Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2022

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: April 7, 2022

Dear Administrator:

On June 3, 2022, we notified you a remedy was imposed. On July 13, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 18, 2022 be discontinued as of June 30, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 3, 2022, 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 20, 2022. This does not apply to or affect any previously imposed NATCEP loss.
The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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
July 15, 2022

CMS Certification Number (CCN): 245282

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

Dear Administrator:

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

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

Effective June 30, 2022 the above facility is certified for:

32 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, 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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 29, 2022

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 7, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 7, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245282	A. BUILDING ______ B. WING ______	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	**211 NORTHWEST SECOND STREET ROCHESTER, MN 55901**

(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 4/4/22 through 4/7/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 4/4/22 through 4/7/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5282015C (MN00081985). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/09/2022

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 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: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R16) who were dependent of staff for nail care, received assistance for long and jagged nails. Findings include: R16's admission Minimum Data Set (MDS) dated 3/23/22, indicated R16 was cognitively intact and required extensive assist with most activities of daily living (ADLs) due to a recent fall that required surgical repair of right hip. MDS indicated R16 had moderate difficulty with vision and hearing and R16 did not wear glasses. R16's care plan indicated R16 had moderate impairment of vision and hearing. During observation on 4/4/4/22, at 5:43 p.m. R16 was lying in bed and noted to have fingernails which were brittle, long, and had jagged, chipped edges. R16 stated she scratched something open on her leg today and a nurse had told her to stop scratching it. During observation on 4/5/22, at 10:08 a.m. R16's nails continued to be long and jagged. R16 stated staff had not assisted her with nail car, "I need help to have this done, as I cannot see clearly." When interviewed on 4/5/22, at 3:27 p.m. nursing	F 677	Nurse and CNA re-education with policy about bath process and nail care including who can do nail care. Nurses will complete the Charter House Skin Check to ensure the assessments are complete based on the pink sheet filled out by aides and visualization. Update bath sheet to include nail care. Nurse can delegate nail care as appropriate. All assessments will be given to RN Care Coordinator to ensure the assessments are complete. Audits to be done daily for two weeks (to May 23); weekly for 1 month (until June 27); monthly x 3 months (July – September) with random audits thereafter. All to be completed June 3, 2022.	6/3/22

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F 677	Continued From page 2	F 677		

assistant (NA)-B stated R16 needed one person assistance with ADL's which included nail care and bathing. NA-B stated NAs do not complete nail care as nurses were required to perform that ADL. NA-B stated he would only clean under the nail bed during baths. NA-B stated R16 had very poor vision.

During an observation on 4/6/22, at 11:19 a.m. R16's fingernails observed to be long and jagged. Registered nurse (RN)-B removed R16's ACE wraps on lower extremities. R16's toenails were observed to be long, jagged, and thick with yellow discoloring. R16 was observed to have a new right calf abrasion with a skin flap hanging off of the area.

When interviewed on 4/6/22, at 11:51 a.m. RN-B stated NAs should be doing nail care on bath days for non-diabetic residents. RN-B stated nail care consisted of cutting, filing, and kept clean. RN-B confirmed R16's fingernails were long and appeared to not have been cut since admission. R16 stated, "I had previously asked for a fingernail clipper as they are too long, so now I just rip them off with my teeth." RN-B asked R16 to perform nail care after lunch and R16 got teary eyed.

When interviewed on 4/6/22, at 12:11 p.m. RN-H stated nail care should be performed for non-diabetic residents on bath days by a NAs. RN-H confirmed R16's bath days were twice a week on Monday mornings and Thursday evenings. RN-H confirmed NAs should complete a pink bath sheet twice a week on bath days and the form is handed to a nurse to document skin changes and resident refusals. RN-H confirmed R16 had no refusals documented since

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F 677	Continued From page 3	F 677		

admission. RN-B and RN-H found one pink bath sheet since admission.

When interviewed on 4/6/22, at 2:29 p.m. RN-E stated nail care should be performed for non-diabetic residents on bath days by a NA. RN-E stated NA should fill out pink bath sheet with each bath and the nurse would document in electronic record as an assessment or progress note.

When interviewed on 4/7/22, at 10:02 a.m. RN-D stated nail care should be completed for non-diabetic residents by facility NA's. RN-D stated she was unaware of when this should be completed.

When interviewed on 4/07/22, at 11:14 a.m. R16 stated her nails were cut and filed down yesterday by RN-B. R16 stated, "They are perfect now and my toenails are getting checked by a provider soon." R16 stated her daughter cut them at home prior to admission.

When interviewed on 4/7/22, at 12:06 p.m. director of nursing (DON) stated NAs should be completing nail care on non-diabetic residents. DON stated expectation for nurses and NAs to be monitoring this on bath days at least weekly if not more often. DON stated NAs should complete pink bath sheet and identify any conditions and give this sheet to nurse to follow-up on any identified concerns. DON stated expectation is for the nurse to document and chart in electronic health record any identified concerns. DON expressed concern for staff not completing a thorough head to toe assessment, lack of hygiene, potential contamination, and possible skin integrity including skin tears.

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F 677	Continued From page 4 The facility policy titled, Nail Care Procedure - Rochester revised on 9/28/21, indicated to ensure the needs of residents who are unable to complete nail care or trim their nails, staff are to provide assistance with fingernail or toenail care and trimming as indicated, and are to follow safe nail care practices including infection control procedures. -Licensed nurses are to be notified by CNAs of the need for assistance for nail trimming and care for residents who are diabetic, immune suppressed, and/or on anticoagulants, so the licensed nurse may complete trimming of resident fingernails and toenails.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide meaningful and ongoing activities for 1 of 1 residents (R16) reviewed for activities. Findings include:	F 679	Staff will read the Resident's chart to be sure what Resident may need. Staff are to review care plan to know if there are vision or hearing restrictions. The Residents will be offered to be brought to activities and encouraged to	6/3/22

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F 679	Continued From page 5 R16's admission Minimum Data Set (MDS) dated 3/23/22, indicated R16 was cognitively intact and required an extensive assist with most activities of daily living (ADLs). The MDS indicated R16 had moderate difficulty with vision and hearing and R16 did not wear glasses. The MDS interview for activity programs dated 3/23/22, identified it was, "important but can't do or no choice," for the following activities: have books, newspapers, and magazines to read, doing favorite activities, and participate in religious services or practices. The interview also identified it was very important to R16 to listen to her favorite music, be around animals and pets, and go outside to get fresh air when weather is good. R16's Activities assessment dated 3/23/22, indicated, "resident had a lot of expressed activity interests however due to vision, hearing and hand deficit it makes it very hard for her to engage in them at this time." R16 was provided a voice amplification device during assessment and was noted to make a huge difference in communication with resident. The assessment indicated R16 grew up growing her own food on the farm. R16 stated she enjoyed listening to the news and watching television but no longer could due to vision and hearing deficits. Due to vision problems R16 needed large print reading material. Goal for R16 included activity and socialization daily over the next 15 days. R16's greatest strength was her ability to socialize and tell different stories from her childhood. R16's care plan dated 3/16/22, indicated R16 was at risk for alteration in socialization related to recent hospitalization and Group activities may be limited or restricted during [COVID-19] outbreak status or when unit is on quarantine. R16 would	F 679	join in. Staff educated to read aloud menu and activity offerings if there is there is a vision impairment (implemented 5-5-22). Staff will specifically ask Residents if they need help with something (i.e., can I read the menu to you). Nurses and CNAs will be more verbal with the Residents on engaging with them regarding their lives, likes and dislikes. Postings of “Three Things You Should Know About Me” for each Resident will be posted in the Resident’s room to be visible to all staff (implemented 5-5-22). RT (Recreation Therapist) created a “Resident 1-1 Referral Form” that is available to all staff to help better identify Residents who are in need of extra care and/or attention (implemented 4-26-22). RT made staff aware there are new tools available for the Residents- tabletop Magnifier and Wireless Headphones (5-5-22). The touchscreen will be utilized to document specific Resident preferences. Audit of referral forms (RT), 3 things to know about me posting (RT) and care plan updates (nurse manager) about Resident needs/preferences weekly x 6 weeks then monthly for 6 months with random audits following.	

