Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 20, 2022

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: September 29, 2022

Dear Administrator:

On November 16, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
October 17, 2022

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: September 29, 2022

Dear Administrator:

On September 29, 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Office/Mobile: (651) 249-1724

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 December 29, 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 March 29, 2023 (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

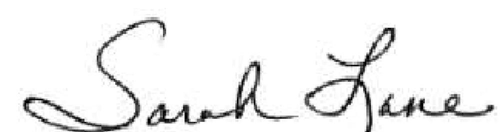
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING ______ B. WING ______	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	**2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

(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 9/26/22 to 9/29/22, a survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted during a standard recertification survey. Southview Acres Healthcare Center was found to be in compliance with the requirements. 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 9/26/22 to 9/29/22, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Southview Acres Healthcare Center was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5189273C (MN79161); however, no non-compliance cited due to actions taken prior to survey. H5189274C (MN82046); with non-compliance cited at F677. The following complaints were found to be unsubstantiated:	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/25/2022

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 000	Continued From page 1 H5189272C (MN79160) H5189276C (MN79394) H5189275C (MN80660) H51894709C (MN83215) H51894750C (MN83412) H51894790C (MN84454) H51894783C (MN84563) H51894802C (MN84746) H51894749C (MN85779) H51894795C (MN86133) H51894794C (MN86442) H51894746C (MN87012) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		11/8/22

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F 582	Continued From page 2 charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 582		

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F 582	Continued From page 3 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform R145 of facility charges for any services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. Findings include: Interview with R145 on 9/26/22, at 2:52 p.m., R145 stated she was not informed of charges for services or provided a receipt by facility despite asking social services and the business office for it since her admission to facility on 8/31/22. R145 stated, "This is bothering me a lot. I worry about it and no one is helping me." Interview with director of social services, (SW)-B on 9/27/22, at 2:09 p.m., stated the role of social services for admissions is to work with business office and admissions team to complete the admissions paperwork once a resident is admitted to the facility. SW-B indicated the cost of facility stay and informed residents and their representatives is the responsibility of the business office. Interview with social worker, (SW)-A on 9/29/22, at 10:33 a.m., indicated that she (SW-A) completed the admission packet paperwork with R145 on 9/1/22, and agreed that R145 asked about pricing of services but SW-A deferred R145 to the business office department. Interview with business office manager, (BM)-F on 9/29/22, at 10:15 a.m., stated that her role is	F 582	R 145 was notified of her daily rate on 9/30/2022. All existing facility residents were issued a statement of charges on 10/26/22. Upon admission, residents will receive explanation of the daily services and charges via the admission agreement signature process. Facility admission, business office manager and social services department team was in-serviced on the billing policy and admission agreement process with emphasis on explaining the daily charges during and throughout the resident facility stay per the policy. Director of Admissions and/or designee is responsible for compliance. Audits on admission agreement and billing statement and request for non-covered products. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 11/8/2022	

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F 582	Continued From page 4 to, "discuss pricing with the resident ...". BM-F stated R145 should have received her bill "before the 14th" of the month (September) and confirmed that this was not done as of 9/29/22. BM-F stated she was responsible for providing the bill to R145 and it was not done. Interview with the facility administrator on 9/29/22, at 1:46 p.m., indicated expectation that residents receive pricing for facility charges, "ideally right away". The administrator indicated R145 should know what how much she is being charged and, "this should have been done with her." R145 ' s Admission Agreement prepared on 9/1/22, "the Daily Rate for your Basic Care Services at Facility will be equal to the rate set for your Care Level by the State of Minnesota" however, no price or charges for services were listed. Facility's policy on billing was requested but not received.	F 582		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 645		11/8/22

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F 645	Continued From page 5	F 645		

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

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

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F 645	Continued From page 6 before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was completed or clarified to ensure mental health needs were adequately addressed for 1 of 2 residents (R141) reviewed for PASARR. Findings include: R141's quarterly Minimum Data Set (MDS), dated 9/6/22, identified R141 admitted to the nursing home in 2020, had moderate cognitive impairment, and required supervision to complete most activities of daily living (ADLs). Further, the MDS identified R141 did not have Alzheimer's Disease or dementia, however, did have manic depression (Bipolar disease) and schizophrenia. R141's current Medical Diagnosis listing, printed 9/29/22, identified R141's active medical diagnoses and conditions. These included, SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE," and, "BIPOLAR DISORDER,	F 645	R 141 had the Level 2 PASARR completed on 10/7/2022. All existing residents were audited and any level 2 PASARR that were not present were requested by Senior Linkage. Upon admission, the PASARR screen will be reviewed by Social Services and will request Level 2 screens per policy. Social Services team was educated on the PASARR Policy was educated on the PASARR Policy with a focus on requesting and/or obtaining level 2 service plans. DSS and or/Designee will be responsible for compliance. Audit on completion of level 1 and Level 2 PASARR screening will be completed by Director of Social Services or Designee weekly X 2 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or DON and brought to QAPI for review and recommendations.	

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F 645	Continued From page 7	F 645	Compliance 11/8/22	

UNSPECIFIED." The listing lacked a diagnosis of dementia or Alzheimer's Disease.

On 9/26/22 at 2:19 p.m., R141 was observed in her room dressed in a pink sweater, however, R141 did not have any pants on and her bed linens were soiled with various stains. R141 stated she had lived at the nursing home for "five months" only, however, did not answer any further questions about her mental health history or needs when asked.

When interviewed on 9/27/22 at 3:26 p.m., R141's family member (FM)-E stated R141 admitted to the nursing home in 2020 after having "the flu or something," as prior R141 had been living with a woman in another town who cared for "unhealthy folks" with physical or mental health issues. FM-E explained R141 had a long "mental health history" and for many years was "sort of not with it mentally." Further, FM-E stated R141's room was typically "messed up" when he visited her and voiced concerns R141 was not being socially engaged in activities at the nursing home adding, "[R141] has to get more involved with things going on."

R141's care plan, dated 6/29/22, identified R141 had several medical diagnoses including schizoaffective disorder, bipolar type and Bipolar disorder. Further, a focus section of the care plan outlined, "A PASARR screening completed with no disability," along with a single intervention which read, "Review PAS for level II if needed."

R141's Screening for Developmental Disabilities or Mental Illness (OBRA Level 1), dated 8/24/20, identified a section labeled, "Mental Illness," which directed a person needed to be referred for

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F 645	Continued From page 8	F 645		

further evaluation and determination of specialized mental health services if all of the following criteria which met: 1) having a major mental disorder (as diagnosable in the Statistical Manual of Mental Disorders); 2) having significantly impaired functioning in major life activities within the past 3 to 6 months; and, 3) the person's treatment history, within the past two years, indicating either psychiatric treatment (more intensive than outpatient care) more than once or the person experienced an episode of significant disruption to the normal living situation which supportive services were required. The OBRA level 1 indicated R141 met all three criteria and directions were listed reading, "If your answer is YES to ALL of the questions above and the person is seeking admission to a MA [Medicaid] certified nursing facility or boarding care facility, refer the person to the county local mental health authority for completion of a Level II evaluation and determination of need for specialized services."

