



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 9, 2025

Administrator
Maplewood Rehabilitation Center
1900 Sherren Avenue East
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: November 7, 2024

Dear Administrator:

On December 20, 2024, the Minnesota Departments 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.

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 22, 2024

Administrator
Maplewood Rehabilitation Center
1900 Sherren Avenue East
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: November 7, 2024

Dear Administrator:

On November 7, 2024, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 February 7, 2025 (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 May 7, 2025 (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)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

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

PRINTED: 12/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2024
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE EAST MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 11/4/24 through 11/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 11/4/24 through 11/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H52761014C (MN00103510) H52761016C (MN00104815) H52761019C (MN00098480) H52761080C (MN00107120). The following complaints were reviewed: H52761015C (MN00098853) Deficient practice was identified related to incidental finding F695 H52761017C (MN00098832) Deficient practice was identified related to incidental finding F578 H52761018C (MN00106790) Deficient practice was identified related to incidental finding F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/27/2024

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 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.	F 000			
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the	F 551			12/16/24

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

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F 551	Continued From page 2 resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's right to determine their own healthcare decisions for 1 of 1 resident (R30), and failed to ensure R30 had a			F 551	R30 will be consulted about any future healthcare decisions. R30 and like residents will be offered to attend their own care conferences, this will be noted		

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F 551	Continued From page 3 right to revoke a power of attorney. Findings include: According to Minnesota Statutes 145C.06, a health care directive is effective for a health care decision when it meets the requirements of section 145C.03, subdivision 1; and the principal in the determination of the attending physician, advanced practice registered nurse, or physician assistant of the principal, lacks decision making capacity to make the health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met. A health care directive is not effective for a health care decision when the principal , in the determination of the attending physician, advanced practice registered nurse, or physician assistant of the principal, recovers decision -making capacity; or if other conditions for effectiveness otherwise specified by the principal have been met. R30's annual Minimum Data Set (MDS) dated 10/24/24, indicated intact cognition, did not have evidence of an acute change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have physical, verbal, or other behaviors, was not important at all to have a family or close friend involved in discussions about care and had the following diagnoses: anemia, hypertension (high blood pressure), dementia, anxiety, depression, borderline personality disorder, and personal history of other mental and behavioral disorders. R30's quarterly MDS dated 7/24/24, indicated intact cognition, did not have an acute change in mental status from baseline, did not have	F 551	on the care conference form moving forward. All like residents have the potential to be affected by this finding. Facility will audit all like residents with health care directives, that decisions are deferring to decision maker, to ensure proper documentation. Facility will audit 10 new admissions for alternative decision maker x3weeks, 6 new admissions for alternative decision maker x3weeks, 3 admissions for alternative decision maker x3weeks, to ensure residents rights to make own decisions abided by. To ensure all residents, including residents with alternative decision makers are being invited to care conferences and offered to make own decisions on their care. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Social Services Director to complete audits.		

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

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F 551	Continued From page 4 inattention, disorganized thinking, or altered level of consciousness, and did not have hallucinations or delusions. R30's quarterly MDS dated 5/2/24, indicated intact cognition, did not have an acute change in mental status from the baseline, did not have inattention, disorganized thinking, altered level of consciousness, and did not have hallucinations or delusions. R30's quarterly MDS dated 2/1/24, indicated intact cognition, did not have an acute change in mental status from the baseline, did not have inattention, disorganized thinking, or an altered level of consciousness, and did not have hallucinations or delusions. R30's significant change in status MDS dated 11/1/23, indicated severe cognitive impairment, did not have inattention, disorganized thinking, or an altered level of consciousness, and did not have hallucinations or delusions. R30's Profile form in the electronic medical record (EMR) indicated R30's FM-A was her financial power of attorney (POA) and next to the heading, "Power of attorney-care" indicated, "Do Not Use". R30's medical record was reviewed and lacked information R30 had a guardian. Additionally, R30's attending physician was (P)-K. R30's care plan dated 11/16/22, indicated R30 was alert and oriented to person and sometimes place, but needed cues and reminders for time and had short-term memory loss and family assisted in decision making. Interventions indicated ACP (Associated Clinic of Psychology) provide brief instructions, repeat instructions as			F 551			

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F 551	Continued From page 5 needed, explain all cares and procedures, if having trouble with word finding, take time to listen, observe for changes in cognitive status. R30's care plan dated 3/17/23, indicated R30 was able to ask questions and answer questions, was easily distracted, had difficulty with word finding and interventions indicated to allow R30 enough time to process and answer questions, ask yes or no questions, gain attention before talking, speak in simple and direct terms, and speak clearly and distinctly and adjust tone of voice. R30's care plan dated 11/28/23, indicated R30 required assistance in reading and understanding health documents and interventions included, family would read instructions, pamphlets, or other written materials, from doctors or pharmacies. R30's IDT (Interdisciplinary team) Care Conference form dated 2/12/24, 5/14/24, and 8/7/24, indicated FM-A attended the care conference. The form lacked documentation R30 attended or declined to go to the care conference. R30's medical record lacked evidence R30 refused to go to care conferences, and documentation lacked evidence R30's participation in care planning was not practicable. R30's Honoring Choices Minnesota Health Care Directive signed by R30 on 9/23/2019, indicated the document gave treatment choices and preferences, and or appointed a health care agent to speak on a person's behalf if a person cannot communicate or make their own health care decisions. R30 identified family member (FM)-A as her primary health care agent. The	F 551			

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F 551	Continued From page 6 form indicated the health care agent had the following powers when R30 was not able to communicate for herself: agree to, refuse, or cancel decisions about her healthcare, interpret any instruction in the document based their understanding of R30's wishes, review and release medical records, arrange for healthcare and treatment, decide which health care providers and organizations provide healthcare, make decisions about organ and tissue donation. Further, the document indicated R30 made the document willingly and was thinking clearly and if R30's wishes changed, would complete a new health care directive. Additionally, the health care instructions directed the health care agent to communicate choices and the health care team to honor them, if R30 could not communicate or make her own choices. R30's Resident Vaccine Administration Consent Form dated 10/1/24, indicated vaccines consented for included a check mark in the box next to influenza. In the box next to COVID-19 Vaccine/Booster appeared to be scribbled out and under the heading, Vaccines Declined, included a check mark in the box next to COVID-19 Vaccine/Booster. Next to the heading, Resident/Resident Representative's Signature, indicated the form was reviewed over the phone with FM. on 10/1/24. R30's physician progress notes dated 10/11/22 at 12:41 p.m., provided by the director of nursing (DON) on 11/7/24 at 11:06 a.m., indicated R30 had a rectovaginal fistula (an abnormal connection between the vagina and rectum) and wall thickening of the colon compatible with colitis (a disease that causes inflammation of the colon) and colonic diverticulosis (a condition where			F 551			

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F 551	Continued From page 7 small pouches form in the large intestine). R30 was admitted to the hospital with acute (an illness that has a rapid onset but usually clears up) metabolic encephalopathy (a problem in the brain) likely secondary to rectovaginal fistula and colitis which were managed with antibiotics. Further, the note indicated R30 did not currently have the ability to make medical decisions for herself possibly due to acute encephalopathy and FM-A expressed concern over the past year R30 did not have the capacity to make medical decisions with progression of her memory issues. The note further indicated the next of kin would need to be involved for decisions. R30's hospital department of psychiatry follow up consultation note dated 3/16/23, indicated psychiatry was consulted to evaluate new visual hallucinations and was seen by neurology who felt the presentation was consistent with delirium. R30's diagnoses included acute encephalopathy that was improving, dementia with Parkinson's, history of major depressive disorder, borderline personality disorder, and seizure disorder. R30 was not currently demonstrating capacity and the note further indicated to involve next of kin for all decision making. The note further indicated R30 did not have visual hallucinations at baseline and at baseline, was social and enjoyed talking to people. R30 was admitted to the hospital for an acute perforated diverticulitis with associated abscess (a condition where a pouch in the colon ruptured, causing a hole in the bowel wall and a pocket of pus formed) and status post drain placement. R30's Associated Clinic of Psychology (ACP) noted dated 2/15/24, indicated R30 was clear cognitively.			F 551			