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F 679	Continued From page 6 eat meals in room the first 14 days following admission if not fully vaccinated. R16 has moderate impairment of vision and hearing. Staff were directed to allow time for R16 to process information, encourage repetition to ensure R16 can hear you including an intervention to encourage use of amplification device for quality of life. R16's activity care plan indicated she would have activity and or socialization daily. The activity care plan directed staff of the following: -During room visits, provide choices for in-room recreational activities from the activity care such as (large print reading materials such as books on history, Z Gray novels, or magazines with recipes or patterns), musical supplies (likes WCCO on radio and used to love to dance) and sewing supplies as desired. -Encourage participation in activities that provide enjoyment (listening to music, reading, and sewing) as R16 is able to tolerate due to vision, hearing, and hand deficits. -Due to hearing impairment, before beginning a conversation with R16 help her put on her pocket talker but respect resident right if she chooses to refuse it. -Provide a copy of activity schedule and allow R16 to choose activities. -Assist R16 to attend/participate as needed such as musical programs, reading groups, and special events while keeping in mind residents right to refuse. -R16 to eat all meals in the dining room as tolerated. Review of electronic medical record, R16 was on isolation precautions until 3/31/22, due to vaccination status. R16's activities note dated 4/1/22, indicated, [R16] observed to be sleeping more and refusing	F 679	All to be implemented by June 3, 2022.	

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F 679	Continued From page 7	F 679		

some meals. The note indicated checks were done daily, and staff engaged her in conversation as well as brought her daily schedules and reading packets from the group activities.

During an observation and interview on 4/4/22, at 5:54 p.m. there was an isolation cart outside of R16's room. Licensed practical nurse (LPN)-A stated R16 had been on quarantine related to COVID-19 precautions, however, R16 was no longer on precautions. R16 stated she had not participated in any activities since admission. R16 stated she had all kinds of hobbies in the past such as sewing, crocheting, knitting, farming, gardening, canning fresh fruits and vegetables, and reading the local newspaper. R16 stated she had carpel tunnel in both of her wrists and had very poor vision which made it difficult to enjoy her past hobbies. R16 was animated and smiling when she spoke about farm life and crocheting activities. R16 indicated prior to admission she still lived on her farm.

During an observation on 4/4/22, at 6:10 p.m. R16 was observed eating alone in the dining room with no other residents seated at table. Other residents were observed seated together in small groups amongst the other tables in dining room.

When interviewed on 4/5/22, at 10:08 a.m. R16 was seated in recliner in room next to window. R16 stated yesterday was the first time she ate in the dining room. R16 stated she was allowed to go to breakfast the day of 4/4/22, but then a nurse stated she had to return to her room to eat alone as she was still on isolation precautions. R16 stated she was supposed to be off isolation precautions last week. R16 stated she was

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F 679		F 679		

Continued From page 8

allowed to come out for lunch and dinner on 4/4/22, but facility staff sat her at a dining table alone. An activities schedule and Daily Chronicle newsletter was observed lying on R16's bed not within reach. When asked if R16 could read the print, R16 replied, "no" and got teary eyed. R16 stated the facility staff did not read the activity schedule or newspaper to her. Multiple newspapers and a big print search-a-word puzzle book was located in R16's window sill. R16 stated daughter-in-law buys the newspaper every Christmas, but she is unable to read the fine print anymore.

Activities schedule for 4/5/22 included:
-10:30 a.m. Bible Study - Church
-11:00 a.m. 27 Dandelion Facts that will blow you away (In Honor of Dandelion Day)
-1:00 p.m. Severe weather awareness presentation in Edwards Hall
-2:30 p.m. Social Hour and Snack
-3:00 p.m. Mind Binders Puzzle.

During an observation on 4/5/22, at 10:23 a.m. R16 sat in a recliner next to the window in her room. RN-B applied pain relieving gel to R16's joints. Staff did not attempt or offer to take R16 to bible study that started at 10:30 a.m. R16 was observed not to be in attendance in bible study.

During an observation on 4/5/22, at 12:48 p.m. R16 was eating lunch in dining room at a table alone with no other residents located at table. A laminated activity cue card was located in the middle of each table. Activity included, "Would you rather dance or sing? Why? What would you name your boat if you had one? What's the most ridiculous fact you know? Fun fact: There is only one fish that blinks with two eyes. A shark." Staff

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F 679	Continued From page 9 were not observed to read or converse with her about the card. After lunch R16 returned to her room and it was not observed staff approached her to offer the 1:00 p.m. activity nor was it observed R16 was in attendance. During an observation on 4/5/22, at 1:47 p.m. R16 was asleep in the recliner in her room. During an observation on 4/5/22, at 2:05 p.m. R16 was asleep in a darkened room in bed. An activities sheet titled, "27 Dandelion Facts that will blow you away" was observed lying on bedside table next to activities schedule and Daily Chronicle. Multiple paged pamphlet observed in regular sized print given to all residents on unit. Pamphlet had not been opened as a staple was located in left hand corner and pages were not bent over. The pages were unwrinkled and remained untouched. During an observation on 4/5/22, at 3:17 p.m. a social worker sitting on edge of bedside discussing discharge plans for R16. When interviewed on 4/5/22, at 3:27 p.m. a nursing assistant (NA)-B stated R16 only walks with staff outside of room. NA-B was unsure if R16 participated with activities. NA-B stated R16 was on quarantine for two weeks but came off of quarantine on 3/31/22. During an observation on 4/5/22, at 3:42 p.m. R16 was sitting on edge of bed with bedside table not within reach. R16 stated she was not aware of the Dandelion activity, nor did staff offer to take her to the activity. During an observation on 4/6/22, at 7:12 a.m.	F 679		

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F 679	Continued From page 10 R16 was lying in bed awake on right side. During an observation on 4/6/22, at 9:20 a.m. R16 was observed sitting at far dining room table by television with no other residents at table. Four other tables of at least two to three residents sitting together socializing after breakfast were observed. During an observation and interview on 4/6/22, at 11:19 a.m. surveyor asked R16 if facility is utilizing the pocket talker microphone to communicate. R16 shrugged shoulders, got teary eyed, and stated "not really." Activity schedule for 4/6/22, located on bedside table and appeared untouched. R16 stated facility did not offer bingo activity at 11:00 a.m. During an observation on 4/6/22, at 11:49 a.m. RN-B walked R16 to dining room and sat R16 at a table alone. RN-B stated that activities (ACT)-A does activities schedule for unit. RN-B stated most of the resident's do not come out to group activities and one-to-one activities are provided individually. During an observation on 4/6/22, at 2:23 p.m. R16 was sleeping in bed on her back in darkened room. ACT-A completing a one-to one in commons area in front of health unit coordinator (HUC) desk with another resident. When interviewed on 4/7/22, at 8:36 a.m. ACT-A stated he was doing a lot of social visits with R16. ACT-A stated he had a difficult time interacting with R16 as she seems more isolated after coming out of quarantine and more withdrawn. ACT-A stated R16 was quarantined for an extended period due to no current COVID-19	F 679		