R141's corresponding Senior Linkage Pre-Admission Screening (PAS), dated 11/30/20, identified R141's Level 1 PAS was received, however, a checkmark was placed next to a determination which read, "If this box is checked, the Senior Linkage Line did not complete the PAS. They forwarded the PAS request to a county/managed care organization for processing. The PAS is not final until the lead agency sends documentation to nursing facility." The PAS outlined R141 was on a community-based services waiver along with a managed care program, and it provided a telephone number to contact for Ramsey county. The PAS continued with a section labeled, "Initial Pre-Admission Screening (PAS) Results," which

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F 645	Continued From page 9 reviewed R141's health, functional, and medical information. R141 was recorded as having schizoaffective disorder with received services for the diagnosis being listed as, "Unknown." The PAS outlined R141 appeared to meet criteria for level of care in a nursing facility, however, two corresponding sections labeled, "Developmental Disability or Related Condition," and, "Mental Illness," both outlined R141 did not meet criteria for these areas; however, both of these section' determinations concluded with, "Please note final determination of the need for further evaluation will be made by Senior Linkage Line." However, R141's medical record was reviewed and lacked evidence a final determination had been received and/or evaluated by the county or managed care program as directed by the PAS (dated 11/30/20). Further, there was no evidence demonstrating the facility had acted upon or clarified R141's mental health needs with Ramsey county or the listed managed care program despite the PAS outlining these determinations were not final from nearly two years prior; nor was there evidence a Level II had been completed with final determinations listed despite R141's care plan directing such information. When interviewed on 9/28/22 at 8:30 a.m., nursing assistant (NA)-C stated R141 was "usually independent" with her cares, however, that day had been incontinent of urine and was "soaking wet." NA-C stated R141 spent a majority of her day in her room and was often "sleeping all the time." NA-C explained R141 had mental health issues and would, at times, pick up her telephone and begin speaking to people who weren't present on the line. NA-C was unaware if R141 was on any managed care programs or	F 645		

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F 645	Continued From page 10 outside mental health services. On 9/28/22 at 2:05 p.m. registered nurse unit manager (RN)-E and social worker (SW)-A were interviewed. SW-A acknowledged there was no evidence a Level II PAS had been completed with a final determination made; nor had there been any attempt, to her knowledge, to clarify the initial PAS results (directing the managed care program and/or county would determine) prior to the surveyor seeking the information. SW-A stated she has discussed the Level I results, and corresponding Senior Linkage Line referral, with the director of social services who was "still looking into that." SW-A explained the initial PAS should have been addressed and clarified by the nursing home's admission team and stated it should have been done more timely so staff can "follow up" with needed mental health services, if necessary. When interviewed on 9/29/22 at 8:40 a.m., the director of social services (SW)-B stated she had contacted the county and they were trying to "figure out what happened" with R141's Level II PASARR not being completed or clarified. SW-B reviewed R141's Level I PAS, and the corresponding Senior Linkage Line evaluation, and verified the PAS outlined a final determination was not made but rather deferred to the managed care program and/or Ramsey county. SW-B stated they had not really encountered this situation before, however, expressed it should have been acted upon or clarified between the social services department or admissions team at the nursing home. SW-B stated it was important to ensure such clarifications were obtained timely as persons may require special mental health needs and "certain things to be successful" and	F 645		

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F 645	Continued From page 11 the nursing home "[has] to make sure we can do that." A facility policy on PASARR was not provided. However, a Social Worker job description, dated 2021, was provided which identified several essential functions of the position which included, "Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident," and, "Ensure that each resident received necessary behavioral health care and services to obtain and maintain the highest practical physical, mental and psychosocial well-being ... ".	F 645		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		11/8/22

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F 676	Continued From page 12 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently utilize a pocket talker for 1 of 1 residents (R90) reviewed for using an adaptive communication device. Findings include: R90's significant change minimal data set (MDS) dated 8/7/22, indicated R90 was moderately cognitively impaired and required extensive assistance for most activities of daily living (ADLs). R90's MDS lacked evidence of a hearing assessment. R90's diagnoses included aphasia (a condition affecting the ability to communicate), hemiplegia (a condition affecting motor function on one side of the body), and dysphagia (difficulty swallowing). R90's communication care area assessment (CAA) from discharge assessment-return anticipated MDS dated 4/4/22, indicated R90 usually understands others and communication	F 676	R 90 was reassessed for the pocket talker and a sign was placed for R 90 to alert all visitors to assist to apply pocket talker. R 90 care plan was reviewed and updated with the current intervention. All other residents who utilize pocket talkers were assessed and their care plan was reviewed and updated as needed. Upon admission, residents hearing status will be assessed per nursing clinical assessment. Nursing staff was in-serviced on the Hearing Impaired policy with emphasis on item #3 that staff will assist with the application of the hearing device. DON and or/Designee will be responsible for compliance. Audit on the presence and use of pocket talkers will be completed by Director of Social Services or Designee weekly X 2 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or	

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F 676	Continued From page 13 would be addressed in the care plan. R90's care plan dated last revised 9/27/22, R90 was dependent on staff for meeting emotional, intellectual, physical, and social needs. R90's care plan lacked reference to a hearing deficit or adaptive communication device. R90's nurse aide care sheet dated 9/20/22, lacked reference to R90s hearing deficit or adaptive communication device. R90's quarterly resident review dated 8/8/22, indicated R90 had adequate hearing (with hearing aid or hearing appliances if normally used). R90's Therapy Admission Screen dated 3/31/22, indicated R90 had a "recent change in level of independence or exacerbation of functional impairments" related to communication. R90's speech therapy note dated 7/11/22, indicated, "Therapist got pt new batteries for pocket talker as this makes a big difference in pt's ability to communicate." R90's associated clinic of psychology (ACP) noted dated 8/23/22, indicated, "We use a Pocket Talker to make it easier for [R90] to hear conversations." During observation and interview on 9/26/22, at 6:21 p.m. R90 struggled to place the pocket talker headphones on her head without assistance. R90 stated the device makes a big difference in communication and that staff do not always use it. R90 developed tears in her eyes and stated, "I wish they would."	F 676	DON and brought to QAPI for review and recommendations. Compliance 11/8/22	