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F 551	Continued From page 8 R30's ACP note dated 10/17/24, indicated R30 had verbal aggression toward FM-A because R30 felt FM-A was preventing her from receiving a vaccine. Additionally, the note indicated R30 was alert and oriented to person, place, and month. The note further indicated R30 clarified she did not need help with decisions, and was agreeable to the idea if she had others helping with health and financial decisions as necessary and feasible and staff were aware and working with FM-A regarding an alternate for decisions. Further, R30 felt strongly about voting and was receptive to potentially changing her decision making helper to a professional if an option as staff and sister have been discussing. R30's nurse practitioner ACP note dated 10/30/24, indicated R30 was alert and oriented, long term recall was adequate, and R30's short term recall was fair and did not want FM-A to be her power of attorney any longer and was planning to look into a non-family member assist with making decisions and managing her finances. Further, R30 was upset staff had to notify FM-A for everything. R30's progress notes dated 10/10/22 at 3:16 p.m., indicated R30 was sent to the hospital for altered mental status. R30's progress notes dated 10/20/22 at 3:57 p.m., indicated severe cognitive impairment. R30's progress notes dated 10/31/22 at 5:03 p.m., indicated R30 was not feeling well and was sent to the hospital. R30's progress note dated 11/15/22 at 9:05 a.m.,	F 551			

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F 551	Continued From page 9 indicated R30 returned to the facility from the hospital due to a diagnoses of a fistula of vagina to the large intestine and had a new colostomy. R30's progress note dated 2/13/23 at 4:00 p.m., indicated R30 had intact cognition. R30's progress note dated 3/1/23, at 1:05 p.m., indicated R30's was doing well cognitively and family has seen improvement at times logic was impaired and was able to make her needs known. R30's progress note dated 3/8/23, at 5:30 p.m., indicated R30 had increased confusion and difficulty with communication. R30's progress note dated 3/9/23 at 1:45 p.m., indicated R30 was lethargic. R30's progress note dated 3/9/23 at 6:59 p.m., indicated R30 was sent to the hospital for an evaluation. R30's progress note dated 3/17/23 at 10:12 p.m., indicated R30 returned, had a JP drain, and was on antibiotics for an abscess. R30's progress note dated 3/20/23 at 3:48 p.m., indicated R30 returned to the facility on 3/17/23 from the hospital with abdominal pain and diverticulitis. R30's progress note dated 4/4/23 at 1:47 p.m., indicated R30's cognition fluctuated a lot and was her judgement and reasoning. R30's progress note dated 6/16/23 at 4:59 p.m., indicated R30 was sent to the hospital for evaluation.			F 551			

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F 551	Continued From page 10 R30's progress note dated 6/22/23 at 2:56 p.m., indicated R30 returned from the hospital with a diagnosis of severe sepsis with shock from an abdominal abscess. R30's progress note dated 7/31/23 at 10:19 a.m., indicated R30 was not oriented to place and asked if she could go back to the care center. R30 has been confused in the past about where she is after returning from a hospitalization or appointment. R30's progress note dated 9/13/23 at 11:16 a.m., indicated R30 was in the hospital for a planned surgery. R30's progress note dated 10/6/23 at 9:02 p.m., indicated R30 returned to the unit and was stable with no pain, ate 100% had a wound vac. R30's progress notes dated 10/9/23 at 2:25 p.m., indicated R30 was admitted to the facility and R30's emergency contact was FM-A. R30's progress note dated 10/9/23 at 4:16 p.m., indicated moderate cognitive impairment. R30's progress note dated 11/1/23 indicated severe cognitive impairment. R30's progress note dated 11/3/23 at 4:06 p.m., indicated R30 was recently diagnosed with pneumonia. R30's progress note dated 11/29/23 at 2:38 p.m., indicated R30's 48 hour care plan and summary was reviewed with FM-A.	F 551			

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F 551	Continued From page 11 R30's progress note dated 12/28/23 at 4:55 p.m., indicated R30 tested positive for influenza A and the nurse received new orders for Tamiflu. R30's social services progress note dated 7/24/24 at 3:49 p.m., indicated R30 had intact cognition with no signs or symptoms of depression and R30 had a "guardian". R30's nursing progress note dated 10/21/24 at 2:54 p.m., indicated R30 requested a COVID-19 vaccination and consent was obtained from the "guardian" via email and the vaccine was administered in the left arm. R30's social service progress note dated 10/23/24 at 4:16 p.m., indicated R30 was upset with FM-A and FM-A was looking into "3rd party guardian" so FM-A was no longer the "guardian". R30's progress note dated 10/29/24 at 3:17 p.m., indicated social services spoke to FM-A, resident's "guardian" who agreed to have R30 seen by in-house psychiatrist instead of going to the community. The progress notes lacked any re-evaluation following the acute illnesses whether R30 had the ability to make medical decisions. During interview on 11/4/24 between 2:19 p.m., and 2:39 p.m., R30 stated the facility contacted FM-A for a care conference, but nobody contacted R30. R30 stated she was upset the facility contacted FM-A and did not include R30 in decisions about her healthcare. R30 stated FM-A was her power of attorney (POA) and it was not working and R30 wanted to change that. R30 stated one of the nurses told R30 that FM-A did	F 551			

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F 551	Continued From page 12 not want R30 to get the COVID shot and the next morning FM-A called and gave them her ok for R30 to receive the COVID shot which R30 stated should have been a given. R30 stated she informed social worker (SW)-A she was trying to change her POA and had also informed FM-A. During interview on 11/7/24 at 8:07 a.m., FM-A stated she was not R30's guardian, but was her POA and further stated R30 had gone to care conferences in the past, but has not gone recently and did not know why R30 had not gone to care conferences. During interview on 11/7/24 at 8:17 a.m., social worker (SW)-A stated care conferences were held per the MDS schedule and held on Tuesdays and on Wednesdays for memory care. SW-A stated they typically send invitations to therapy, activities, nursing, and dietary and discuss medications, code status, appointments, activities, and funeral home. SW-A stated she calls or emails the guardian or family and the resident is notified and can choose if they want to come. SW-A further stated she would document a note under social services in the care conference note if a resident did not want to attend. SW-A stated they looked on the profile form to know if a resident was capable of making their own decisions. SW-A stated if a resident had a guardianship, the guardianship paperwork was scanned into the miscellaneous file and would be identified on the Profile form in the electronic medical record (EMR). SW-A stated a resident would have to go through the court for a guardianship and stated it was up to the family to complete a POA and stated she did not assist residents in completing paperwork, but instructs the family to fill it out and she provided a contact			F 551			

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F 551	Continued From page 13 card for the notary. SW-A further stated FM-A was R30's POA and guardian, then stated FM-A was not R30's guardian after viewing the Profile form, and thought FM-A was working on becoming R30's guardian and R30 made her own decisions and FM-A respected her decisions. SW-A stated FM-A lived in another state and started the process for guardianship and added R30 did not attend care conferences, but she could ask her if she wanted to attend her care conference 11/8/24, and stated they didn't want to confuse anyone or upset them and further stated R30 had intact cognition and should have been asked if she wanted to attend care conferences and further stated they would have the POA sign consents if a resident had a POA, even if the resident was their own decision maker, and added she could not speak for nurses for consents. SW-A stated FM-A wanted to look into a third party guardianship and thought she contacted somebody from Minnesota and would get in contact with FM-A for the care conference 11/8/24, and stated it would be up to FM-A to make a determination whether R30 needed a guardian because the facility does not have anything to do with it and stated she would enter a note about FM-A wanting a 3rd party guardian. During interview on 11/7/24 at 8:43 a.m., the director of nursing (DON) stated SW-A scheduled care conferences quarterly and asks residents if they want to participate and documents a note in the care conference summary if a resident does not want to be present and stated if R30 hasn't been deemed incapacitated or incompetent should be invited to care conferences and sign consents. A policy was requested on resident rights and the DON stated they had a bill of rights they review upon admission.	F 551			

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F 551	Continued From page 14 During interview on 11/7/24 at 1:34 p.m., the administrator stated they had no other documentation for incapacitation and were going off a document the DON sent in an email on 11/7/24 at 11:06 a.m. A form, Resident Bill of Rights Minnesota Nursing Home and Boarding Care Home, dated 12/4/2015, indicated residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. A policy, Care Planning-Interdisciplinary Team, dated 7/21/23, indicated the resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan and every effort will be made to schedule interdisciplinary (IDT) care plan meetings at the best time of the day for the resident and family.	F 551			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580			12/16/24