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F 679	Continued From page 11 vaccination and now seems to be set in her ways. ACT-A offered large print reading material, music, and sewing supplies upon admission, but R16 refused as one of her hands no longer works to knit. ACT-A stated he brings in activity schedule and group packet information daily to R16. ACT-A confirmed he did not read it out loud or provide information in larger font. ACT-A stated one-to-one social visits are one to two times weekly and he completes weekly notes for all residents on every Friday. ACT-A stated R16 does not engage with him other than enjoying having someone to speak to about her daily life. ACT-A confirmed R16 came out to dining room on 4/4/22, for first time since admission. ACT-A stated he was uncertain why R16 was kept in her room beyond the discontinuation of quarantine precautions. ACT-A stated a nurse brought R16 out to breakfast on 4/4/22, but then shortly thereafter R16 was brought back to eat in her room alone. ACT-A stated will not wake R16 when sleeping but does not go back to room to reevaluate at a later time. ACT-A confirmed he did not know R16 lived on a farm previously but then retracted statement stating a majority of his activities do not include farm, gardening, or knitting related activities. ACT-A stated he felt it was hard to replicate farm life to R16. When interviewed on 4/7/22, at 9:49 a.m. ACT-A stated he uses activity connection and cater activities to look at special days of the week such as dandelion day. ACT-A stated he provided lots of activity packets so residents can complete and read at their leisure. ACT-A completes two group activities per day, but R16 was not included since 3/31/22. ACT-A stated R16 was very "sleepy" lately and seemed to be withdrawn since COVID-19 quarantine precautions. ACT-A	F 679		

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F 679	Continued From page 12 confirmed he charts refusals of all group activities. When interviewed on 4/7/22, at 10:02 a.m. RN-D confirmed R16 was seen listening to music or reading a newspaper in the activities area approximately one week ago with ACT-A on only two occasions. RN-D stated R16 enjoyed sewing, being a home-maker, farming, and speaking about her life and great grandchildren who also learned to sew. RN-D stated she will read R16 the memo and agenda for day, but only works three days per week. RN-D stated she did not think other staff completed this with R16. During an observation and interview on 4/7/22, at 11:14 a.m. daily activity schedule was observed sitting in cupboard space located between bathroom and resident bed. R16 stated facility staff did not notify her of schedule or read it aloud to her that day. At 11:29 a.m. occupational therapist arrived to R16's room and going to walk R16 down to therapy room. When interviewed on 4/7/22, at 11:37 a.m. RN-A stated expectation for activities to be completed daily by staff and if a resident was on isolation the activity would be completed with resident in room. RN-A expected ACT-A to encourage R16 to come out of room as much as possible. RN-A stated ACT-A charting should be completed daily and marking refusals appropriately. RN-A stated it was not observed if R16 had come out of room this week for activities. R16 was only observed out of room for meals and not aware R16 was placed at table alone. RN-A confirmed she was not certain if staff was reading activities schedule and education pamphlets to R16 due to vision deficits. RN-A was unaware of staff bringing R16	F 679		

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F 679	Continued From page 13 out to dining room for breakfast on 4/4/22, and then bringing her back to room to eat alone. RN-A stated she only observed staff speaking to resident and never observed R16 participating in activities. When interviewed on 4/7/22, at 12:06 p.m. director of nursing (DON) stated expectation is for staff to provide meaningful and individualized activities for each resident based on initial activities assessment upon admission. DON stated she would expect staff to read information out loud to a resident with visual deficits. DON stated she would expect staff to ensure each resident could read material and not just assume a resident could read. She would expect staff to engage with resident to come out of room for activities and to encourage socialization. DON stated if a resident is on isolation/quarantine she would expect staff to bring activities into a residents room. DON expressed concern stating a resident could become depressed due to lack of activities and social isolation. DON stated she would encourage staff to adapt to resident wishes and hobbies they enjoy such as providing an I-pad device to do a zoom visit with family members. When interviewed on 4/7/22, at 12:48 p.m. RN-A stated R16 refuses voice amplification device sometimes. RN-A stated that ACT-A completes daily notes, offered a sewing kit upon admission, but did not use activities that R16 was interested in. RN-A confirmed ACT-A did not know R16 enjoyed farming. During an observation on 4/7/22, at 2:01 p.m. activities pamphlet titled 100 Facts about Billie Holiday's Life and Legacy was found lying on R16	F 679		

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F 679	Continued From page 14 bed between two pillows unopened. R16 was asleep in recliner next to window. Pamphlet was not provided in large font and same material used on all residents residing in the facility without visual deficits. When interviewed on 4/7/22, at 2:11 p.m. R16 stated today was first time ACT-A spent any significant time speaking to her and discussed her previous farm life and hobbies. R16 appeared happy and content with a smile on her face for the first time all week. R16 stated she didn't understand why facility could not have completed activities or socialization with her prior to today. A facility policy and procedure regarding activities including individualized care was requested but was not provided.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, facility failed to follow orders, assessment and treatment protocol for 1 of 1 residents (R119) reviewed for non-pressure related skin problems. In addition, the facility failed to identify/evaluate	F 684	Review/revise the existing policies and procedures on wound care with links to existing resources including standing orders, products available and Mayo resources (by May 31, 2022).	6/30/22

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and monitor edema and failed to ensure physician orders were followed for edema management for 1 of 1 residents (R16) reviewed for fluid overload.

Findings include:

R119's progress note in the medical record dated 3/22/22, indicated R119 was admitted to the facility for rehabilitation and cardiac monitoring. The note indicated R119 was alert and oriented to person, place and time. The note further indicated R119, had "several skin issues related to graft bypass surgery-see skin assessment."

R119's progress note dated 3/22/22, indicated R119 was admitted with skin issues to his lower abdomen, bilateral groin and inner thighs were extremely dry.

R119's progress note dated 3/26/22, indicated, "Several skin issues related to graft bypass surgery-see skin assessment. Slight excoriation noted coccyx. Barrier cream applied. Mepilex (an adherent, occlusive foam dressing) to be applied."

A review of R119's electronic Treatment Administration Record (TAR) did not identify a treatment order had been obtained or transcribed for the excoriated coccyx area. R119's record did not include a comprehensive wound assessment after the area of excoriation had been identified.

R119's progress note dated 3/30/22, written by registered nurse (RN)-C indicated R119's "coccyx open area 4.5 cm's [centimeters] length, width 1 cm, also another area next to that is 0.5 cm's. Appearance is friction and moisture,

Staff education with Wound Care simulation, monitoring, and proper skin documentation (by June 30, 2022).
EduCare Clinical Comprehensive Assessments assigned to nurses to complete (due by June 30, 2022).

Wound care binder and poster available in the nurses station (by May 31, 2022).

The bath sheet process outlined in POC for 677 will also apply to F684 for skin monitoring.

Staff will document each day in MyUnity regarding assessments on Residents. This can be tied to the TAR as a task. Each day the staff will be prompted to do the assessment and this duty can be divided up.

Daily weights will be added to the TAR - daily weight expected for 3 days upon admission and then weekly thereafter unless Nurse or provider indicates otherwise due to weight fluctuations or diuretic issues.

Compression wraps ordered by PT or provider will be entered on the TAR. This can be delegated by the Nurse to the CNAs. Compression wraps are a skill for annual competency check off for CNAs.

Reinforce staff education about use of the Clinical Smartboards (myUnity checklist) and the Touchscreen for care plan charting (by May 31, 2022).