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F 676	Continued From page 14 During observation 9/27/22, at 11:43 a.m. R90 was in the dining room working with speech therapist (ST)-A and was not wearing the pocket talker. The pocket talker was observed in R90's room on the bedside table. During interview on 9/27/22, at 1:58 p.m. R90 was assisted with application of pocket talker and stated, "I hear so much better with this." During interview on 9/27/22, at 3:35 p.m. licensed practical nurse (LPN)-F stated he worked with R90 yesterday (9/26/22) and occasionally at other times. LPN-F stated he would use the pocket talker if R90 had it on when outside her room but did not use it when she was in her room. LPN-F stated, "I just talk slowly." During interview on 9/27/22, at 3:45 p.m. LPN-E stated, "I do not use the pocket talker with her [R90]-other people do. But our communication is good." During interview on 9/27/22, at 3:10 p.m. nursing assistant LPN-G stated he usually used the pocket talker with R90. Nursing assistant (NA)-E joined the conversation and stated, she also usually used the pocket talker with R90. During interview on 9/27/22, at 3:27 p.m. R90 stated some staff do use the pocket talker but not everyone. During observation on 9/28/22, at 10:11 a.m. occupational therapist (OT)-A entered R90's room to fit her with a brace. OT-A started talking to R90 and did not use the pocket talker. During interview on 9/28/22, at 2:39 p.m.	F 676		

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F 676	Continued From page 15 registered nurse (RN)-D stated, "I've never had to use it [the pocket talker]." RN-D then confirmed and stated the pocket talker was for R90's benefit not her own. RN-D further stated she was the one who completed the quarterly resident review which included a hearing assessment and had indicated R90 had "adequate hearing". During observation on 9/28/22, at 2:52 p.m. RN-D entered R90's room and assisted R90 with the pocket talker and stated this was the first time she was using it. RN-D then confirmed with R90 that she did not want to wear it all the time, but whenever someone was speaking to her. During interview on 9/29/22, at 10:31 a.m. ST-A stated being the person who initially provided R90 with the pocket talker in June of this year. ST-A further stated, "It was a barrier to treatment without it." ST-A stated typically being very good about using it and confirmed R90 did not have the pocket talker on 9/27/22 during the therapy session in the dining room. ST-A stated nursing staff typically bring R90 to the dining room and if they had not applied it, then R90 would not have had it. The facility policy Care of Hearing Impaired Resident reviewed 2/8/22, indicated, "Staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. The policy further indicated staff will evaluate the resident's preferred method of communication and regularly communicate with the resident using that preferred method.	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		11/8/22

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F 677	Continued From page 16 §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 routine bathing and personal grooming (i.e., nail care) was provided and completed for 4 of 6 residents (R53, R141, R31, R144) reviewed for activities of daily living (ADLs) and who were dependent upon staff for their care. Findings include: R53's significant change Minimum Data Set (MDS), dated 6/21/22, identified R53 had intact cognition, demonstrated no rejection of care behaviors, and required physical assistance to complete bathing. R53's care plan, dated 6/29/22, identified R53 had ADL self-care needs due to adult failure to thrive and heart failure. The care plan listed several interventions to help R53 maintain her current functioning which included, "BATHING/SHOWERING: The resident requires extensive A1 [assist of one]." On 9/26/22 at 2:54 p.m., R53 was observed laying in bed in her room and was dressed in a hospital gown. R53 was interviewed about her care and stated she was not routinely getting her scheduled weekly bathing which she wanted. When interviewed on 9/28/22, at 8:23 a.m., nursing assistant (NA)-C stated they routinely	F 677	Bathing and Nail Care was provided to R 141, R52, R 31. Care Plans were updated with their preferences. R144 Received a tub bath on 9/27/22 and was subsequently on discharged from the facility on 10/3/22. All other residents who require assistance with ADL care were audited for completion of bath and nail care and care plans updated for preferences. Upon admission, residents who require ADL care will be assessed and care plan developed. Nursing department will be in-serviced on the bathing policy and tools to ensure it is scheduled, completed and documented per resident preferences. ADON and or/Designee will be responsible for compliance. Audit on completion of bathing and nail care will be completed by ADON or designee weekly X 4 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or DON and brought to QAPI for review and recommendations. Compliance 11/8/22	

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worked with R53 and described R53 as being usually receptive to cares and bathing. NA-C stated R53 was scheduled for a Tuesday morning bath, however, does not like having male staff provide them. NA-C stated completed, or offered and refused baths, should be recorded in the computer charting. Further, NA-C stated he had heard some baths were not being completely lately due to lower staffing levels, however, added he felt "most of the time" they were getting done.

R53's POC (Point of Care) Response History, dated 9/29/22, identified a task which read, "ADL - Bathing TUES AM," with all recorded baths for the previous 30-day look back period. However, only a single shower was recorded as completed, or offered, which was on 9/20/22.

R53's electronic medical record Weekly Bath Audit, dated 8/16/22, identified R53 received a shower on 8/16/22. The next audit, dated 9/14/22, identified R53 did not receive a shower or bath as she refused it. However, no further audits were located in the medical record demonstrating R53 had been bathed, showered, or been offered one and refused, between 8/16/22 to 9/14/22.

When interviewed on 9/28/22 at 11:21 a.m., licensed practical nurse (LPN)-H stated bathing or showers not being completed when staffing is low was "true," as when there was only four NA(s) present on the unit, the baths and showers "just don't get done" as "there's no time." However, the staff try to re-schedule the showers or baths or complete them later in the week, if able. LPN-H explained baths or showers should be recorded by the NA in the electronic charting and the nurse should complete a corresponding Weekly Bath Audit in the record. LPN-C reviewed R53's

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medical record and verified there was no evidence of bathing or showers being completed from 8/17/22 to 9/13/22, and stated they should have been done if a bath was provided or offered and refused.

On 9/28/22 at 2:35 p.m., registered nurse unit manager (RN)-E was interviewed. RN-E explained the NA staff should be recording baths or showers in the POC charting, and the nurses should be completing the corresponding Weekly Bath Audit(s) in the record. RN-E stated if those areas lacked documentation, then there was not "any way of knowing if they did or didn't [get bathed]." RN-E stated she was aware of the bathing not being completed when the unit was not staffed correctly, however, felt it had "gotten better" in the past weeks.

R141's quarterly MDS, dated 9/6/22, identified R141 had moderate cognitive impairment, demonstrated no rejection of care behaviors, was diabetic, and required supervision to complete personal hygiene.

R141's care plan, dated 6/29/22, identified R141 had several ADL self-care needs. The care plan outlined R141 required assist of one to complete bathing and/or showering and dressing. However, the care plan lacked any identified preferences for R141 to have long fingernails prior to 9/28/22 (after the surveyor investigated R141's fingernail care).

On 9/26/22 at 2:19 p.m., R141 was observed in her room wearing a pink-colored sweater, however, she did not have any pants on exposing a white-colored incontinence brief. R141 had visibly long fingernails, with many of them

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approximately 1/2 inch in length, on both hands. R141 was interviewed about her nails and stated she didn't like long fingernails and wanted them clipped.