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F 580	Continued From page 15 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various			F 580			

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F 580	Continued From page 16 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physician of a change in condition for 1 of 1 resident (R18) who was experiencing new vision loss. Findings include: R18's 5-day Minimum Data Set (MDS) dated 10/16/24, indicated intact cognition and diagnoses of type II diabetes mellitus, hypertension (HTN), and congestive heart failure (CHF). It further indicated R18 had adequate vision and didn't wear corrective lenses. R18's care plan dated 4/1/24, indicated adequate vision, able to read 12 point font, and does not wear glasses with an intervention to observe for signs and symptoms of changes in visual status and to notify the medical doctor (MD) if noted. R18's visit summary note from his last eye exam dated 7/30/24, indicated to schedule an appointment with a local retinal specialist/ophthalmology as soon as possible (ASAP) for evaluation and treatment. R18's physician's orders dated 11/6/24, indicated R18 had an appointment on 11/21/24 at 9:00 a.m. to see the retina specialist. R18's progress notes for the begining of November (11/1/24-11/6/24) lacked documentation the physician had been notified or	F 580	R18's chart updated with note from provider discussion. All residents have the chance to be affected by this finding. All residents were audited and updated for recent change of conditions. Facility Nursing staff will be educated on "SBAR"/Change-of-condition note process. Facility will audit progress notes for change of conditions to ensure SBAR notations and follow up completed during weekly stand-up meeting. Facility will audit 10 residents' charts x 3 weeks, 6 resident charts x3 weeks, 3 resident charts x3weeks. To ensure that all change of conditions' are addressed. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. DON or Designee to complete audits.		

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F 580	Continued From page 17 an appotinment had been made. During observation and interview on 11/04/24 at 1:11 p.m. R18 had a band-aid taped over some gauze on his right eye, stating he lost his vision yesterday, it had been happening for 3 weeks, and nobody had done anything. R18 further stated it was like he was looking through a "red fog." During interview on 11/06/24 at 10:11 a.m. the assistant director of nursing (ADON) stated R18 came back from Dialysis on Monday (11/4/24) with a patch over his right eye, stating he needed to make an eye appointment because his eye was irritated. The ADON further stated she had asked him what happened but since R18 had come back from Dialysis with new orders and they hadn't sent him to the hospital (right from Dialysis) that she didn't feel it was a cause for concern. The ADON stated she didn't know if anyone had assessed his eye and she would expect the nurses on each shift, (especially the nurse who worked on Monday, unkown) to have looked at his eye, assessed it, and documented on it. The surveyor asked the ADON how they would determine if R18's injury was severe or was an emergency situation and the ADON responded "that's a good question." The provider was walking out of the building on Monday and the ADON stopped her and stated R18's eye was irritated and he had an eye appointment scheduled (did not tell her the date), and was wondering if he was still able to go out into the community. The ADON verified she did not document anything about the incident or that she had notified the provider stating "It was my fault, I should have put in a note." The ADON also verified none of the nurses had documented they			F 580			

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F 580	Continued From page 18 had assessed R18's eye or notified the provider. During a follow up interview on 11/6/24 at 12:46 p.m., R18 stated LPN-B put the eye patch/bandage on his eye on Monday (11/4/24) before he went to Dialysis and no one had looked at his eye or assessed it since then. "It's bleeding inside and swirls of blood are coming into my sight, it's irritated, if I look into the light, it hurts. If I take the patch off my right eye, it screws up my vision in my left eye." The eye doctor had told him previously he had "bleeders" in both eyes but it wasn't that bad and his vision was still clear, but he should see a specialist to get a better scan. R18 stated his eye has been irritated for 3 weeks and felt like he had "hair in his eyes." They (facility) was supposed to make another appointment in early September but they never did. During interview on 11/6/24 at 1:05 p.m., licensed practical nurse (LPN)-B stated R18 had the eye patch on before leaving for Dialysis on Monday (11/4/24). R18 told him he had the patch because the light was bothering his eye and the night nurse had put the eye patch/bandage on for him. LPN-B further stated he only applied more tape to the bandage because R18 stated the light was shining through it but didn't assess his eye or document on it. LPN also stated he looked in the physician's orders but he didn't see anything regarding R18's eye. During interview on 11/7/24 at 9:35 a.m. the doctor of Optometry (OD) stated R18 had bleeding in both eyes and it was getting very close to the macula. When the blood get's into the macula it can cause vision loss and at the time of the appointment his vision was 20/20			F 580			

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F 580	Continued From page 19 therefore it was very important to get him into the retina specialist to prevent that from happening. The OD stated that was why she indicated on the visit summary to make him an appointment ASAP stating she rarely puts ASAP for a follow up appointment but felt "very strongly" about it in this case. During interview on 11/7/24 at 9:50 a.m. registered nurse (RN)-A stated if a resident had a new injury/bandage, they would ask the resident what happened, remove the dressing/bandage to assess the area, notify the physician, and document it. During interview on 11/7/24 at 9:55 a.m. (RN)-C stated if a resident had a new injury or bandage/dressing, etc. they would ask the resident how it happened, remove the bandage, assess the area, document, and notify the nurse practioner (NP). During interview on 11/7/24 at 10:07 a.m., the Health Information Manager (HIM) stated she and one other staff HIM-B were responsible for scheduling appointments for residents. She further stated R18 came to her at the begining of the week (not sure what day, possibly Tuesday) and said he needed to see the eye doctor so she went to look for the documentation of last visit (with Healthdrive) and couldn't find it, so she called them to fax it to her. The HIM further stated she wasn't aware R18 was supposed to make a follow up appointment and the first time she heard about it was when R18 told her his eye was bothering him. Usually Healthdrive sends the documentation over after each appointment and there was no system in place to check and make sure the documentation was sent over. The	F 580			

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F 580	Continued From page 20 surveyor asked the HIM why the appointment for the retina specialist was scheduled out a few weeks when the visit summary from the last eye appointment stated it should be made ASAP. The HIM verified she thought it indicated to schedule a follow up appointment in 1-2 months but verified she missed seeing that it actually said to schedule it ASAP. During interview on 11/7/24 at 12:15 p.m., the director of nursing (DON) stated if a resident had a change in condition or new injury/bandage the nurses were responbile for removing the bandage, assessing the area, try to find out how it happened, fill out a risk management, call the provider to receive further instruction, and doumen The facility's policy on notification of a change in condition dated 3/2024, indicated it is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.			F 580			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of			F 657			12/16/24

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F 657	Continued From page 21 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure residents were invited to care conferences for 1 of 1 resident (R30) reviewed for care planning. Findings include: R30's annual Minimum Data Set (MDS) dated 10/24/24, indicated intact cognition, did not have evidence of an acute change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have physical, verbal, or other behaviors, was not important at all to have a family or close friend	F 657	R30 was offered to attend care conference. All residents have the chance to be affected by this finding. All residents were audited and offered the chance to attend their upcoming care conferences, if refused, documentation added to progress notes. Social services educate on the importance of residents of offering residents to attend their own care conferences, including care conference policy. Facility to offer every resident the opportunity to attend their care conferences. Facility will audit 10 care conferences weekly x3 weeks, 6 care		

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F 657	Continued From page 22 involved in discussions about care and had the following diagnoses: anemia, hypertension (high blood pressure), dementia, anxiety, depression, borderline personality disorder, and personal history of other mental and behavioral disorders. R30's Profile form in the electronic medical record (EMR) indicated R30's FM-A was her financial power of attorney (POA) and next to the heading, "Power of attorney-care" indicated, "Do Not Use". R30's medical record was reviewed and lacked information R30 had a guardian. R30's care plan dated 11/16/22, indicated R30 was alert and oriented to person and sometimes place, but needed cues and reminders for time and had short-term memory loss and family assisted in decision making. Interventions indicated ACP (Associated Clinic of Psychology) provide brief instructions, repeat instructions as needed, explain all cares and procedures, if having trouble with word finding, take time to listen, observe for changes in cognitive status. R30's care plan dated 3/17/23, indicated R30 was able to ask questions and answer questions, was easily distracted, had difficulty with word finding and interventions indicated to allow R30 enough time to process and answer questions, ask yes or no questions, gain attention before talking, speak in simple and direct terms, and speak clearly and distinctly and adjust tone of voice. R30's care plan dated 11/28/23, indicated R30 required assistance in reading and understanding health documents and interventions included, family would read instructions, pamphlets, or other written materials, from doctors or pharmacies.			F 657	conferences x3weeks, 3care conferences x3weeks, to ensure that residents and representatives were offered and attendance noted in care conference form. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Social Services Director to complete audits.		