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F 684	Continued From page 16 TX [treatment] xeroform [a medicated dressing] to wound bed and covered with Mepilex border dressing was applied and to be changed every other day." This note indicated the medical provider was notified, but did not indicate an order had been received; however, the TAR indicated that RN-C had written in the recommendations as a physician order on 3/30/22, and the (treatments) were discontinued on 4/5/22. R119's corresponding Wound Assessment Detail report dated 3/30/22, identified the area as moisture associated skin damage. Progress note dated 4/3/22, indicated, "coccyx has 2 open areas 4.5 cm's by 1 cm and an area of 0.4 cm's TX Xeroform covered with Mepilex border dressing." R119's record did not include an assessment of the newly identified open area that measured 0.4 cm. During an observation on 4/5/22, at 10:31 a.m. R119 had two bright red areas about the size of a nickel, one under each of the ischium of buttocks (the bony prominence at the bottom of the pelvis) with peeling skin surrounding each of them. Small scattered sacral open areas were also noted. Licensed practical nurse (LPN)-A said they had just noted these areas but was not sure there was a treatment order, however, a Mepilex dressing had been covering the sacrum, so that is what LPN-A planned to do for a treatment. LPN-A asked a nursing assistant (NA)-A if they used anything else, and NA-A pointed to a container labeled Z-guard (an over the counter barrier cream containing petroleum and zinc that protects against moisture). LPN-A put a large amount of Z-guard in palm and spread over entire	F 684	RN care coordinator to identify residents for Nurse Manager to complete chart audit for weights, skin assessment and documentation, TAR, and care plan - 3 residents per week for one month, then 3 charts a month for 6 months with random audits thereafter. NM could delegate to get staff involvement. All to be completed by June 30, 2022.	

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F 684	Continued From page 17 buttocks and sacrum and then placed the Mepilex over the wet ointment. R119's progress note dated 4/5/22, 12:23 p.m. included, "coccyx has multiple small open areas. NP [nurse practitioner] was there to assess all skin concerns." R119's record did not identify or address the skin breakdown on the ischium. R119's provider note dated 4/5/22, a nurse practitioner (NP)-A wrote that two SBAR's [a notification of change in condition] had been received from the facility however, indicated the SBAR's were unrelated to R119's impaired skin integrity to his coccyx, sacrum, or ischium. NP-A did note a non-pressure related "pin point" open area of the left gluteal cleft was found during assessment, however, the assessment did not identify or address the observed red and peeling areas of the ischium. NP-A wrote an order to apply a prophylactic Mepilex to sacrum and coccyx, ensure it is in direct contact with skin to prevent moisture related breakdown, lift twice daily to check skin and change every three days and as needed. The provider note did not include a treatment plan to areas on the ischium. When interviewed on 4/5/22, at 3:57 p.m. LPN-A stated a nurse finding a new area of skin concern should first check the resident's chart to see if that problem had previously been noted and documented. If not, LPN-A stated the nurse should notify the medical provider to get an order, and then follow that order. LPN-A also stated the wound should be assessed and findings documented. This assessment should include a description of the wound, any pain or any sign of infection. LPN-A stated, "I wasn't 100% sure if wound care had been done [before she applied	F 684		

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application of Z-guard and dressing], the provider came today and looked at it. She just gave us an order now. I was just helping out. I don't necessarily do a treatment without looking at an order, but I just knew we were covering it in the meantime." LPN-A stated a nurse could use facility standing orders if there was not an order in the TAR, but then should enter that order into the TAR. LPN-A was unable to find a list of standing orders in R119's chart. LPN-A was not sure if Z-guard was a standing order or if it could be used on open areas. LPN-A reviewed standing orders in another resident's chart and noted "lubricating barrier cream" could be used on reddened skin, but LPN-A did not know if Z-guard was considered lubricating, and confirmed R119's skin was open on some areas of buttocks and sacrum.

During an interview 4/5/22, at 4:18 p.m. RN-A stated a superficially open area may be described as excoriation, but would still require an order for care. RN-A said a nurse should check the TAR prior to performing any treatment. If no treatment order was found, the nurse should assess the wound and enter the information into a computer app they called the "Risk Watch system." RN-A stated a nurse must have an order to provide a treatment; could use standing orders, but should notify the provider. RN-A said Z-guard is a barrier cream but is generally used for incontinence as it helps to dry the skin. RN-A stated it did not match facility standing orders that say to use a "lubricating barrier" for red areas.

R119's physician orders of 4/5/22, entered into the computer at 3:14 p.m. indicated care of the coccyx was:
1. Clean and dry areas

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2. Apply prophylactic Mepilex boarder sacrum dressing. Lift twice daily to asses skin and ensure dressing is changed every 3 days and as needed."

During an interview on 4/6/22, at 8:55 a.m. RN-A stated when a new area of concern, such as a wound, was noted the nurse should assess the wound and enter information into a computer app they called the "Risk Watch system" so staff and providers would be aware of the problem. RN-A stated she was unable to find that R119's skin problems were listed in the app. RN-A stated the facility does have standing orders, but they must be reviewed and signed each time a person is admitted. If they are not in the chart, they should not be used, and an order from the medical provider must be sought out. RN-A stated the physician and family should be notified of any new wounds, and this should be documented in the chart. If standing orders are utilized they must be transcribed from the hard copy into the electronic record so they flow to the TAR.

During an observation on 4/6/22, at 9:49 a.m. RN-B stated R119 did have superficial, upper layers of skin peeling off the ischium on the right side extending up in an oblong path for about 3 inches, and also, a less noticeable area on the left ischium. RN-B also stated there were several tiny open areas to the left and right sides of the coccyx, inside the crack of the buttocks, and wondered if this was due to friction from using a lift sheet during transfers.

R119's progress note dated 4/6/22, included, "coccyx has multiple small open areas. There are areas that are healing from what might be friction. These areas are blanchable, slightly pink in color

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F 684	Continued From page 20 and not open." When interviewed on 4/6/22, at 9:59 a.m. RN-H reviewed R119's chart and stated R119 did not have a signed current standing order sheet. RN-H reviewed standing orders in another residents' charts and stated xeroform dressings were not listed on the standing orders and to use the product an order from a physician would need to be obtained. RN-H also stated Z-guard does not meet the criteria of a "lubricating barrier cream" and should not be applied to open areas without an order. When interviewed on 4/6/22, at 10:25 a.m. the director of nursing (DON) stated any new area of concern on the skin should be followed by a, "good clinical assessment and obviously notification to the provider, and then documentation is the Unity Wound Assessment [facility electronic assessment form]." DON stated if a wound was superficial, "I don't know if would notify family but should be documentation and monitor so does not get infected. If very superficial we might notify physician but assess for worsening and then notify MD as needed." DON stated she was in charge of over site of all nursing in the facility and the associated assisted living facility, so did not stay closely in-tune to all orders, but said nursing staff should use standing orders, and any policy or wound care protocol. DON did not know if Xeroform was on standing orders or if Z-guard was a lubricating ointment that would match standing orders. DON stated a nurse cannot write orders, but can transcribe what is given by a provider. A facility policy titled, Skin and Wound Management undated indicated, "aid staff will	F 684		

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perform routine skin inspections daily with cares, nurses are to be notified to inspect the skin if any skin conditions and/or pressure ulcers are identified. Document on any pressure, stasis skin ulcer, skin tear or open wound with treatment will include: location and size, type, stage of wound, drainage, signs symptoms of infection, treatment, date and time of dressing change." Additionally, policy indicated "skin care alert form is to be used if there is noted disruption in skin integrity" and "the physician/NP and family will be notified upon discovery of a skin concern." The policy did not include reference to the facility standing orders.