When interviewed on 9/27/22 at 3:26 p.m., R141's family member (FM)-E stated R141 had lived at the nursing home since 2020, and was "sort of not with it mentally." FM-E stated he would visit R141 every few weeks and, unless he called ahead prior, would usually find her dressed in pajamas or undressed when he arrived. FM-E stated he had never noticed R141 to have long fingernails in the past, and explained R141 never had a previous preference of wanting long fingernails to his knowledge adding, "[This was] a surprise to me." FM-E added, "I can't believe they'd let it get to that [long length]."

During subsequent observation on 9/28/22 at 7:59 a.m. (two days after the long fingernails were first observed), R141 continued to have visibly long fingernails on both hands.

R141's most recent Weekly Bath Audit, dated 9/24/22, identified R141 received a shower on that date and was not resistive to bathing. A section was provided which read, "Any further comments or observations noted ... ," however, this was left blank. There was no evidence on the completed audit R141 had nail care completed, offered and/or refused. Further, R141's medical record was reviewed and lacked evidence fingernail care had been provided, offered and/or refused in the past weeks despite having visibly long fingernails which extended nearly 1/2 inch (approximately) in length.

On 9/28/22 at 8:30 a.m., nursing assistant (NA)-C

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stated R141 was "usually independent" with most of her cares and verified he had noticed the long fingernails today during morning care, but R141 would often decline staff help to clip them in the past. However, later on 9/28/22 at 8:40 a.m. (10 minutes later) NA-C approached the surveyor and stated he asked R141 if she would allow him to clip her fingernails and she was agreeable. NA-C proceeded to clip all of R141's fingernails then and verified their length adding they were "very long." R141 stated her nails had not been clipped since "like four months ago." NA-C stated if fingernail care had been offered and refused by R141 prior, it should be recorded in the medical record as the NA staff report refusals to the nurse.

When interviewed on 9/28/22 at 11:55 a.m., licensed practical nurse (LPN)-H stated she believed R141 had a preference to have long fingernails and was surprised she allowed NA-C to clip them. LPN-H if a resident was offered and refused cares, including nail care, she would record it in a progress note; however, added the staff were not directed to do such rather "that's just the way I do it." LPN-H verified nail care should be completed on a weekly basis during a resident' bath or shower, and diabetic residents should have their nails clipped by a nurse.

On 9/28/22 at 2:42 p.m., registered nurse unit manager (RN)-E stated refusals of care should be recorded in a progress note adding that was, "In my opinion." RN-E explained R141 typically did not like "a lot of care done" and had several mental health diagnoses which contributed to such. RN-E verified nail care should be completed on a resident's bath or shower day and expressed it was important to ensure nails were

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F 677	Continued From page 21 clipped to reduce bacterial presence and make the resident less "injury prone" if they scratched themselves. R31's annual MDS dated 10/15/21, indicated R31 was cognitively intact and required the assistance of one person for bathing. R31's Diagnosis Report dated 9/29/22, indicated R31 was administered for care following surgery on the digestive system. R31's provider orders dated 3/23/21, indicated a weekly bath and bath audit was to be provided on Tuesdays. R31's bath audits indicated she had a bath on 9/23/22. There were no other bath audits recorded in the electronic medical record (EMR) for September. When interviewed on 9/26/22, at 2:11 p.m. R31 stated she had missed many weekly baths but would like to have a weekly bath. R144's admission MDS dated 9/8/22, indicated R144 was admitted 9/2/22, was cognitively intact, and required the assistance of one staff to assist with bathing. R144's Diagnosis Report dated 9/29/22, indicated a fractured sacrum (tailbone) and fractured right pubis (pelvic bone). R144's progress notes lacked any indication R144 refused a bath.	F 677		

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F 677	Continued From page 22	F 677		

R144's Weekly Bath Audits indicated a weekly audit on 9/27/22, but no other days since admission on 9/2/22.

When interviewed on 9/26/22, at 2:37 p.m. R144 stated she had not had a bath since admission and would like at least a weekly bath.

When interviewed on 9/27/22 03:55 p.m. licensed practical nurse (LPN)-B. stated when there are not enough aides on the schedule, baths did not always get provided as scheduled and described baths as a low-priority task.

When interviewed on 9/28/22, at 7:50 a.m. registered nurse (RN)-C stated sometimes the shifts were short-staffed and baths were not always provided. RN-C stated resident bath days were indicated on the aide care sheets, and bath audits, also known as skin assessments were supposed to be completed on bath days. RN-C stated aides were to provide the bath, and then notify the nurse working the shift the bath was done so the nurse could do the skin assessment. RN-C stated the when the Bath Audit form in the electronic medical record was completed, that would indicate both a bath and a skin audit had been performed. RN-C confirmed R31 and R144 had not been getting weekly baths and had each had one bath so far in September.

When interviewed on 9/28/22, at 8:07 a.m. nursing assistant (NA)-A stated her care sheet indicated who was supposed to get a bath on which day. NA-A stated that sometimes the aides did not get the baths done when they were short an aide on a shift.

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F 677	Continued From page 23 When interviewed on 9/28/22, at 8:17 a.m. RN-B stated baths did not always get done as ordered, and it was a legitimate concern for residents. When interviewed on 9/28/22, at 1:32 p.m. the staffing coordinator (SC) stated when staffing was short, especially Friday evenings, Monday mornings, and weekend shifts which were the most difficult to fill if there were call-ins, baths were not getting done as ordered. When interviewed on 9/28/22, at 2:10 p.m. the director of nursing (DON) confirmed the weekly bath audits were not getting completed weekly and further stated her expectation was for weekly baths and weekly bath audits were completed, or staff would complete documentation to express why they were not completed. A provided Fingernails/Toenails, Care of policy, dated 2/2022, identified nail care included daily cleaning, regular trimming, and can aid in the prevention of skin problems around the nail bed. The policy listed a section labeled, "Documentation," which outlined the date, time, name of person(s) providing the care, and condition of the nail and nail bed should all be recorded in the medical record along with, "If the resident refused the treatment, the reason(s) why and the intervention taken." The Bed Bath Policy (the bath policy provided) dated 2/8/22, indicated bath documentation would include the date and time the bath was performed, and the name and title of the person who completed the bath. Further the policy instructed staff to notify a supervisor it the resident refused the bath.	F 677		

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 690	R103 indwelling catheter was removed	11/8/22