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F 657	Continued From page 23 R30's IDT (Interdisciplinary team) Care Conference form dated 2/12/24, 5/14/24, and 8/7/24, indicated FM-A attended the care conferences. The form lacked documentation R30 attended or declined to go to the care conference. R30's medical record lacked evidence R30 refused to go to care conferences, and documentation lacked evidence R30's participation in care planning was not practicable. R30's Honoring Choices Minnesota Health Care Directive signed by R30 on 9/23/2019, indicated the document gave treatment choices and preferences, and or appointed a health care agent to speak on a person's behalf if a person cannot communicate or make their own health care decisions. R30 identified family member (FM)-A as her primary health care agent. The form indicated the health care agent had the following powers when R30 was not able to communicate for herself: agree to, refuse, or cancel decisions about her healthcare, interpret any instruction in the document based their understanding of R30's wishes, review and release medical records, arrange for healthcare and treatment, decide which health care providers and organizations provide healthcare, make decisions about organ and tissue donation. Further, the document indicated R30 made the document willingly and was thinking clearly and if R30's wishes changed, would complete a new health care directive. R30's ACP note dated 10/17/24, indicated R30 had verbal aggression toward FM-A because R30 felt FM-A was preventing her from receiving a			F 657			

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F 657	Continued From page 24 vaccine. Additionally, the note indicated R30 was alert and oriented to person, place, and month. The note further indicated R30 clarified she did not need help with decisions, and was agreeable to the idea if she had others helping with health and financial decisions as necessary and feasible and staff were aware and working with FM-A regarding an alternate for decisions. Further, R30 felt strongly about voting and was receptive to potentially changing her decision making helper to a professional if an option as staff and sister have been discussing. R30's nurse practitioner ACP note dated 10/30/24, indicated R30 was alert and oriented, long term recall was adequate, and R30's short term recall was fair and did not want FM-A to be her power of attorney any longer and was planning to look into a non-family member assist with making decisions and managing her finances. Further, R30 was upset staff had to notify FM-A for everything. During interview on 11/4/24 at 2:39 p.m., R30 stated the facility contacted FM-A for a care conference, but nobody contacted R30. R30 stated she was upset the facility contacted FM-A and did not include R30 in decisions about her healthcare. During interview on 11/7/24 at 8:07 a.m., FM-A stated she was not R30's guardian, but was her POA and further stated R30 had gone to care conferences in the past, but has not gone recently and did not know why R30 had not gone to care conferences. During interview on 11/7/24 at 8:17 a.m., social worker (SW)-A stated care conferences were			F 657			

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F 657	Continued From page 25 held per the MDS schedule and held on Tuesdays and on Wednesdays for memory care. SW-A stated they typically send invitations to therapy, activities, nursing, and dietary and discuss medications, code status, appointments, activities, and funeral home. SW-A stated she calls or emails the guardian or family and the resident is notified and can choose if they want to come. SW-A further stated she would document a note under social services in the care conference note if a resident did not want to attend. SW-A stated they looked on the profile form to know if a resident was capable of making their own decisions. SW-A stated if a resident had a guardianship, the guardianship paperwork was scanned into the miscellaneous file and would be identified on the Profile form in the EMR. SW-A stated a resident would have to go through the court for a guardianship and stated it was up to the family to complete a POA and stated she did not assist residents in completing paperwork, but instructs the family to fill it out and she provided a contact card for the notary. SW-A further stated FM-A was R30's POA and guardian, then stated FM-A was not R30's guardian after viewing the Profile form, and thought FM-A was working on becoming R30's guardian and R30 made her own decisions and FM-A respected her decisions. SW-A stated FM-A lived in another state and started the process for guardianship and added R30 did not attend care conferences, but she could ask her if she wanted to attend her care conference 11/8/24, and stated they didn't want to confuse anyone or upset them and further stated R30 had intact cognition and should have been asked if she wanted to attend care conferences and further stated they would have the POA sign consents if a resident had a POA, even if the	F 657			

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F 657	Continued From page 26 resident was their own decision maker, and added she could not speak for nurses regarding the consents nurses obtained. SW-A stated FM-A wanted to look into a third party guardianship and thought she contacted somebody from Minnesota and would get in contact with FM-A for the care conference 11/8/24, and stated it would be up to FM-A to make a determination whether R30 needed a guardian because the facility does not have anything to do with assisting with guardianship and stated she would enter a note about FM-A wanting a 3rd party guardian. During interview on 11/7/24 at 8:43 a.m., the director of nursing (DON) stated SW-A scheduled care conferences quarterly and asks residents if they want to participate and documents a note in the care conference summary if a resident does not want to be present and stated if R30 hasn't been deemed incapacitated or incompetent should be invited to care conferences and sign consents. A policy was requested on resident rights and the DON stated they had a bill of rights they review upon admission. During interview on 11/7/24 at 1:34 p.m., the administrator stated they had no other documentation for incapacitation and were going off a document the DON sent in an email on 11/7/24 at 11:06 a.m. A form, Resident Bill of Rights Minnesota Nursing Home and Boarding Care Home, dated 12/4/2015, indicated residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, to request and participate in formal			F 657			

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F 657	Continued From page 27 care conferences, and the right to include a family member or other chosen representative, or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. A policy, Care Planning-Interdisciplinary Team, dated 7/21/23, indicated the resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan and every effort will be made to schedule interdisciplinary (IDT) care plan meetings at the best time of the day for the resident and family.	F 657			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined	F 660			12/16/24

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F 660	Continued From page 28 by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient	F 660			

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F 660	Continued From page 29 assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure swallow study referral discharge needs were identified in the post-discharge plan for 1 of 1 resident (R54) reviewed for discharge. Findings include: R54's admission Minimum Data Set (MDS) dated 9/18/24, identified intact cognition and diagnoses of type one diabetes mellitus (DM1), dysphagia (difficulty swallowing), heart failure, hypertension, kidney disease and depression. R54 was on a therapeutic diet and active discharge planning was place. R54's Care Area Assessment (CAA) dated 9/25/24, identified functional abilities (self-care and mobility) was triggered. R54 was admitted with poorly controlled DM1, end stage renal disease on dialysis, dysphagia, weakness, and muscle spasms. Physical, occupational and speech therapy were to evaluate. R54 had a history of noncompliance with medications and	F 660	R54 was contacted and notified of upcoming appointments post-discharge. Including phone number and information on reasoning for appointment. All residents have the potential to be affected by this finding. Facility audited all like residents with upcoming discharges to ensure upcoming appointments, post-discharge was included on discharge summary. Social Services and Nurse managers educated on roles and responsibilities with discharge summaries. Nurse managers discuss with residents importance of appointments including phone numbers. Facility will audit 10 discharge instruction summaries weekly x3 weeks, 6 discharge instruction summary x3weeks, 3 discharge instruction summary x3weeks, to ensure that residents are able to attend appointments post-discharge. The result of these audits will be shared with facility QAPI committee for input on needed to		

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F 660	Continued From page 30 was at risk for decline related to medication noncompliance and diabetic complications. R54's care plan dated 9/13/24, identified the goal was to return to the community once rehab was completed and medically stable. Interventions included staff would make necessary referrals as needed to carry out discharge goals. The care plan lacked intervention of R54 making her own post discharge appointments for a swallow study. R54's speech language pathologist (SLP) Evaluation and Plan of Care dated 9/13/24 through 10/12/24, identified R54 reported a swallow study was previously recommended, which has yet to be scheduled. Additionally, dysphagia was present and without skilled therapeutic intervention the patient was at risk for aspiration. Additionally, R54 lacked capacity for chronic disease management. R54's SLP Discharge Summary dated 9/13/24 through 9/25/24, identified she was referred for a swallow study and nursing would schedule the appointment. R54's SLP order dated 9/19/24, identified a swallow study was recommended for esophageal like symptoms. R54's progress notes dated 9/12/24 through 11/4/24, lacked documentation if the swallow study was scheduled, or if a discussion was held with R54 regarding any arrangements. R54's Care Conference Form dated 9/20/24, identified SLP worked on swallowing strategies, and a swallow study was recommended for follow up. The care conference had not addressed who	F 660	increase or decrease or discontinue audits. DON to complete audits.		

