4/24/25, indicated diagnoses of weakness, adult failure to thrive, morbid obesity, and bipolar disorder with psychotic features. R30's significant change minimum data set (MDS) assessment dated 3/26/25, indicated intact cognition, no rejection of care, use of a wheelchair, substantial assistance with upper body dressing, and dependence on staff for lower body dressing. R30's care plan printed 4/24/25, indicated R30 required extensive assistance of one staff for dressing, and limited assistance of one staff for bed mobility and eating. During interview on 4/21/25 at 3:27 p.m., R30 stated one of the nursing assistants had a terrible attitude and scolded her for accidentally getting				

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21805	Continued From page 117 vomit on her shirt. R30 stated she did not think it was abuse, but did not appreciate being scolded like a little kid. R30 further stated she had reported this incident to a nurse but could not recall which nurse. R30 identified the nursing assistant who scolded her as a nursing assistant with letters HCAC in her name, but did not know her actual name. R30 further stated this nursing assistant had continued to work with her since the incident. During interview on 4/23/25 at 11:51 a.m., R30 stated she knew the assistant director of nursing (ADON) was notified of the scolding event because a nurse had R30 write up a note to give to the ADON. R30 stated she could not write, so she dictated the note describing the event to the nurse and the nurse was supposed to give it to the ADON. R30 thought the incident happened two weeks ago. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated she was not aware of R30 being scolded by a nursing assistant but that should not have happened. During interview on 4/24/25 at 10:10 a.m., NA-M stated she did not recall scolding R30 and maybe R30 did not understand her or maybe she was talking too loud. NA-M further stated she would not scold a resident. During interview on 4/23/25 at 8:47 a.m., social services (SS)-A stated she was not aware of a nursing assistant scolding R30. SS-A further stated if she had heard that she would have reported it because nursing assistants should not scold residents.	21805			

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21805	Continued From page 118 During interview on 4/23/25 at 12:23 p.m., ADON stated she recalled a nurse reporting R30 being scolded by a nursing assistant and had asked the nurse to complete a grievance form. ADON was not able to recall name of nurse or nursing assistant. ADON did not recall receiving the grievance form and had not followed up on the report from R30. ADON stated she was trying to make the nurses more accountable. ADON stated the incident likely would not have been addressed if R30 had not brought it up again but it was addressed today. During interview on 4/24/25 at 8:45 a.m., director of nursing (DON) stated nursing assistants should not scold residents, and she expected the ADON to follow up on the reported grievance. DON further stated the grievance had been reported today and would be investigated. R1's face sheet printed 4/24/25, indicated an admission date of 8/11/24, diagnoses of non-pressure chronic ulcer of left ankle, depression, chronic kidney disease, and adult failure to thrive. R1's quarterly MDS assessment dated 2/16/25, indicated moderately impaired cognition, verbal behavioral symptoms directed at others four to six days, rejection of care one to three days, use of a walker, supervision for bathing, and independent with upper and lower body dressing. R1's care plan dated 3/28/25, indicated resident independent with dressing, resistive to cares related to poor impulse control with intervention of encourage to participate and provide interaction. During interview and observation on 4/21/25 at 5:55 p.m., R1 was naked on her bed and stated	21805			

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21805	Continued From page 119 she did not have any clothes at the facility and her only clothing was a robe and a pair of slippers. A blue robe was observed hanging on a chair in R1's room. No other clothing was observed. R1 stated she came from the hospital and did not have anyone to bring her clothing. R1 further stated she used to wear gowns provided by the facility, but the facility no longer provided gowns. During observation on 4/22/25 at 1:03 p.m., R1 was in the common dining room in a blue robe and slippers. During observation on 4/24/25 at 8:40 a.m., R1 was in the common dining room in a blue robe and slippers. During interview on 4/23/25 at 8:15 a.m., nursing assistant (NA)-K stated R1 was very particular and wanted her own clothing. During interview on 4/23/25 at 9:15 a.m., licensed practical nurse (LPN)-C stated R1 did not have any clothes. LPN-C stated she recalled social services (SS)-A tried to contact someone to bring R1's personal belongings but had not heard anything since then. LPN-C further stated R1 used to wear gowns provided by the facility but the facility no longer provided gowns so R1 only wore her robe. During interview on 4/23/25 at 8:47 a.m., SS-A stated R1 had no clothing other than a robe due to her clothing being at her previous group home. SS-A stated she knew R1 wanted her clothing here at the facility and she had tried to work with the previous group home when R1 admitted to the facility but the previous group home did not bring the clothes. SS-A stated she was unaware	21805			