Charter House Standing orders 10/19/21 signed by medical director, indicated: "Facility lubricating/barrier cream or ointment three times daily PRN (as needed) for dry skin and/or for prevention of skin breakdown secondary to incontinence (E.g. Lubriderm®). For Stage I OR Reddened area: If affected by friction & shear: For prevention, may apply a film dressing and change every 5 days prn soiling. For Stage II Pressure OR Partial Skin Loss Area: Intact serum filled blister: apply hydrogel impregnated dressing, attempting to avoid rupturing blister and change every five days prn soiling, secure with secondary dressing. Shallow crater: apply hydrogel impregnated dressing/hydrocolloid (if minimal drainage) or foam dressing (if moderate drainage) and change every 5 days prn soiling, secure with secondary dressing.)

R16's admission MDS dated 3/23/22, indicated R16 was cognitively intact and required an extensive one assist. R16's medical diagnosis included: heart failure (a condition which occurs when the heart muscle does not pump blood as well as it should resulting in swelling in the legs,

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ankles, or feet) and disorders of veins in bilateral legs.

R16's physician orders dated 3/22/22, indicated daily weights were to be completed in the mornings as R16 was on a diuretic. Notify certified nurse practitioner (CNP) if three pound weight gain overnight or five pound weight gain in one week. Also notify CNP of 5 pound weight loss in one week. On 4/5/22, apply compression wraps in the morning and take off at bedtime was ordered.

R16's physician notes dated 3/22/22, indicated, R16 had trace edema in bilateral lower extremities and compression wraps to bilateral knees. Daily weights were requested but these had not been completed by facility. Daily weights reordered with notification of CNP.

R16's care plan dated 3/16/22, indicated to obtain weight per orders by nurse or nursing assistant, float heels on pillow in bed, and encourage elevation of legs as able to reduce swelling. Weekly head to toe skin monitoring. R16 is at risk for fluid imbalance related to cardiac issues.

R16's treatment administration record (TAR), compression wraps were initiated on 4/5/22. Weight monitoring daily starting 3/23/22. Skin assessment and weight completed two times weekly starting 4/6/22. Requested March 2022 TAR on 4/7/22, but facility did not provide.

During an observation and interview on 4/4/22, at 5:43 p.m. R16 was observed lying in bed with no compression or ACE wraps applied to legs. R16's legs were observed to have edema present in

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both bilateral lower extremities and feet. R16's left leg was more swollen than right leg and was wearing white cotton socks. R16's legs were not elevated on a pillows in bed. R16 stated she is supposed to wear compression stockings on legs at all times due to past medical history of vascular problems and previous venous stasis ulcers. R16 was observed to have purplish discoloration of skin to bilateral lower extremities. R16 stated a nurse previously applied ACE wraps to her leg one day, but then looked at her white paper sheet located in her pocket and immediately removed the wraps stating R16 did not have an order for them. R16 questioned staff why she was unable to wear her compression wraps on numerous occasions but could not remember specifics dates and times since admission.

During an observation on 4/4/22, at 6:10 p.m. registered nurse (RN)-B was observed walking R16 to dining room table. R16 was wearing white cotton socks and black crocks on feet with notable edema present in both lower extremities and feet.

During an observation on 4/4/22, at 9:52 a.m. R16 was observed sitting in recliner next to window in room with lower extremities on floor. RN-B present in room with resident taking her vital signs.

During an observation and interview on 4/5/22, at 10:08 a.m. R16 was observed sitting in recliner in room next to window with bilateral extremities on floor. R16 stated her legs were wrapped by RN-B earlier this morning . R16 observed wearing bilateral ACE wrap compressions from feet to knees. At 10:23 a.m. RN-B came into R16's room to apply pain relieving gel. R16 stated legs felt

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F 684	Continued From page 24 better now that they were wrapped this morning. During an observation on 4/5/22, at 12:47 p.m. R16 was observed asleep in recliner with ACE wraps to bilateral lower extremities, but legs were not elevated. During an observation on 4/5/22, at 2:05 p.m. R16 was asleep in bed with ACE wraps on bilateral legs with pillows located under both legs. During an observation on 4/5/22, at 3:42 p.m. R16 was sitting on edge of bed with ACE wrapped legs dangling to the floor. During an observation on 4/6/22, at 7:12 a.m. R16 was asleep in bed with legs elevated on pillows, but no ACE wraps on. During an observation on 4/6/22, at 9:20 a.m. R16 was observed sitting at dining room table with ACE wraps on. During an observation on 4/6/22, at 10:30 a.m. R16 was observed sleeping in recliner in room with ACE wraps on, but legs not elevated. During an observation and interview on 4/6/22, at 11:19 a.m. R16 notably upset after physical therapy and nursing staff as facility placed white cotton skin protection wraps underneath ACE wraps today. R16 was observed with ACE wraps on bilateral lower extremities, but legs were not elevated. RN-B came to R16's room after physical therapist voiced to her that R16 was very upset in room. R16 requested wraps be removed immediately as it was causing her extreme pain. RN-B took wraps off and educated R16 that the cotton wraps located underneath ACE wraps	F 684		

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were for skin protection. R16 stated staff did not inform her why those were added this morning. R16 observed with considerable edema in bilateral feet as wraps were placed from ankle to knee and fluid built up in feet as a result.

When interviewed on 4/6/22, at 11:36 a.m. RN-B stated R16's ACE wraps were not ordered until 4/5/22. RN-B confirmed R16 wore compression wraps at home prior to admission. RN-B stated R16 preferred leg wraps to be applied after she gets back from the bathroom in the morning. RN-B confirmed she placed wraps on R16 today while resident was in bed prior to going to the bathroom. RN-B stated R16 had not had swelling in her legs until she noticed it in R16's feet today due to the wraps not being placed correctly. RN-B stated R16 wore compression wraps for comfort verses edema. RN-B stated R16 did not have edema in legs yesterday. RN-B stated R16's physician confirmed she did not have edema in legs since admission to facility. RN-B confirmed R16 asked for compression wraps. RN-B stated R16 normally does not sit in her recliner and only lies in bed or walks with physical therapy. RN-B stated R16 should have pillows underneath legs at all times while in bed with heels floating off the edge.

When interviewed on 4/6/22, at 12:11 p.m. RN-H stated he would not know if R16 wanted compression leg wraps nor if she would have edema. RN-H confirmed nursing staff should be completing a head-to-toe assessment daily. RN-H stated assessment should be documented daily in skilled nursing Medicare progress notes.

When interviewed on 4/6/22, at 2:29 p.m. RN-E confirmed nurses should be completing an

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edema assessments and if a resident had edema staff would elevate extremities right away and send a note to physician for further intervention and treatment plan. RN-E stated R16 should have legs elevated on pillow in bed or elevated while sitting in recliner to reduce fluid in legs.

When interviewed on 4/7/22, at 10:02 a.m. RN-D stated she heard that R16 requested compression wraps this week. RN-D stated she completed R16's admission assessment and noted edema in bilateral legs. RN-D confirmed R16 was wearing compression hosiery and elevated her legs on pillows while in bed and while sitting in recliner in room. RN-D indicated wraps should have been on R16 since admission to present. RN-D stated nursing assistants (NA's) applied these daily in the mornings and were removed at bedtime. RN-D stated R16's legs were +1 edema (when compressed with digit, would leave an impression of 2 millimeters) upon admission and not as swollen as they were this week.

When interviewed on 4/7/22, at 11:14 a.m. R16 stated her legs were wrapped this week on 4/5/22 mid-morning suddenly. R16 stated, "I don't know why facility did not listen to me requesting leg wraps prior to this." R16's room was observed to have no compression hosiery socks located in room other than current ACE wraps which were applied to her legs.