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F 660	Continued From page 31 would set up the swallow study. R54's progress note dated 9/26/24 at 1:56 p.m., identified she declined dialysis because while eating popcorn the night before, a "hub" got stuck in her throat, causing coughing to the point of vomiting. R54's Discharge Instructions and Summary form dated 11/1/24 identified the reason for discharge was OT/PT (occupational and physical) therapy were completed and R54 was ready to discharge home with home care. Follow up appointments were included to see the primary doctor seven to 10 days after discharge. R54's corresponding Order Summary Reort dated 11/1/24, identified on 9/19/24, a swallow study was recommended but lacked identification of R54's needs related to making the appointment. During an interview on 11/6/24 at 11:13 a.m., R54 stated she was discharged recently but was not made aware of arrangements for her recommended swallow study. R54 stated the appointment should have been set up before she was discharged because she feels food gets stuck in her throat. R54 stated instructions or appointments for swallow study were not on her discharge paperwork. During an interview on 11/6/24 at 11:35 a.m., the therapy program manager (TPM) stated SLP evaluated and treated R54 while she was a resident of the facility, and a recommendation was made for a swallow up study. The TPM stated the order was given to nursing and would have expected the appointment to be scheduled. The order was placed on 9/19/24 and R54 discharged on 11/4/24, which was 45 days after	F 660			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2024
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F 660	Continued From page 32 the order was placed. During an interview on 11/6/24 at 11:46 a.m., licensed practical nurse (LPN)-A stated typically social services (SW)-A would coordinate the discharge planning and was not aware of any SLP referrals for swallow study. If there was one, it would be present on the discharge summary in the electronic health record (EHR). During an interview on 11/6/24 at 11:48 a.m., SW-A stated updates from therapy should be included in the discharge summary given to the patient along with any referrals. SW-A stated SW-B had managed R54's discharge and was not aware of the status of a swallow study. During an interview on 11/6/24 at 11:54 a.m., R54's home health care intake provider (HHC) stated they were not made aware of any referrals for a swallow study but could pursue one if needed. During an interview on 11/6/24 at 12:04 p.m., SW-B stated referrals would be documented on care conferences and discharge summary. SW-B stated she made home health referrals for physical and occupational therapy but not for swallow study. During an interview on 11/6/24 at 1:15 p.m., the SLP stated she made R54's recommendation on 9/19/24, for a swallow study because of esophageal dysphagia. The SLP reviewed R54's medical record and could not find documentation on the follow up arrangements for a swallow study. The SLP stated she would have expected nursing to set up the appointment while a resident to ensure safe swallowing.	F 660			

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F 660	Continued From page 33 During a follow up interview on 11/6/24 at 2:00 p.m., LPN-A reviewed R54's medical record and stated the swallow study arrangements should have done while R54 was a resident. LPN-A added nursing would not schedule it, but the health unit coordinator would (HUC). During an interview on 11/6/24 at 2:41 p.m., the HUC stated when she gets an order for a referral, she puts it in the computer and nursing verifies the order. The HUC stated she would schedule appointments as needed. The HUC stated she thinks she remembers when the order was written and R54 was also scheduled to discharge, but she thought R54 would make the appointment independently. However, R54's medical record and discharge summary lacked instructions for R54 to do so. During a follow up interview on 11/7/24 at 8:08 a.m., R54 stated she wanted the facility to help her schedule it as she was not aware how to do that. R54 denied stating she would make the appointment independently. During an interview on 11/7/24 at 12:00 p.m., the director of nursing (DON) stated outside referrals such as swallow studies should have instructions included on the discharge summary. The facility's Discharge Planning Policy dated 11/2016, identified a discharge planning would be coordinated is coordinated by the interdisciplinary team in cooperation with community resources. The discharge plan would provide the resident with needed care and services, and to work out an acceptable solution for all concerned. Discharge planning was done to assure continuity	F 660			

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F 660	Continued From page 34			F 660			
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: During observation, interview, and record review the facility failed to ensure that residents received proper treatment to maintain vision for 1 of 1 resident (R18) reviewed for vision services. Findings include: R18's 5-day Minimum Data Set (MDS) dated 10/16/24, indicated intact cognition and diagnoses of type II diabetes mellitus, hypertension (HTN), and congestive heart failure (CHF). It further indicated R18 had adequate vision and didn't wear corrective lenses. R18's care plan dated 4/1/24, indicated adequate vision, able to read 12 point font, and does not wear glasses with an intervention to observe for signs and symptoms of changes in visual status			F 685			12/16/24
					R18's vision follow-up uploaded to chart, new appointment for vision set for soonest appointment available. All residents have the potential to be affected by this finding. Facility audited all like residents with recent inhouse services r/t vision and hearing to ensure documentation obtained and/or any new orders were received. Facility implemented DON to be second check after HIM reviews in house services after-visit summaries. Facility will complete a second check audit to ensure that any new orders are entered after each visit. Facility will audit weekly x3 weeks for new orders, transcribed or made. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease		

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F 685	Continued From page 35 and to notify the medical doctor (MD) if noted. R18's visit summary note from his last eye exam dated 7/30/24, indicated to schedule an appointment with a local retinal specialist/ophthalmology as soon as possible (ASAP) for evaluation and treatment. R18's physician's orders dated 11/6/24, indicated R18 had an appointment on 11/21/24 at 9:00 a.m. to see the retina specialist. R18's progress notes for the begining of November (11/1/24-11/6/24) lacked documentation the physician had been notified or an apotinment had been made. During observation and interview on 11/04/24 at 1:11 p.m. R18 had a band-aid taped over some gauze on his right eye, stating he lost his vision yesterday, it had been happening for 3 weeks, and nobody had done anything. R18 further stated it was like he was looking through a "red fog." During interview on 11/06/24 at 10:11 a.m. the assistant director of nursing (ADON) stated R18 came back from Dialysis on Monday (11/4/24) with a patch over his right eye, stating he needed to make an eye appointment because his eye was irritated. The ADON further stated she had asked him what happened but since R18 had come back from Dialysis with new orders and they hadn't sent him to the hospital (right from Dialysis) that she didn't feel it was a cause for concern. The ADON stated she didn't know if anyone had assessed his eye and she would expect the nurses on each shift, (especially the nurse who worked on Monday, unkown) to have	F 685	or discontinue audits. DON to complete audits.		

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F 685	Continued From page 36 looked at his eye, assessed it, and documented on it. The surveyor asked the ADON how they would determine if R18's injury was severe or was an emergency situation and the ADON responded "that's a good question." The provider was walking out of the building on Monday and the ADON stopped her and stated R18's eye was irritated and he had an eye appointment scheduled (did not tell her the date), and was wondering if he was still able to go out into the community. The ADON verified she did not document anything about the incident or that she had notified the provider stating "It was my fault, I should have put in a note." The ADON also verified none of the nurses had documented they had assessed R18's eye or notified the provider. During a follow up interview on 11/6/24 at 12:46 p.m., R18 stated LPN-B put the eye patch/bandage on his eye on Monday (11/4/24) before he went to Dialysis and no one had looked at his eye or assessed it since then. "It's bleeding inside and swirls of blood are coming into my sight, it's irritated, if I look into the light, it hurts. If I take the patch off my right eye, it screws up my vision in my left eye." The eye doctor had told him previously he had "bleeders" in both eyes but it wasn't that bad and his vision was still clear, but he should see a specialist to get a better scan. R18 stated his eye has been irritated for 3 weeks and felt like he had "hair in his eyes." They (facility) was supposed to make another appointment in early September but they never did. During interview on 11/6/24 at 1:05 p.m., licensed practical nurse (LPN)-B stated R18 had the eye patch on before leaving for Dialysis on Monday (11/4/24). R18 told him he had the patch because	F 685			