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F 690	Continued From page 25 review, the facility failed to assess catheter removal and ensure appropriate follow-up and continued medical justification was obtained for 1 of 1 resident (R103) reviewed for indwelling catheters. Findings include: R103's discharge Minimum Data Set (MDS) dated 7/24/22, indicated R103 was cognitively intact and had diagnoses of congestive heart failure and diabetes. Furthermore, the assessment indicated R103 did not have a catheter and was frequently incontinent. R103's hospital discharge orders dated 8/16/22, indicated R103 had a urinary catheter placed and a urology consult was needed. R103's care plan revised 8/24/22, indicated R103 had a foley catheter for neurogenic bladder and indicated staff to observe for kinks in tubing and pain. R103's provider progress note dated 8/29/22, indicated R103 had a catheter for urinary retention. The note further indicated R103 had urinary retention and required intermittent catheterization during hospital admission and the concern was discussed with urology. Foley catheter was placed and R103 required outpatient urology follow up. R103's medial record lacked evidence of orders for the catheter/catheter management and trial voids to determine if the catheter was still required. Furthermore, R103's medical record lacked evidence a urology appointment was made.	F 690	following MD order. All existing residents with indwelling catheters were audited for appropriate use and any follow up urologist appointment were made if warranted. Newly admitted residents with urinary catheters will be assessed upon admission and any follow up appointments will be implemented. Facility health unit coordinators were in-serviced on setting follow up appointments and the MDS coordinators will review documentation for indwelling catheter and use of the appropriate diagnosis. MDS Director and/or designee will be responsible for compliance. Audit on appropriate use and follow up for catheter use will be weekly X 2 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or DON and brought to QAPI for review and recommendations. Compliance 11/8/22	

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F 690	Continued From page 26	F 690		

During an observation on 9/26/22, at 6:09 p.m. R103 was sitting on the edge of her bed. A catheter bag was seen secured to her leg. R103 stated the catheter was placed during a hospitalization in August and she had returned to the facility with it. R103 further stated the tubing was uncomfortable when sitting and she had asked for it to be removed.
R103 confirmed she had not seen a urologist.

An interview on 9/28/22, at 1:45 p.m. nursing assistant (NA)-D was not sure how long R103 had the catheter or why it was in place.

An interview on 9/28/22, at 1:48 p.m. licensed practical nurse (LPN)-F was not sure why R103 had a catheter, but felt it was chronic as R103 had always had one. LPN-F further stated an order was important to have as it gave direction on how often the catheter needed to be exchanged or when to discontinue it. LPN-F verified there was no urology appointment listed in R103's orders and explained the nurses or unit secretary was responsible to make the appointments and place it as an order in the chart.

An interview on 9/29/22, at 1:58 p.m. registered nurse (RN)-D stated R103 had moved to her unit right after R103's hospital stay and was not aware of R103's ability to void or need for the catheter. RN-D stated a urology appointment or trial voids would be the next step. RN-D acknowledged R103's urology appointment was missed and was not set up. Furthermore, RN-D expected the unit secretary or nurse to make the appointment as ordered upon hospital return. RN-D stated any resident with a catheter was at risk for infection

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F 690	Continued From page 27 and it was not best practice to have a catheter that was not necessary. A follow up interview on 9/29/22, 2:35 p.m. RN-D stated the provider was notified and orders were placed for catheter removal and trial voiding. R103's catheter had been removed. An interview on 9/29/22, at 1:14 p.m. the director of nursing (DON) expected staff to schedule follow-up appointments upon hospital return. DON further stated she was made aware of the missed appointment and what had happened. A facility policy titled Urinary Incontinence- Clinical Protocol revised 11/2021, directed the attending physician and staff to evaluate the potential for removing a catheter for residents recently admitted to the facility from yjr hospital with a newly placed indwelling catheter.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to provide post-dialysis assessment of a resident's condition and monitoring for post-dialysis complications for 1 of 1 resident (R131) reviewed for dialysis. Findings include:	F 698	R 131 had a dialysis assessment completed on 9/27/22. All other residents who receive dialysis services was audited and assessment was completed after receiving dialysis services. Future residents who receive dialysis services will have a post dialysis assessment	11/8/22

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F 698	Continued From page 28 R131's admission minimum data set (MDS) dated 8/29/22, indicated R131 was cognitively intact and required dialysis services. R131's Diagnosis Report dated 9/29/22, indicated diagnoses of dependence on renal (kidney) dialysis and end stage renal disease. R131's orders dated 9/24/22, indicated R131 go to dialysis on Tuesdays and Saturdays. An order dated 9/13/22, indicated nursing was to provide a post-dialysis assessment after returning from dialysis. R131's dialysis schedule indicated he should have attended dialysis on ten days since admission 8/27/22, 8/30/22, 9/3/22, 9/6/22, 9/10/22, 9/13/22, 9/17/22, 9/20/22, 9/24/22, and 9/27/22. R131's post-dialysis assessments were completed three of ten days on 8/24/22, 9/20/22, and 9/27/22. A post-dialysis assessment for 9/10/22, was listed as in progress and had no data entered. When interviewed on 9/26/22, at 3:44 p.m. R131 stated he has dialysis on Tuesdays and Saturdays. R131 stated he was not always assessed by the nurses when he returned from dialysis. R131 was observed at this time to have a port for dialysis on his chest. When interviewed on 9/28/22, at 10:37 a.m. registered nurse (RN)-A stated a post-dialysis assessment for R131 meant she should check the port, ensure the dressing over the port was clean and intact, and to complete the	F 698	completed upon return to the facility. Licensed nurses were in-serviced on the Dialysis Care Policy with emphasis on item #3 that residents who return from dialysis will be assessed for bleeding and dialysis complications. ADON and or/Designee will be responsible for compliance. Audit on completion of Dialysis UDA□s will be completed by ADON or Designee weekly X 4 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or DON and brought to QAPI for review and recommendations. Compliance 11/8/22	

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F 698	Continued From page 29 post-dialysis form in the electronic medical record (EMR). RN-A stated she completed the form on 9/27/22, after R131 returned from dialysis. RN-A confirmed the post-dialysis assessments had not been completed each time after dialysis. RN-A stated the assessment was to assess for bleeding, and to ensure R131 was safe and medically stable after dialysis. When interviewed on 9/28/22, at 10:44 a.m. licensed practical nurse (LPN)-A stated a post-dialysis assessment should include assessment of the port or shunt, a neurological assessment, and assessment for weakness. LPN-A stated nurses were to complete a post-dialysis assessment form in the electronic medical record (EMR) every time R131 returned from dialysis. LPN-A confirmed the forms were not completed as ordered each time after R131 returned from dialysis. When interviewed on 9/29/22, at 10:27 a.m. RN-B stated the purpose of the post-dialysis assessment was to assess for signs of infection, bleeding, dehydration, and renal concerns and to assess that R131 was medically stable after dialysis. RN-B confirmed the post-dialysis assessments were completed for 3 out 10 dialysis days. When interviewed on 9/29/22, at 12:32 p.m. the director of nursing (DON) stated her expectation was that when a resident returns from dialysis, during the shift following the arrival, a post-dialysis assessment would be completed. The Dialysis Care policy dated 11/3/22, indicated the nursing home staff would observe and document the status of the resident's dialysis	F 698		