When interviewed on 4/7/22, at 11:37 a.m. RN-A stated expectation for nurses to assess for edema daily and ensure physician is notified for treatment and intervention orders. RN-A confirmed if a resident requested leg wraps, facility staff should notify physician immediately.

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F 684	Continued From page 27 RN-A stated nursing interventions of elevating legs on recliner foot rest, encouraging ambulation to shift fluid build-up, and use of pillows to elevate extremities should have been completed for R16. RN-A stated facility had standing orders for compression wraps and was unsure if facility completed an edema assessment upon admission. RN-A was uncertain if edema was monitored daily. When interviewed on 4/7/22, at 12:06 p.m. director of nursing (DON) stated expectation for edema assessment to be completed upon admission with a skilled nursing note to be completed daily on each resident; especially for residents with known heart failure or known edema. DON expected nursing staff to complete interventions such as weight monitoring, assessing skin integrity and pressure spots, listening to lung sounds, elevating legs so swelling did not become dependent, care planning, monitoring, measurements of swelling, and ensuring physician was aware of condition. DON stated concern for static edema to worsen medical diagnosis of residents. The facility provided a lower extremity edema algorithm to follow for patients with lower leg = to or > than +2 peripheral edema not dated which indicated, elevate and provide medical management x 24 hrs. If patient meets at least 1 exclusion criteria of (pitting edema +1 or less), that lower leg wraps NOT recommended and to discuss with provider and consider vascular studies. If patient is ambulatory, apply short stretch & padding for 24 hrs. If edema decreases within 24 hrs, continue to elevate and apply previous compression wraps only if patient continues to have >+1 edema. Discontinue if	F 684		

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F 684	Continued From page 28 edema resolves. If edema does not decrease in 24 hrs, discuss with primary provider for ongoing independent edema management. A facility policy related to lower extremity edema was requested on 4/7/22, but facility did not provide. A care plan on R16 related to edema was not provided.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		5/31/22

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F 755	Continued From page 29 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were transcribed correctly for 1 of 1 residents (R3) reviewed for medication administration. Findings include: R3's face sheet indicated resident had medical diagnoses which included: type 2 diabetes mellitus with chronic kidney disease and long term (current) use of insulin. R3's physician orders dated 3/22/22, indicated R3 was to receive insulin Aspart 100 unit/ml (3 mL) subcutaneous pen and to inject 4 units under the skin 3 (three) times a day with meals. Hold if skipping a meal. Monitor blood glucose four times a day, before meals and at bedtime. R3's electronic medication administration record (EMAR) dated April 2022, R3 received Fiasp FlexTouch 100 unit/ml (3 mL) subcutaneous four units three times a day starting 3/22/22 Inject four units under skin three times a day with meals. Hold if skipping a meal. "Also known as Aspart." Fiasp insulin documented as received by R3 from 4/1/22-4/6/22. (Fiasp is a modified form of Insulin Aspart. The addition of vitamin B3 to the structure of Insulin Aspart results in its rapid onset of action and rapid absorption via the skin when administered into the skin).	F 755	Create new policy for Medication and Treatment orders and educate staff about new policy(due by May 31, 2022). Nurses and unit coordinators education about resources to search for medication names and an alternate medication name cannot be added. Reeducation for current staff and added to orientation. Nurse reeducated to verify Order again Order and must verify the Order against the Medication once received (completed 4-22-22). Educate nurse and unit coordinators how to request a medication be added to myUnity if needed (by May 31, 2022). Nurse manager and medical records coordinator to audit order entry accuracy: 3 charts per week for one month, then 3 charts per month for 6 months and random thereafter. All to be completed by May 31, 2022.	

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Fiasp insulin order re-transcribed by registered nurse (RN)-F on 4/6/22 at 10:07 a.m. to corrected order received by physician on 3/22/22. Incorrect insulin charted by numerous facility staff from 3/22/22 until 4/6/22 when surveyor was monitoring medication administration at 9:21 a.m. with RN-F.

During an observation and interview of medication administration on 4/6/22, at 9:21 a.m. RN-F observed to check insulin pen orders against EMAR and noted R3's insulin pen from pharmacy did not match R3's orders in record. RN-F looked up Fiasp insulin on Google website and noted it was not the same medication as insulin Aspart. Fiasp is insulin Aspart plus vitamin b3 which has the potential to work more rapidly against elevated high blood sugars. RN-F brought insulin Aspart pen over to hard paper chart and checked pen against last physician orders dated 3/22/22 and noticed the wrong medication was transcribed into EMAR on 3/22/22.

When interviewed on 4/6/22, at 9:45 a.m. RN-H confirmed insulin order in EMAR, stated R3 should receive Fiasp. RN-H printed off original physician order from 3/22/22 and confirmed R3 should receive insulin Aspart. RN-H stated RN-B transcribed the order incorrectly into EMAR. RN-H confirmed order was entered on 3/22/22 for R3 to receive 4 units of insulin Aspart with meals and at bedtime. RN-H confirmed correct insulin had been administered by facility staff and EMAR was incorrectly transcribed from the physician order in the electronic chart.

When interviewed on 4/6/22, at 10:25 a.m. RN-F expressed concern of R3 could have received the wrong type of insulin. RN-F confirmed staff

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should be performing five rights of medication administration with every medication pass. RN-F stated staff should be checking residents name, date of birth, right dose, right time, right route, and right medication against physician orders. RN-F stated the health unit coordinator (HUC) transcribed all medication orders into EMAR when they are working or the nurses will enter them if the HUC is off duty. A second person will double check orders for accuracy. RN-F stated facility had been trying to enforce second and third medication transcription checks for some time now. RN-F stated the facility had sent out emails regarding this enforcement recently for staff to complete second and third (24 hour) checks. RN-F stated she thought the nurses were responsible for entering orders, checking the fax machine regularly for new orders, and notifying the nurse assigned to the resident if a new order came through for the day.

When interviewed on 4/6/22, at 12:30 a.m. RN-B stated new medication orders are entered by the HUC if they are on-duty, enter it into a draft mode and flag the medication, flag gives alert to nurse so they can complete the second check, and night shift nurse would complete the 24 hour check against the hard copy orders to EMAR transcription order. RN-B stated she specifically remembered R3's Fiasp insulin order as she had never heard of that type of insulin before. RN-B admitted to looking up insulin Fiasp and discovering on a random medication website that Fiasp was also known as insulin Aspart. RN-B stated she did not look further into medication discrepancy prior to performing the second check on R3's orders. RN-B admitted to now knowing that Fiasp insulin also contained vitamin B3 which could have had the potential for adverse

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CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 32	F 755		

reactions for R3. RN-B stated the insulin pen that facility received from Thrifty White pharmacy was a regular insulin Aspart pen so facility felt comfortable administering medication to R3. RN-B confirmed she did not consult with a pharmacist that day and she was part of entering R3's orders. RN-B confirmed licensed practical nurse (LPN)-A entered R3's initial orders from physician on 3/22/22 at 12:22 p.m. RN-B stated she edited the order transcribed at 7:07 p.m. to include a notation on the Fiasp order "Also known as insulin Aspart." RN-B admitted to not understanding why R3's insulin pen was labeled as insulin Aspart and the transcribed orders stated insulin Fiasp. RN-B stated she received training from facility on how to edit/discontinue medication orders into EMAR and just started entering orders on 4/5/22 on her own without having RN-H walking her through the process step by step. RN-B stated agency pool staff receive formal facility training of two days which included: outlook email, Educare modules, MyUnity charting system, EPIC charting system, a brief overview on how to find things in the system, order entry, and practice on a simulated "fake dummy" resident record. RN-B stated, "I should have looked it up better and questioned it better, but I felt comfortable as it said insulin Aspart as it was the same number of units per ml and that's why I only entered an additional comment into the order saying also known as insulin Aspart."