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F 685	Continued From page 37 the light was bothering his eye and the night nurse had put the eye patch/bandage on for him. LPN-B further stated he only applied more tape to the bandage because R18 stated the light was shining through it but didn't assess his eye or document on it. LPN also stated he looked in the physician's orders but he didn't see anything regarding R18's eye. During interview on 11/7/24 at 9:35 a.m. the doctor of Optometry (OD) stated R18 had bleeding in both eyes and it was getting very close to the macula. When the blood get's into the macula it can cause vision loss and at the time of the appointment his vision was 20/20 therefore it was very important to get him into the retina specialist to prevent that from happening. The OD stated that was why she indicated on the visit summary to make him an appointment ASAP stating she rarely puts ASAP for a follow up appointment but felt "very strongly" about it in this case. During interview on 11/7/24 at 9:50 a.m. registered nurse (RN)-A stated if a resident had a new injury/bandage, they would ask the resident what happened, remove the dressing/bandage to assess the area, notify the physician, and document it. During interview on 11/7/24 at 9:55 a.m. (RN)-C stated if a resident had a new injury or bandage/dressing, etc. they would ask the resident how it happened, remove the bandage, assess the area, document, and notify the nurse practioner (NP). During interview on 11/7/24 at 10:07 a.m., the Health Information Manager (HIM) stated she and	F 685			

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F 685	Continued From page 38 one other staff HIM-B were responsible for scheduling appointments for residents. She further stated R18 came to her at the begining of the week (not sure what day, possibly Tuesday) and said he needed to see the eye doctor so she went to look for the documentation of last visit (with Healthdrive) and couldn't find it, so she called them to fax it to her. The HIM further stated she wasn't aware R18 was supposed to make a follow up appointment and the first time she heard about it was when R18 told her his eye was bothering him. Usually Healthdrive sends the documentation over after each appointment and there was no system in place to check and make sure the documentation was sent over. The surveyor asked the HIM why the appointment for the retina specialist was scheduled out a few weeks when the visit summary from the last eye appointment stated it should be made ASAP. The HIM verified she thought it indicated to schedule a follow up appointment in 1-2 months but verified she missed seeing that it actually said to schedule it ASAP. During interview on 11/7/24 at 12:15 p.m., the director of nursing (DON) stated if a resident had a change in condition or new injury/bandage the nurses were responbile for removing the bandage, assessing the area, try to find out how it happened, fill out a risk management, call the provider to receive further instruction, and doument. A facility policy regarding ancilliary appointments was requested but not received.	F 685			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689			12/16/24

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F 689	Continued From page 39 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident was adequately assessed for safe smoking for 1 of 1 resident (R15) reviewed for smoking. In addition, the facility failed to ensure an identified safety hazard was acted upon for 1 of 2 residents (R50) reviewed for resident to resident abuse. Findings include: R15's PPS (prospective payment system) Part A-Minimum Data Set (MDS) dated 3/29/24, indicated R15 was cognitively intact, was independent or required supervision with most activities of daily living (ADLs), used intermittent oxygen therapy, and required a wheelchair for mobility. R15's diagnoses included hereditary motor and sensory neuropathy (nerve condition causing tingling, swelling or muscle weakness), and chronic respiratory failure. R15's care plan last updated prior to survey start on 10/21/24, indicated R15 smoked independently, agreed to wear a smoking apron, and required smoking material to be stored in the treatment cart. The care plan further indicated a smoking incident occurred on 2/21/24 and instructed staff to complete a smoking evaluation per facility policy and as needed.			F 689	R15's clothing audited for any new burn marks/holes, if yes were thrown away. R50 was reinterviewed on intention of flashlight use, Residents care plan updated related to previous safety concerning comments. All other like residents have the potential to be affected by this finding. Facility audited all like residents who smoke for updated smoking assessments that indicated need for smoking materials. Social Service and Nursing educated on smoking assessment policy. Complete second interview with resident regarding comments of safety concerns post resident to resident altercations, update care plan accordingly. Facility will audit 10 smokers, smoking assessments weekly x3 weeks, 6 smokers, smoking assessments x3weeks, 3 smokers, smoking assessments x3weeks, to ensure that residents smoking assessments with modifications are added to their care plan. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Social Service Director to complete audits.		

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F 689	Continued From page 40 R15's smoking assessment dated 2/27/24, indicated R15 was safe to smoke independently, could keep cigarettes and lighter in room, did not require adaptive equipment (smoking apron), and did not use oxygen. R15's smoking assessment dated 10/8/24, indicated R15 was safe to smoke independently, could keep cigarettes and lighter in room, and used oxygen. The assessment further indicated, "Resident had old clothes with holes. Resident has agreed to throw away any clothes with holes ...and remove items with burn holes ...Resident understands that if new burn holes are seen cigarettes/lighter will be locked and will need to wear a smoking apron." R15's smoking assessment dated 10/21/24, indicated R15 was not deemed safe to store/handle cigarette and lighter and used oxygen. The assessment further indicated, "Resident had lit a cigarette in her room ...While observing resident on 10/21/24 at one time and ash dropped from her cigarette onto her sweater. Writer had to tell her it was there ...Cigarettes/lighter will be locked in the nurse cart. She needs to wear a smoking apron, has to ask the nurse for her cigarettes and lighter each time she goes out and return them to the nurse when she comes in." R15's electronic health record (EHR) lacked evidence of any additional smoking assessments. During observation and interview on 11/5/24 at 9:12 a.m., R15 was lying in bed and was not wearing oxygen. The oxygen tank was not turned on. R15 stated having an incident a couple weeks	F 689			

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F 689	Continued From page 41 ago when she lit up a cigarette in her room upon waking but put it out right away. R15 stated she was confused upon waking and did not have her oxygen on at that time and was independent with her oxygen use, which was primarily overnight. R15 stated staff evaluated her ability to smoke safely when she admitted in February and could not recall another evaluation until October when they found burn holes in her clothing. During interview on 11/6/24 at 9:58 a.m., R15 stated staff just recently watched her smoke and saw that she dropped some ash on her sweater. R15 stated she also had several burn holes in her clothing but could not say when the burn holes happened. R15 stated, "they want to make sure I don't burn the place down or burn myself so now they hold onto my cigarettes and lighters, and I put this apron on before I can get them from the nurse cart." During interview on 11/6/24 at 10:11 a.m., registered nurse (RN)-A stated R15's cigarettes were stored in the cart and that R15 had to have the apron on prior to retrieving. RN-A stated social services performed the smoking assessments to determine if the residents were safe to smoke, but did not know how often those assessments occurred. During interview on 11/6/24 at 10:22 a.m., social work (SW)-A stated all residents were assessed on admission for smoking status and if they identified as a smoker then social services would complete a smoking assessment. SW-A further stated additional smoking assessments were completed by social services quarterly, with significant change and as needed. SW-A stated R15 had an assessment on admission and was	F 689			

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F 689	Continued From page 42 identified as a safe smoker and did not have another assessment until 10/8/24 when they identified burn holes in her clothing. SW-A stated another assessment was completed after a smoking incident on 10/21/24 when R15 lit a cigarette in her room. SW-A stated during that assessment, R15 was observed dropping ash on her sweater and therefore, an apron was then required. SW-A further stated R15 should have had two additional quarterly smoking assessments between admission and 10/8/24, and that they could not determine when the burn holes had occurred. During interview on 11/6/24 at 10:43 a.m., assistant director of nursing (ADON) stated smoking assessments were completed upon admission, quarterly and as needed. ADON stated R15 recently had a smoking incident and had burn holes identified and observed with shaky hands and dropping ash on her clothing. ADON stated they took her smoking materials away to be stored in the cart and provided a smoking apron. ADON confirmed R15 lacked two quarterly smoking assessments and could not identify when the burn holes had occurred. During interview on 11/6/24 at 10:56 a.m., director of nursing (DON) stated residents were assessed upon admission by the admission nurse and that the smoking assessment included observation to determine if the resident was safe to smoke independently and hold their own material. DON stated social services would follow up with additional assessments and ensure appropriate interventions were in place and care plan up to date. DON stated the expectation was that smoking assessments were completed on admission, quarterly and with significant changes.	F 689			