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F 698	Continued From page 30 access site upon return from dialysis treatment to observed for bleeding and other complications.	F 698		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed failed to ensure repeated requests for new clothing were acted upon and addressed for 1 of 1 resident (R80) reviewed who made such requests. In addition, the facility failed to ensure outside pastoral care was coordinated and obtained for 1 of 1 resident (R355) who had requested to see a priest. Findings include: R80's quarterly Minimum Data Set (MDS), dated 8/9/22, identified R80 had intact cognition, demonstrated no delusional behavior, and required extensive assistance to complete most activities of daily living (ADLs). On 9/26/22 at 2:01 p.m., R80 was interviewed, and he explained he had repeatedly asked staff to help him get new, light-weight pants using the money from his personal funds account. When questioned on whom he'd been asking this request to, R80 responded with the name of registered nurse unit manager (RN)-E and voiced he'd been asking for "a couple weeks" now with no follow-up provided. R80 stated he understood staff, including RN-E, were busy but expressed	F 745	Clothing items was purchased for R80 on 10/14/22. A priest was present to visit R355 on 9/28/22. Review of the Grievance Log revealed no other requests for new clothing or pastoral care services request. Future resident request will be responded to as soon as possible. Clinical Leadership Team was in-serviced on resident rights with a focus on the right to have access to people and services both inside and out of the facility and the right to have the facility assist to manage his or her funds if he or she wishes. An emphasis on timely communication is noted. Director of Social Services and or/designee will be responsible for compliance. Audit on will be completed by Director of Social Services or Designee weekly X 2 weeks, Q 2 weeks X 1 and then monthly thereafter. Audits will be reviewed by LNHA and/or DON and brought to QAPI for review and recommendations. Compliance 11/8/22	11/8/22

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F 745	Continued From page 31 he would like some follow-up on the situation. When interviewed on 9/28/22 at 11:05 a.m., nursing assistant (NA)-F stated R80 spent a majority of his day in bed, however, did get up at times and wore pants when he did. On 9/28/22 at 2:13 p.m., RN-E and social worker (SW)-A were interviewed. RN-E acknowledged R80 had asked her several times to get him new "scrub pants" and use his trust account money to purchase them. RN-E stated she had been "swamped" and just forgot to act on the request though despite R80 asking for the pants for "[what] could very well be a month." SW-A verified she was unaware R80 had requested new pants, and she stated if someone needed new clothing they had several options, including ordering from a catalog, to facilitate that. SW-A if she had been aware of R80's repeated requests for new pants, she could have helped him. SW-A added it was important to ensure such requests were handled timely. R80's medical record was reviewed and lacked evidence R80's request for new pants had been acted upon or addressed despite being voiced for several weeks. When interviewed on 9/29/22 at 8:40 a.m., the director of social services (SW)-B stated she was unaware R80 had been repeatedly asking to get new pants. SW-B explained such information should be passed to leadership or social services so it could be acted upon; however, added obtaining clothing items was something "typically that probably would go to social services [to be addressed]." SW-B stated it was important to ensure requests were handled timely so residents	F 745		

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F 745	Continued From page 32	F 745		

"can get their basic needs met" and have "basic stuff" like clothing available for them.

A provided Social Worker job description, dated 8/2021, identified several essential functions of the position which included coordinating social service activities with other members of the interdisciplinary team (IDT) and, "Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident."

R355's admission MDS, dated 9/13/22, indicated R355 was cognitively intact.

R355's progress note dated 9/12/22, written by social worker (SW) indicated R355 would like to speak with a priest. Subsequent progress notes did not indicate R355 was provided that service.

When interviewed on 09/27/22, at 12:41 p.m. R355 stated she had not seen a priest as requested.

When interviewed on 09/27/22, at 1:55 p.m. the assistant director of nursing (ADON) stated she reviewed the clinical record and there was no follow-up by the SW for R355 to see a priest and the SW had not passed that information on to her. The ADON further indicated the SW who wrote the progress note about R355 wanting to see a priest was no longer employed by the facility as of 9/27/22 for lack of follow-up and notes about his work. Additionally, the ADON stated R355 had a 72-hour care conference, but there were no notes about the priest visit in those notes either.

When interviewed on 9/28/22, at 10:53 a.m.

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	245189	A. BUILDING ______ B. WING ______	C 09/29/2022

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SOUTHVIEW ACRES HEALTHCARE CENTER	**2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

(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 745	Continued From page 33 SW-B stated she found some hand-written notes from the SW who was no longer employed there, but did not find any mention of follow-up to arrange the priest visit, nor did she find any follow-up to arrange the priest visit in the electronic medical record. When interviewed on 9/29/22, at 12:28 p.m. the director of nursing (DON) stated her expectation when someone requests pastoral care would be for staff to first offer services by the in-house chaplain, and the chaplain could make a further recommendation as needed. A social services policy was requested, but not received.	F 745		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria.	F 811		11/8/22

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F 811	Continued From page 34 (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 health unit coordinators (HUC)-A was prohibited from feeding 1 of 1 resident (R91) with complicated feeding problems requiring a mechanically altered diet. Findings include: On 9/26/22 at 11:51 a.m., the entrance conference for the recertification survey was completed with the director of nursing (DON). At this time, the DON stated the facility used a "five meal plan," however, there were no paid-feeding assistants used or employed. R91's quarterly Minimum Data Set (MDS) dated 8/10/22, indicated R91 had severe cognitive impairment and had diagnoses of congestive heart failure and dementia. R91's MDS further indicated R91 required extensive assist of one with feeding. R91's nutrition Care Area Assessment (CAA) dated 5/12/22, indicated R91 required nectar thick liquids and a mechanically altered diet was	F 811	R 91 was assessed and there was no ill effects from this practice. The Paid Feeding Assistant program was stopped. Facility staff was informed on 10/20/22. The facility assessment was reviewed and updated as needed. Compliance date: 11/08/2022	

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F 811	Continued From page 35 in place to prevent complications of dysphagia. R91's care plan revised 7/28/20, indicated R91 required total assistance with one staff for eating. R91's provider order dated 2/18/2021, indicated R91 required a regular diet with puree texture and nectar thickened liquids. R91's assessment to determine safety/appropriateness for eating assistance from a paid feeding assistance was requested however was not received. During an observation on 9/28/22, at 11:07 a.m. R91 and HUC-A were seated at a table and HCU-A was assisting R91 with eating. Licensed practical nurse (LPN)-D was present and seated at another table in the dining area. R91's menu slip indicated R91 was on a regular/puree diet with nectar thickened beverages. R91's meal contained pureed pea soup, scrambled eggs, cream of wheat. HCU-A assisted R1 to finish approximately 50% of soup, 50% of eggs, and 50% of the drink. HUC-A stated she was not a nursing assistant but had taken a course on how to feed residents to assist during COVID-19 times. R91 had finished the meal without coughing. An interview on 9/29/22, at 10:40 a.m. registered nurse (RN)-H stated HUC-A helped residents with feeding if necessary. RN-H further stated HUC-A had education on feeding and could feed any resident. An interview on 9/29/22, at 10:46 a.m. LPN-D recalled the meal observation the prior day and verified HUC-A had occasionally helped residents	F 811		