When interviewed on 4/6/22, at 12:51 p.m. LPN-A stated staff transcribed physician orders into EMAR, then double to verify by placing the medication with a flag, medication sits in draft mode until a second nurse can verify the original order entered. LPN-A confirmed staff should be

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F 755	Continued From page 33 signing off original hard copy physician orders with both checks and then the night shift nurse will complete what is known as the third check or 24 hour check and that's completed in red ink. LPN-A confirmed he did not sign or place black checks next to original physician orders nor question himself upon entering insulin Aspart into EMAR as insulin Fiasp. LPN-A admitted to not knowing what insulin Fiasp was and he would have to get back to surveyor on that question. LPN-A confirmed insulin Aspart was originally ordered for R3 on 3/22/22 and insulin Fiasp was entered into EMAR. LPN-A indicated the two insulins are not the same and could not remember who he requested to complete his second check. LPN-A stated he was unable to look at MAR prior to the seven day lock back period. LPN-A confirmed R3 did not receive insulin ordered at lunch time on 3/22/22 and there was not a note stating why it wasn't given. LPN-A stated medication was administered late at 9:04 p.m. LPN-A stated insulin Aspart should be administered with meals and uncertain why no dinner dose was given. LPN-A confirmed R3's blood glucose was 196 at dinner time. LPN-A expressed concern that medication orders transcribed did not match for R3 and concern noted R3's blood sugars could have been "off" due to her not receiving correct insulin ordered. LPN-A stated his concerns for R3 included: possible allergy to Fiasp insulin, possible anaphylaxis as different insulin types work differently on each resident and control blood sugars differently. LPN-A indicated he did not complete five rights of medication administration correctly for R3 and not triple checking verification prior to administering R3's medications. LPN-A stated he received two days of orientation to facility which included: going	F 755		

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F 755	Continued From page 34	F 755		

through physician orders, care plans, MyUnity charting system, and received three shifts of being precepted by a Charter House experienced nurse. LPN-A stated if he has a question that he would ask a peer, RN-H, a nurse manager on duty or the Charter House nurse supervisor that covers the entire building on evenings and night shift.

When interviewed on 4/7/22, at 10:51 a.m. Thrifty White pharmacist consultant confirmed the local Thrifty White store receives original physician orders from provider verses receiving transcription orders from facility. Pharmacist consultant confirmed there is not an interface between facility system and Thrifty White system. Pharmacist consultant stated Fiasp insulin would work faster than regular insulin Apsart as it contains vitamin D. He stated it could have potentially been a big medication error which could have resulted in R3 receiving adverse reactions and low blood sugars.

When interviewed on 4/7/22, at 12:06 p.m. director of nursing (DON) stated expectation of nurses to check physician orders and have a second and third nurse check order for accuracy. DON stated nurses should be initialing and dating the original order with who checks the transcription into their EMAR. DON expressed concern regarding staff not completing the five rights of medication administration and following the correct facility process for resident safety. DON confirmed facility needed more steps in place to mitigate medication errors. DON stated facility has two different groups of pool agency nurses hired; one hired by Charter House and the other hired by Mayo Clinic. Charter House pool agency nurses get four weeks of training; while

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F 755	Continued From page 35 Mayo Clinic pool agency nurses only get three days of orientation which included Educare online modules, only 3 shifts on the floor prior to being alone. Training included physician order entry and introduction to facility electronic charting system. DON reinforced that good training is based off of a good preceptor and that can make or break how a nurse's training outcome will be. Pool agency staff are precepted by an experienced Charter House nurse. The facility policy titled Administering Medications Charter House Procedure - Rochester reviewed on 4/7/20, indicated medications shall be administered in a safe and timely manner, and as prescribed. -If a dosage is believe to be inappropriate or excessive for the resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss concerns. -The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. -If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document reason medication not administered at the scheduled time.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		5/31/22

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F 761	Continued From page 36 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document the facility failed to ensure a medication brought from home was appropriately labeled and secured for 1 of 1 residents (R122), failed to ensure 2 of 2 medication carts were appropriately secured, and failed to ensure eye drops and insulin were labeled/refrigerated/and discarded in accordance with manufacturer's guidelines for 2 of 2 residents (R3, R13). Findings include: R122's admission Minimum Data Set (MDS)	F 761	Tamper proof bags implemented for storage of resident home medications that cannot be sent home with family (implemented 5-9-22). Reeducate staff to ask new Residents if they have any creams, medications, eye drops, etc. and if they do, let them know these need to be locked for safety as part of the inventory checklist upon admission (by May 13, 2022). Reeducate nurses and TMAs about	

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F 761	Continued From page 37	F 761		

dated 3/31/22, included cognitively intact with diagnoses including right hip bursitis and tendinitis.

R122's physician orders dated 4/2/22 indicated R122 was to receive Voltaren 1% topical gel (350 g) four times a day as needed for bilateral knee pain.

During observation on 4/4/22, at 2:56 p.m. an unlabeled, undated, home medication silver tube of Voltaren 1% topical gel was on R122's bedside table in room.

During observation on 4/4/22, at 3:04 p.m. registered nurse (RN)-D applied Voltaren 1% topical gel that was on R122's bedside table to R122's right hip.

During observation on 4/4/22, at 3:42 p.m. RN-D removed Voltaren 1% topical gel from R122's room and proceeded out to hallway. R122 stated the facility leaves her Voltaren gel at her bedside at all times, R122 stated she was not aware why it was now removed from her bedside table. Shortly after R122 put on call light to ask staff where it went as she was concerned that it was her tube of medication from home.

When interviewed on 4/4/22, at 5:15 p.m. R122 stated RN-D had notified her the medication was removed from her room and placed in the East medication cart in hallway.

When interviewed on 4/5/22, at 10:38 a.m. R122 stated she thought the Voltaren 1% topical gel was accidentally left on her bedside table and has noticed this happen previously.

writing expiration date on the bottles (not boxes) and disposing upon expiration.

Nurse manager to explore options to how to protect labels to retain print for readability.

Reeducation of nurses and TMAs to never leave carts unlocked and unattended, even for surveyors (done 5-8-22).

Designated staff (TMA and house supervisors) to audit med carts for correct expiration date labeling and removal of expired medications weekly x 2 weeks, then q 2 weeks for 2 months, then monthly for 6 months.

All to be completed May 31, 2022.

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F 761	Continued From page 38 When interviewed on 4/5/22, at 3:05 p.m. R122 stated RN-D thought the Voltaren 1% topical gel had been left out accidentally prior to her shift During observation and interview on 4/5/22, at 3:53 p.m. surveyor requested to see inside medication cart for R122's medication slot and observed an unlabeled silver tube of Voltaren 1% topical gel was inside cart licensed practical nurse (LPN)-A confirmed the silver tube of Voltaren did not come from facility's pharmacy and was uncertain how it got in the medication cart. LPN-A confirmed facility should not leave medications at bedside LPN-A stated medications brought from home should be sent home with family or have facility pharmacy identify the medication and staff nurses would apply a proper label. When interviewed on 4/5/22, at 3:58 p.m. director of nursing (DON) stated expectation for medication reconciliation to be completed by nurse and physician for any home medications brought into facility. DON stated expectation for medications be in a locked box inside resident room as her concern is there would always be an opportunity for other staff or resident's to come in and take someone else's medications. DON stated the facility staff should be verifying any unlabeled medication with the pharmacy and obtain an identifying label for each medication. DON stated medication should be dated on the day it was opened, marked for expiration after 30 days, and expect if a medication was dated that it should be opened. On 4/5/22, at 4:02 p.m. Surveyor returned to East medication cart to complete the medication storage review, although no further concerns with	F 761		

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labeling and storage were identified, LPN-A left his medication cart unlocked and walked away with RN-B while surveyor was still going through medication storage of cart.