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F 689	Continued From page 43 Facility policy Resident Smoking Policy dated 10/2024, indicated, "Residents who choose to smoke will be evaluated upon admission, quarterly, annually and if significant change in condition/cognition exists or resident exhibits inability to follow safe smoking practices." R50's annual Minimum Data Set (MDS) dated 9/5/24, indicated moderate cognitive impairment, and prior Brief Interview for Mental Status (BIMS) indicated intact cognition, did not have hallucinations or delusions, physical, verbal, or other behaviors directed towards others, did not reject care, had a motorized wheelchair, and had depression, alcohol use with intoxication, nicotine dependence, and took antipsychotics, antianxiety, and antidepressant medications. R50's Medical Diagnosis form undated, indicated the following diagnoses: major depressive disorder, recurrent, severe with psychotic symptoms, nicotine dependence, alcohol use with intoxication, and depression unspecified. R50's care plan dated 10/11/23, indicated R50 became frustrated and overwhelmed at times on the smoking patio with others and knew to call the nurse on-call in this situation. R50's care plan dated 10/31/23, indicated R50's safety would be protected through staff interventions that included R50 to report to staff if feeling threatened or bothered by other residents and or staff, remove R50 from potentially abusive situations, provide a safe environment for individual and others and ensure the safety of others, and if R50 displayed persistent or inappropriate behaviors, remove R50 to an area away from others.			F 689			

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F 689	Continued From page 44 R50's care plan dated 12/1/23, indicated R50 had a behavior problem due to a diagnoses of depression, dementia and had a judgment or reasoning deficit and could be irritable at times and make comments about others especially when R50 felt disrespected and will tell others they are rude and inconsiderate and will attempt to defend others when R50 feels they are being disrespected especially female staff and residents and was in a resident to resident altercation 9/2024. Interventions included not to argue with resident and encourage R50 to come to staff when upset. R50's care plan dated 12/6/23, indicated R50 could easily become agitated by noise and environment and required redirection as able. An intervention included to redirect resident as needed from environment that can upset him. R50's care plan dated 12/6/23, indicated R50 had psychosocial issues and impaired coping mechanisms due to depression, judgement or reasoning deficit and became upset when other residents do not keep the smoking area clean and interventions dated 11/4/24, indicated to remind resident he does not need to clean the smoking area, and R50 has the on-call nurse number to call when he is upset with what other residents are doing or saying on the patio and agreed to call the number when upset. R50's care plan dated 9/20/24, indicated R50 was at risk for alterations in behavior related to trauma including resident to resident altercation and triggers included when people say dumb stuff and are rude.			F 689			

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F 689	Continued From page 45 R50's care plan dated 10/7/24, indicated R50 had a history and diagnosis of substance use and interventions indicated monitoring R50 for intoxication or impairment. R50's nursing progress note dated 9/18/24 at 9:58 a.m., indicated a nurse reported when attempting to change R50's catheter, R50 stated, "If you mess it up, I will kill you." R50 then refused catheter change and wanted a male nurse to complete. The director of nursing (DON) followed up with R50 who stated he did not mean what he said and was just kidding. R50's interdisciplinary team (IDT) progress note dated 9/19/24 at 12:08 p.m., indicated R50 had a resident to resident incident on 9/18/24. R50 was outside smoking and heard another resident (R71) who was intoxicated make sexually inappropriate comments to other female residents and staff. R50 asked multiple times for R71 to stop and R50 rammed his wheelchair into R71. The two residents were separated by a visitor. The note further indicated R50 had been easily agitated. R50's social services progress note dated 11/1/24 at 4:46 p.m., indicated R50 was instructed he could not tell people to leave the smoking area and felt he needed to clean the area all the time and the assistant director of nursing (ADON) came in and explained to R50 he had to allow others to use the smoking area and to ignore the residents. R50 became upset and was not able to be redirected. R50's social services late entry progress note created on 11/4/24 at 7:24 p.m., for 11/1/2024, indicated social worker (SW)-A followed up with			F 689			

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F 689	Continued From page 46 R50 regarding smoking on the patio and provided R50 a nurse on call phone number and directed R50 to call the nurse on call if he had concerns with other residents and R50 stated he would do this moving forward rather than approaching other residents himself. R50's Incident Review and Analysis form dated 9/19/24, indicated on 9/18/24 at 8:40 p.m., R50 had a resident to resident altercation. R50 was outside smoking and overheard R71 being vulgar and inappropriate towards another resident and R50 became frustrated and asked R71 to stop. When R71 did not stop, R50 used his wheelchair to sit in front of R71. R50 continued to tell R71 to stop and R71 began threatening R50. R50 then wheeled his chair into R71's chair causing R71 to move backwards. Under a heading, Contributing Factors that Impacted Incident, included, "Easily irritable". R50 reported feeling safe and did not want to file a police report. R50's Trauma Questionnaire form dated 9/20/24, at 9:24 a.m., indicated R50 had trauma that occurred after another resident made inappropriate comments and reported his triggers included when people said dumb stuff and were rude. R50 was not comfortable disclosing any coping strategies and allowing the strategies to be included with his plan of care. R50's nurse practitioner (NP) progress note dated 10/14/24, indicated when R50 was first admitted to the facility had frequent complaints, issues with compliance, and impulsivity and has less behavioral issues. Further R50's seroquel (antipsychotic) was decreased slightly in September and R50 was drinking heavily for a couple of weeks in September and had an	F 689			

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F 689	Continued From page 47 altercation with another resident. The note indicated R50's cognitive impairment seemed more mild and had no significant mood disturbance and planned to continue tapering Seroquel very slowly, and R50's brief excessive drinking appeared to be resolved. During interview on 11/4/24 at 5:53 p.m., R50 stated R71 made the most profane remarks. R50 further stated R71 hasn't tried to do anything after the incident, except yell at him and give him the finger and stated he noticed R71 was back to smoking in the smoking area again. R50 stated R71 was not going to change and stated he tried to stay away from R71, but if R71 started again, R50 stated he would either call the nurse on call or if it becomes like last time will call 911. R50 stated he told SW-A he had a flashlight in case anybody tried to hit him and he could not get away, otherwise planned to call the nurse and 911. During interview on 11/4/24 at 6:35 p.m., R15 stated R71 was showing up outside after he was banned and nobody liked it. During interview on 11/4/24 at 6:59 p.m., SW-A stated there was an interaction in the smoking area where R50 pushed R71 and was determined R71 would smoke in the front to avoid altercations from happening and there had been no further incidents, and R71 could smoke in the back again and R50 was aware. SW-A stated R50 showed her the flashlight the other day and they tried to take it away, but R50 wanted it as protection and SW-A stated they reminded R50 there were nurses that could come down and instructed R50 to remove himself from the situation. SW-A stated R50 would not allow her			F 689			

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F 689	Continued From page 48 or the assistant director of nursing (ADON) to take the flashlight. SW-A verified there was no mention of the flashlight in the care plan and stated R50 told them about the flashlight on 11/1/24, and they asked R50 to please not use it and keep it in his room and stated it should be on the care plan. SW-A stated she would have to talk with the ADON whether she changed the nurse aide sheets because SW-A did not touch those forms. SW-A stated R71 started going on the smoking patio again on 11/1/24. Further, SW-A stated they wanted to take the flashlight out of the room for safe keeping so R50 wouldn't hurt anyone, but R50 refused and R71 was on a leave of absence. During interview on 11/5/24 between 2:45 p.m., and 2:52 p.m., with the administrator, SW-A, and the director of nursing (DON), the DON stated R50 had the flashlight in case the lights went out or if out on a leave of absence. At 2:52 p.m., the DON stated she did not know why the facility would want to take a flash light and kept emphasizing it was a flashlight and stated they didn't take it and R50 did not make any threat of violence. SW-A verified notes from interview 11/4/24, they wanted to take the flashlight away. When asked why take the flashlight away if there were no concerns, they did not provide a response and the DON stated she thought R50 wanted the flashlight in case of an emergency. During interview on 11/5/24 at 3:04 p.m., the DON stated she clarified with R50 and R50 stated he would rather she take the flashlight than think he had bad intentions and stated residents could smoke in the back or the front and stated both residents had no restrictions on smoking and stated they gave guidance on where to smoke			F 689			