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F 811	Continued From page 36 eat. LPN-D was not aware a resident list determining which residents were appropriate to be assisted with feeding by HUC-A. Furthermore, LPN-D stated she had never been directed to watch or monitor HUC-A when feeding residents. An interview on 9/29/22, at 10:50 a.m. RN-F verified R91 required assistance and supervision when eating. RN-F further stated R91 had difficulty swallowing and could choke easily. RN-F stated HUC-A was able to assist any resident with feeding as long as the diet orders were followed and could assist residents with eating in the dining area or in the resident's room. RN-F further stated residents who required isolation would not be appropriate for HUC-A to assist, but other residents would be fine if diet orders were followed. An interview on 9/29/22, at 11:02 a.m. RN-E stated there was a nurse who oversees the dining area, but HUC-A did not require supervision when assisting residents to eat. An interview on 9/29/22, at 1:29 p.m. DON stated the feeding assistant training occurred as part of the emergency staffing plan in 2020. The trained staff were then assigned to residents who needed assistance with eating. DON verified HUC-A was assigned to R91. DON was not sure if there was a list of residents who were appropriate for HUC-A to assist with eating or if any assessment was completed to determine which residents were appropriate for feeding assistants to help. A facility policy titled Paid Feeding Assistants revised 12/9/2021, directed residents are assessed for appropriateness for the feeding assistance program and received services	F 811		

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F 811	Continued From page 37 according to their plan of care.	F 811		
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a state approved training program for paid feeding assistants was provided for 1 of 1 health unit coordinators (HUC)-A who completed job duties of a paid feeding assistant for 1 of 1 residents (R91) who required feeding assistance. Finding include: Based on observation, interview and record review the facility failed to ensure an approved training program for paid feeding assistants (PFA) was provided for 1 of 2 activity assistants (AA)-A who completed job duties of a paid feeding assistant (PFA). This had the potential to affect 17 residents who utilized the "Dine with Assist" facility program administered by PFA's. Findings include: On 9/26/22 at 11:51 a.m., the entrance conference for the recertification survey was completed with the director of nursing (DON). At this time, the DON stated the facility used a "five meal plan," however, stated there were no	F 948	R 91 was assessed and there was no ill effects from this practice. The Paid Feeding Assistant program was stopped. Facility staff was informed on 10/20/22. The facility assessment was reviewed and updated as needed. Compliance date: 11/08/2022	11/8/22

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F 948	Continued From page 38 paid-feeding assistants used or employed. R91's quarterly Minimum Data Set (MDS) dated 8/10/22, indicated R91 had severe cognitive impairment and had diagnoses of congestive heart failure and dementia. R91's MDS further indicated R91 required extensive assist of one with feeding. During an observation on 9/28/22, at 11:07 a.m. R91 and HUC-A was seated at a table and HCU-A was assisting R91 with eating. HUC-A stated she was not a nursing assistant and had taken a course on how to feed to assist during COVID. An interview on 9/29/22, at 10:40 a.m. registered nurse (RN)-H stated HUC-A had received education and helped residents with feeding if necessary. An interview on 9/29/22, at 10:50 a.m. RN-F stated HUC-A had received education and was able to assist any resident with feeding if the diet orders were followed. An interview on 9/29/22, at 11:02 a.m. RN-E stated HUC-A had received education and training and was able to assist any residents with eating. An interview on 9/29/22, at 12:25 p.m. the staff in-service coordinator (SISC) stated the facility trained several non-nursing licensed staff to assist with feeding residents in 2020 to support emergency staffing during COVID. The class was based off a Minnesota Department of Health (MDH) feeding assistant training program but was not an 8-hour class. The facility program was	F 948		

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F 948	Continued From page 39	F 948		

approximately 1.5 hours. The SISC explained the MDH course included content that was currently covered in the facility's annual training. Examples included abuse, hand washing, fire alerts, and communication. An interdisciplinary team (IDT) decision was made to separate the content as some training was duplicated. SISC verified there was not collaboration with the state authority to ensure requirements for the facility's feeding assistance program were met.

An interview on 9/29/22, at 1:29 p.m. DON stated the feeding assistant training occurred as part of the emergency staffing plan in 2020. Non-nursing staff were asked and those who wanted to help residens with eating. Those who wanted to do this were then trained.

A facility policy titled Paid Feeding Assistants revised 12/9/2021, directed the facility's state-approved program will consist of 8 hours of training in for the following topics: feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, appropriate responses to resident behavior, safety and emergency procedures, infection control, resident rights, and recognizing changes in residents that are inconsistent with their normal behavior and reporting changes.

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/29/2022. At the time of this survey, Southview Acres Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/25/2022

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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K 000	Continued From page 1	K 000		

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Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

The Southview Acres Health Care Center is a 4-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1973, 1978 additions were constructed to the West Wing that was determined to be of Type II(222) construction. In 2000, additions were added to the East Wing that were determined to be of Type II (222) construction. Because the original building and the 3 additions are of the

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K 000	Continued From page 2 same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 220 beds and had a census of 152 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health	K 131		11/7/22

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K 131	Continued From page 3 Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain occupancy separations per NFPA 101 (2012 edition) section 19.1.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/29/2022 between the hours of 9:00 AM and 4:00 PM, it was revealed by observation that the fire door located by the 1st floor elevator did not latch close when tested. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 131	Fire door on 1st floor failed to latch closed during inspection and was repaired on 09/30/2022. All residents have potential to be affected by this. All fire doors in the building have been assessed and tested and no others were found to be deficient. The regulations related to Multiple Occupancies was reviewed by the Administrator and Maintenance Director. To ensure that the deficient practice does not reoccur, the following will be implemented: The Maintenance Director will continue to conduct his monthly fire door checks, to ensure proper closure. The Director of Maintenance will document his findings monthly to ensure compliance. The Director of Maintenance, in conjunction with the Administrator, will be responsible for reviewing all audits. Compliance date 11/07/22	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced	K 225		11/7/22