During observation and interview on 4/5/22, at 4:05 p.m. surveyor requested RN-G to secure the East medication cart. RN-G stated medications should never be left at the bedside as facility would want to ensure safety of all residents and staff. RN-G stated facility policy requires family to take medications from home back out of the facility. RN-G stated that medications should be dated with the date they were opened and to discard of any medication in cart if found unlabeled.

During an observation of West wing medication cart on 4/5/22, at 4:15 p.m. RN-I proceeded to leave unlocked and opened medication cart with surveyor despite knowing surveyor was doing medication storage and handling of cart as she had to do medication pass with a resident. Survey team requested RN-A come out of her office to assist with medication storage. R3 had an opened but not dated bottle of Latanoprost 0.005% eye drops. The box identified it was opened 2/14/22, and according to manufacturer's guidelines it should be discarded and not used after 28 days. Medication received by facility on 3/10/22. A second bottle of R3's Latanoprost 0.005% eye drops were found in cart opened but not dated. The box identified it should be refrigerated per Thrifty White Pharmacy and was found in medication cart. R13's Latanoprost 0.005% eye drops were opened on 2/14/22, but not discarded at 28 days and facility was administering these daily. Medication was received by facility on 1/27/22.

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When interviewed on 4/5/22, at 4:50 p.m. RN-A confirmed medication carts should be locked by facility staff before walking away. RN-A stated unlabeled and expired medications could potentially affect resident safety as medications can increase or decrease in strength beyond their expiration dates. RN-A confirmed medications from home should not be in the medication carts and pharmacy should verify home medications with medication reconciliation prior to use.
During an observation of medication administration on 4/6/22, at 9:21 a.m. R3's Lantus Solostar U-100 Insulin 100 unit/ml (3 mL) subcutaneous pen observed opened on 3/6/22 and should have been discarded per pharmaceutical guidelines after 28 days. RN-F called pharmacy for renewal of medication as new pen was not located on unit.

When interviewed on 4/6/22, at 2:29 p.m. RN-E stated facility does not usually accept home medications and they do not use them if not provided from our pharmacy. Facility will encourage a family member to bring them back home or should be stored in a locked box and placed inside the secure medication storage room.
RN-E stated that insulin and eye drops are discarded after 28 days from being opened. RN-E voiced concern that medications would no longer be safe to use past their expiration date.

When interviewed on 4/7/22, at 9:29 a.m. RN-D stated medications should not be kept in resident's room at the bedside. Home medications would be labeled with resident identifiers and kept in the locked medication storage room. RN-D stated she just started on

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F 761	Continued From page 41 duty on 4/4/22 when R122's Voltaren gel was noted to be at resident's bedside. RN-D confirmed she removed it from resident room and placed it in east med cart on 4/4/22, however, the medication had since been removed. RN-D was unable to confirm when the date of the silver tube with Voltaren had been opened prior to administering on 4/4/22. RN-D confirmed she was not aware it was a home medication. RN-D stated facility policy for home medications would consist of locking them into a secure medication storage area on the unit, labeling them with correct resident identifiers, informing both the resident and family, telling facility staff, and informing her nurse manager. When interviewed on 4/07/22, at 12:06 p.m. DON stated expectation that home medications should be sent home with family or stored in a lock box in a secured medication storage room. Medication should include resident name, mayo clinic number, and date of birth using at least two resident identifiers. DON confirmed home medications should not be stored in medication cart and the only time would be in a special situation if facility is unable to obtain from pharmacy. DON expressed her expectation for staff to not leave medication at the bedside and it is ideal for staff to watch medication is taken by resident. DON stated most medications expire at 30 days but not sure which medications expire prior to that. Medications should be dated upon opening and discarded upon expiration. DON's concern would be that expired medication would not be as effective in treating medical diagnoses and staff need to order new medications prior to being discarded so resident's did not miss doses. DON stated expectation to keep medication carts on unit at all times as her concern would include resident safety and medication diversion.	F 761		

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F 761	Continued From page 42 Medications from home should be verified online and with facility pharmacist. The facility policy Medications Brought to the Facility by the Resident/Family Guideline - Charter House - Rochester revised 9/28/2020 indicated, the facility shall ordinarily not permit residents and families to bring medications into the facility. -Medications brought into the facility that are not approved for the resident's use shall be returned to the family. -Medication(s) awaiting return to family will be recorded on the Drug Inventory record, which shall include the date, medication name/strength, by two licensed staff and noted on resident inventory record and shall be stored in the medication room until returned to resident and/or family. The facility policy Administering Medications Charter House Procedure - Rochester reviewed 4/7/2020 specified medications shall be administered in a safe and timely manner, and as prescribed. -Medications must be administered in accordance with the orders, including any required time frame. -If a dosage is believed to be inappropriate or excessive for the resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concerns. -The individual administering the medication must check the label THREE (3) times to verify the	F 761		

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F 761	Continued From page 43 right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. -The expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be written on the container. -During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. -The individual administering the medication must utilize the "Pulled" function when preparing medications for administration. Initial verification of the 5 Rights occurs during the "Pulled" process, second verification occurs when medication is placed in medication cup and third verification occurs when reviewing medications against the MAR prior to administration of medications.	F 761		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # **245282**	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING ______	DATE SURVEY COMPLETE: **4/5/2022**
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/05/2022 between 08:00 AM to 12:30 PM, it was revealed by observation that on the 3rd floor in Stairwell D that cabling was attached to the fire sprinkler system piping An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

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CHARTER HOUSE	**211 NORTHWEST SECOND STREET** **ROCHESTER, MN 55901**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/05/2022. At the time of this survey, CHARTER HOUSE was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245282	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/05/2022**

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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. CHARTER HOUSE is a 24 story building with full basement The building was constructed in 1985 and was determined to be of Type I (322) construction. The SNF is located on the 3rd floor only. Kitchens are located on the 2nd and 22nd floor. 3rd floor has a warming / serving kitchen only The building is protected by a full fire sprinkler	K 000		

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K 000	Continued From page 2 systems. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification via Mayo Clinic Security Central. The facility has a capacity of 50 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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	K 363		6/3/22

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	245282	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/05/2022**

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K 363	Continued From page 3 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/05/2022 between 08:00 AM to 12:30 PM, it was revealed by observation that upon testing the 3rd floor resident sleeping room doors, there was a door-to-door air gap greater than a 1/8 of an inch between the active and inactive leaves. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	All resident sleeping room doors are currently being inspected and required repairs made to ensure 1/8" maximum gap between active and inactive leaves is maintained. Preventative maintenance (PM) inspections will be implemented to ensure no recurrence. PM inspections will be tracked. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring. Corrections are currently underway and 06/03/2022 is anticipated completion.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		4/5/22

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K 511	Continued From page 4 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 stagg interview, the facility failed to secure an electirecal panels per NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/05/2022 between 08:00 AM to 12:30 PM, it was revealed by observation that the electrical panel (L-302) in a resident accessible corridor was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	Electrical panel L-302 was secured with a new lock on access door. Preventative maintenance (PM) inspections and routine work in electrical panels will be used to ensure no recurrence. PM inspections and other repaired deficiencies will be tracked. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring. Electrical contractors and Charter House staff will be instructed to inform CH maintenance department of required repairs. Correction was completed on 04/05/2022.	