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21805	Continued From page 120 R1 did not have facility provided gowns and was only wearing a robe with no clothing underneath. SS-A stated that would be a dignity concern to not have any clothing to wear. During interview on 4/23/25 at 12:23 p.m., assistant director of nursing (ADON) stated she knew R1's belongings were at her previous group home and did not know why her belongings were not at the facility yet. ADON stated she would expect after nine months of R1 being at the facility someone would have figured out how to get her clothing. ADON further stated R1 wore facility provided gowns as her clothing prior to the facility no longer providing gowns. During interview on 4/24/25 at 9:15 a.m., R1 stated she had asked someone to get her clothes, and they brought her sweatpants and a button up shirt. R1 stated she did not want to wear those facility provided clothes and preferred her own slacks and blouses. R1 further stated she was told someone would get her clothes a long time ago. During interview on 4/24/25 at 11:07 a.m., administrator stated the facility provided gowns to the first floor residents who were there for short term rehabilitation stays, but no longer provided gowns to second floor residents if residents used them as regular clothing. Administrator stated the facility offered to assist residents who chose to wear gowns as regular clothing with purchasing gowns if they desired them and further stated she could not confirm whether R1 had replacement gowns or clothing prior to facility gowns being taken away. Facility Dignity policy reviewed 4/24/25, indicated the following:	21805			

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21805	Continued From page 121 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: c. encouraged to dress in clothing that they prefer. 8. Staff speak respectfully to residents at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The DON or designee could educate staff on facility policies, and develop a monitoring systems to ensure ongoing compliance. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805			
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before	21925			5/30/25

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21925	Continued From page 122 transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notice of transfer was sent to the resident and/or resident representative for 2 of 2 residents (R7 and R41) reviewed for hospitalization. Findings include: R7's face sheet printed 4/24/25, indicated R7 had diagnoses including fracture of shaft of right tibia (main long bone of lower leg), type 2 diabetes mellitus, morbid obesity, noninfective gastroenteritis and colitis (inflammation of the digestive tracts not caused by bacteria or virus) and pulmonary embolism (blood clot that blocks blood flow in the lung). R7's admission Minimum Data Set (MDS)	21925	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2025
NAME OF PROVIDER OR SUPPLIER HIGHLAND CHATEAU HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(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
21925	Continued From page 123 assessment dated 2/14/25, indicated R7 was cognitively intact, had clear speech, could understand and be understood. R7's activities of daily living section was not completed. A nursing progress note on 4/17/25 at 2:25 p.m., indicated R7 was complaining of abdominal pain, nausea and diarrhea. The provider evaluated the patient and resident was sent to emergency department at 1:10 p.m. with emergency medical services (EMS). A nursing progress note on 4/21/25 at 5:13 p.m., included R7 was readmitted today from hospital by EMS. R7 is able to make her needs known. On 4/22/25 at 8:37 a.m., during interview, R7 stated she never got anything in writing from the facility when she was transferred to the hospital. R7 stated "I was just told I was going there". A Minnesota Notice of Bed-Hold policy undated, but signed by R7 on 4/17/25, indicated R7 wanted to have her bed held during the time of her absence. The electronic medical record (EMR) did not include a notice of transfer was given to the resident or family member in writing. R41's face sheet printed 4/24/25, included diagnoses of malignant neoplasm of right female breast, and multiple fractures of pelvis. R41's quarterly MDS dated 4/10/25, indicated severe cognitive impairment with inattention behavior and disorganized thinking continuously present but no behaviors. A nurse progress note 4/20/25 at 4:48 p.m., indicated R41 was sent to the hospital around 3:40 p.m. due to pain and inability to swallow oral	21925			

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21925	Continued From page 124 pills. A Minnesota Notice of Bed-Hold Policy included telephone contact made with family member 4/21/25, and requested bed be held during the time of leave of absence. R41's EMR did not include a notice of transfer was given to R41 and or family member. On interview 4/23/25 at 2:06 p.m., licensed practical nurse (LPN)-A stated they have the patient or family member sign the bed hold, and get an order from the provider to transfer to the hospital. LPN-A indicated she isn't aware of a transfer notice that is given in writing to the resident or family member. On interview 4/23/25 at 2:10 p.m., registered nurse (RN)-A stated she asks the patient or gets verbal permission for a bed hold, gets a provider order for transfer but does not give a notice of transfer in writing to either the patient or the family. On interview 4/23/25 at 2:24 p.m., LPN-B stated the facility does not have a transfer notice in writing given to the resident or the family but they let them know verbally the reason for the transfer. On interview 4/24/25 at 9:00 a.m., the director of nursing (DON) confirmed they do not give a notice of transfer for resident's transferred to the hospital in writing to the family or the resident. The DON indicated she was not familiar with a requirement for a transfer notice and the facility currently does not have one. Facility Transfer or Discharge, Preparing a Resident form, dated 1/25/23, included: Nurse services is responsible for obtaining orders	21925			

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21925	Continued From page 125 for discharge or transfer, as well as the recommended discharge services and equipment...assisting with transportation as applicable (calling for an ambulance); completing discharge note in the medical record.. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review policy and procedures, educate staff, and audit to ensure resident(s) are given proper discharge notice. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925			