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K 225	Continued From page 4 by: Based on observation and staff interview, the facility failed to maintain egress stairwells per NFPA 101 (2012 edition), Life Safety Code section 7.1.3.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM and 4:00 PM, it was revealed by observation that a chair used for physical therapy was located in the stairwell by room N311. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 225	Stairwell on North Side was found to have a chair inside and the chair was removed on 09/29/2022. All residents have potential to be affected by this. Chair was removed from the stairwell. All additional stairwells were searched and no others were found to be deficient. The regulation on regarding Stairways and Smokeproof Enclosures have been reviewed. To ensure that the deficient practice does not reoccur, the following will be implemented: The Maintenance Director will conduct daily audits of every stairwell to ensure they are clear of any items. Therapy staff has been educated of need to remove any chairs from stairwell if/when utilizing stairwells for therapy use. The Director of Maintenance will audit the stairwells daily and document his findings daily to ensure compliance. The Director of Maintenance, in conjunction with the Administrator, will be responsible for reviewing all audits. Compliance date 11/07/22	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by:	K 271		9/28/23

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K 271	Continued From page 5 Based on observation and staff interview, the facility failed to maintain Discharge from Exits per NFPA 101 (2012 edition), Life Safety Code, section 7.2.8.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM and 4:00 PM, it was revealed by observation that the 2nd exit off the 4th floor did not have handrails and guards across the intervening rooftop exit pathway. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 271	Facility requesting a K400 Waiver.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Illumination of Means of Egress per NFPA 101 (2012 edition), Life Safety Code section 19.2.8 and 7.8.1.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 281	Quotes were requested from 3 local lighting companies on 10/20/2022 to have additional egress pathway lighting installed by the physical therapy exit. Lightning will be installed on building per contractor timeframe. No further action is needed. The regulation regarding Illumination of Means to Egress were reviewed by the	11/7/22

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	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/29/2022**

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K 281	Continued From page 6 On 09/29/2022 between 9:00 AM and 4:00 PM., it was revealed by observation that there was no outdoor lighting for the egress pathway next to the physical therapy exit located on the west side of the building outer perimeter. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 281	Maintenance Director and Administrator. Compliance date 11/07/22	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3 and NFPA 72 (2010 edition), Fire Alarm and Signaling Code, 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM and 4:00 PM, it was revealed by a review of available documentation that the facility did not conducted a semi-annual visual inspection of the fire alarm	K 345	The facility did not conduct a semi-annual visual inspection of the fire alarm system. A visual inspection of the fire alarm system was conducted on 10-07-2022. The policy and procedures regarding Fire Alarm System-Testing and Maintenance have been reviewed. No updates are warranted at this time. To ensure that the deficient practice does not reoccur, the following will be implemented as official facility policy: The Maintenance Director will conduct a visual inspection of the Fire Alarm system semi-annually. The Director of Maintenance will document his inspection	11/7/22

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K 345	Continued From page 7 system. An interview with Facility Maintenance Director verified these deficiency finding at the time of discovery.	K 345	semi-annually to ensure compliance. The Director of Maintenance, in conjunction with the Administrator, will be responsible to review the document to ensure the inspection was completed. Compliance date 11/07/22	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an automatic fire spinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.3.3. This deficient finding could have an isolated impact on the residents within the facility.	K 351	A fire sprinkler head on the 1st floor hallway is located closer than 4" from the wall above the smoke compartment doors. An audit of additional sprinkler heads was completed on 10/20/2022. Mentioned sprinkler head was moved on 10/19/2021 to gain compliance with the regulation. No further action is needed.	11/7/22

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K 351	Continued From page 8 Findings include: On 09/29/2022 between 9:00 AM and 4:00 PM., it was revealed by observation that a fire sprinkler head on the 1st floor hallway is located closer than 4" from the wall above the smoke compartment doors. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 351	The policy and procedures regarding Sprinkler System Installation have been reviewed. Compliance date 11/07/22	
K 353 SS=E	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 automatic fire	K 353	1. In stairwell, located by S310, there were two missing tiles from water	11/7/22

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K 353	Continued From page 9 sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems sections 4.1.5, 4.1.5.2, 5.2.1.1.4, and 5.2.1.3, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM and 4:00 PM, observation revealed sprinkler system findings in the following locations: 1. In stairwell located by S310 was mssing two ceiling tiles from water damage. 2. 1st floor hallway by the offices have small penaration around (13) 2" pipes going through the ceiling tiles. 3. Room E130 is a stoarge room with plastic bins stack to ceiling on one side not meeting the 18" clearance. 4. Fire sprinkler heads in the main kitchen are showing signed of dust build up around the fusable bulbs. An interview with Facility Maintenance Director verified these deficiency findings at the time of discovery.	K 353	damage. Missing ceiling tiles were replaced on 09/29/2022 2. 1st floor hallway by the offices have some pipes penetrating through the ceiling tiles, around (13) 2". Pipes were sealed on 09/30/2022 3. Room E130 is a storage room with plastic bins stacked to ceiling on one side not meeting the 18" clearance. Bins were removed on 09/30/2022 4. Fire sprinkler heads in the main kitchen are showing signs of dust build up around the fusible bulbs. Fire Heads were aired out and cleaned on 10/21/2022. The policy and procedures regarding Sprinkler System-Maintenance and Testing have been reviewed. No updates are warranted at this time. To ensure that the deficient practice does not recur, the following will be implemented: The Maintenance Director will conduct audits monthly for a year on the above items. The Director of Maintenance will document his findings/audit to ensure compliance. The Director of Maintenance, in conjunction with the Administrator, will be responsible to review the audits to ensure compliance. Compliance date 11/07/22	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		11/7/22

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K 920	Continued From page 10 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Equipment - Power Cords and Extension Cords per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM 4:00 PM, it was revealed by observation that an extension cord was being used as permanent power for the time clock located on the 1st floor corridor.	K 920	The facility time clock identified during survey was relocated 10/20/2022 to remove the need for an extension cord. The 2nd facility time clock was inspected and there was no additional adjustments were warranted. No further action is needed. The regulation regarding Electrical Equipment - Power Cords and Extension Cords were reviewed by the Maintenance Director and Administrator were reviewed. Compliance date 11/07/22	

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K 920	Continued From page 11 An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 920		
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain liquid oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/29/2022 between 9:00 AM 4:00 PM, it was revealed by observation that in room E322 has two portable (41) liter tanks in storage and one oxygen concentrator in use. An interview with Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 930	In room E322 has two portable (41) liter tanks in storage and one oxygen concentrator in use. All residents on oxygen have potential to be affected by this practice. Two oxygen tanks were removed from E322 on 09/29/2022. The policy and procedures regarding Gas Equipment - Liquid Oxygen Equipment have been reviewed. To ensure that the deficient practice does not reoccur, the following will be implemented: The Maintenance Director will conduct audits monthly for a year to ensure that rooms do not have additional oxygen tanks inside. Oxygen provider have been notified of need not to place additional tanks in resident room, but rather in storage room on unit. The Director of Maintenance will document his findings to ensure compliance. The Director of Maintenance, in conjunction with the Administrator, will be responsible for reviewing all audits.	11/7/22

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K 930	Continued From page 12	K 930	Compliance date 11/07/22	