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F 689	Continued From page 49 and those had been lifted and further stated R50 and R71 avoid each other and did not hang out. During interview on 11/6/24 at 10:30 a.m., the certified occupational therapy assistant (COTA)-J stated he had been working in this building since 8/23/24, and had worked in previous facilities prior. COTA-J stated he did not know the process for when residents were evaluated for safety with power wheelchairs and was not familiar with R50 and stated occupational therapy (OT) completed the power chair screens. COTA-J stated for power wheel chair screens they look at whether a patient was the right size for the chair and not falling out and for safety wise, looked at whether a resident could control the wheelchair and get in safely and a resident's mental capacity and whether a resident was going to race through hallways or adjust the wheelchair so they weren't going too fast, and was not sure if they would conduct an assessment if a resident used a power chair purposefully to run into somebody and would have to ask their director of rehab. COTA-J viewed therapy notes and stated R50 had no OT notes. During interview on 11/6/24 at 10:44 a.m., nursing assistant (NA)-G stated she worked at the facility 5.5 years and stated the hearsay was R71 was drinking and rude to the women and R50 told him to stop and rammed into R71's chair. NA-G stated R50 sometimes states R71 is rude to ladies but does not associate with R71. During interview on 11/6/24 at 10:50 a.m., nursing assistant (NA)-F stated she worked at the facility for two years and was not aware R50 had a flashlight.	F 689			

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F 689	Continued From page 50 During interview on 11/6/24 at 10:56 a.m., the assistant director of nursing (ADON)-F stated prior to the incident, everyone smoked on the back patio and after the incident with R50 and R71, the plan was R71 would smoke in the front and R50 still smoked in the back and when things died down they approached R50 and R71 to see if both were ok with going to the smoking patio and both seemed ok with no concerns so they went back to smoking in the same area and have not heard any issues, but was aware R71's alcohol use bothered R50. ADON-F further stated she and SW-A spoke with R50 on 11/1/24, because R50 was telling people they could not smoke and R50 was very upset and they didn't want R50 to get into another resident to resident incident. R50 was upset so she left and went back and R50 was calm and stated he would let the nurse know if he was bothered. ADON-F stated she was directed by the DON to provide the on-call phone number for the nurse and R50 agreed to use if he was feeling mad or overwhelmed. ADON-F stated they had a live camera outside, but other than that did not know it was safe for R50 and R71 to smoke together again and stated R50 was only bothered by R71 when R71 was drunk. ADON-F stated she did not think OT assessed R50 after the incident and reviewed the Power Operated Vehicle policy that indicated the resident will be expected to complete an assessment with OT upon presentation of a power operated vehicle (POV) at the facility. Updated assessments may be required annually or more often as determined by a change of condition, or incident related to operating POV. ADON-F stated R50 should have had an assessment completed according to the policy.	F 689			

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F 689	Continued From page 51 During interview on 11/7/24 at 8:52 a.m., the director of nursing (DON) stated every conversation they had was for lighting and R50 never mentioned physically using the flashlight on anyone. Further, was told ADON-F and SW-A went in to talk to R50 about a smoking plan and did not know where the conversation led and stated R50 was upset and had a flashlight in his hand and was told they asked if they could hang on to the flashlight, and R50 did not say he was going to use it to harm anyone and did not know why they were trying to take it because he was using it for light purposes. Further, the DON stated the wheelchair policy indicated if an incident occurred additional evaluations may be required and stated it wouldn't be appropriate because R50 had the dexterity and could drive the POV and further stated they discussed it as a team and decided no additional assessment was needed and stated she would have to check where that information was documented and stated it might be in the OHFC file and stated IDT discussions were documented in the chart of OFHC file and no where else. An email from the DON sent on 11/7/24 at 11:06 a.m., indicated there was documentation R50 was not appropriate for an OT assessment on a daily follow up check list and the facility did not have a policy pertaining to resident safety. During interview on 11/7/24 at 1:34 p.m., the administrator provided a form, 9/19/24 Follow Up, that indicated to complete the POV form and that no OT was needed as per discussion in stand up.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695			12/16/24

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F 695	Continued From page 52 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was properly maintained and accurately documented per professional standards for 1 of 1 resident (R20). Findings include: R20's significant change Minimum Data Set (MDS) dated 9/4/24, indicated R20 had intact cognition and the following diagnoses: pulmonary embolism (a blockage in the lung artery) without acute cor pulmonale (enlarged right ventricle due to a lung condition), enterocolitis due to clostridium difficile, and unspecified dyspnea. R20's Physician Orders form indicated the following orders: 8/26/24, monitor for skin breakdown around the nose and behind the ears caused by oxygen tubing every shift. 8/27/24, and discontinued on 10/29/24, staff to follow enteric contact precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) due to C. Difficile (a bacteria that	F 695	R20's Oxygen tubing was changed immediately, post finding. All like residents have the potential to be affected by this finding. Facility will audit all like residents for Oxygen tubing dates. Nursing education on Oxygen policy, facility to change tubing on residents' shower date. Facility will audit 10 Oxygen tubing weekly x3 weeks, 6 Oxygen tubing x3weeks, 3 Oxygen tubing x3weeks, to ensure that all Oxygen tubing is changed and dated per policy. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. ADON or Designee to complete audits.		

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F 695	Continued From page 53 causes infection of the colon) every shift. 8/30/24, and discontinued on 10/2/24, oxygen sats 2 liters every shift for maintaining oxygen saturation at 88% or above and wean oxygen as able. 9/1/24, change oxygen tubing weekly every night shift every Monday. 10/2/24, oxygen sats 2 liters every shift for hypoxia wean oxygen as able, maintain oxygen saturation at 88% or above. R20's medication administration record (MAR) and treatment administration record (TAR) dated September 2024, indicated the following: 8/27/24, to 10/29/24, Staff documented they were following contact precautions due to C. Difficile (a bacteria that causes infection of the colon) every shift. R20 was on 1 to 2 liters of oxygen 28 out of 30 days. R20's oxygen tubing was documented as changed on the night shift on 9/2/24, 9/9/24, 9/16/24, 9/23/24, and 9/30/24. R20's MAR and TAR dated October 2024, indicated the following: Staff documented they followed contact precautions due to C. Difficile from 10/1/24, to 10/29/24. R20 was on 2 liters of oxygen 31 of 31 days. R20's oxygen tubing was documented as changed on the night shift on 10/7/24, 10/14, 24, 10/21/24, and 10/28/24. R20's MAR and TAR dated November 2024, saved on 11/4/24 at 4:40 p.m., indicated the following: R20 was on 2 liters of oxygen for 4 of 4 days.	F 695			

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F 695	Continued From page 54 R20's care plan dated 11/13/22, indicated R20 had frequent bladder incontinence and was occasionally incontinent of the bowel and required brief changes. R20's care plan dated 9/9/24, indicated R20 had an altered respiratory status and difficulty breathing due to pulmonary edema. During observation on 11/4/24 at 1:33 p.m., R20 was on 2 liters of oxygen in her room and the sticker on the tubing was dated 9/3. The tubing had not been signed off as changed in the MAR/TAR as of 4:42 p.m. During observation on 11/5/24 at 9:23 a.m., R2's oxygen tubing still contained the tape that indicated a date 9/3. During interview and observation on 11/5/24 at 9:34 a.m., registered nurse (RN)-A stated oxygen tubing was changed weekly when a resident used oxygen and further stated they sometimes dated the tubing and the order was also in the computer to change weekly. At 9:38 a.m., RN-A verified the oxygen tubing plugged into the oxygen unit contained a piece of tape and stated the tape was dated 9/3/24, and thought the extension and nasal cannula tubing was supposed to be changed weekly. During interview on 11/5/24 at 1:53 p.m., the assistant director of nursing (ADON) stated oxygen tubing should be changed weekly and dated with the date the tubing was changed and the old tubing discarded and further stated it was on the TAR and expected the nasal cannula and extension tubing to be changed and stated staff should document in the TAR once they changed	F 695			

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PRINTED: 12/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2024
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE EAST MAPLEWOOD, MN 55109		
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F 695	Continued From page 55 the tubing. ADON stated staff should not have signed off they completed the task in the TAR because it was false documentation and was also important to change for infection control. A policy on respiratory care was requested. An email from the director of nursing (DON) dated 11/6/24 at 9:22 a.m., indicated they did not have a policy on oxygen tubing, but followed batch orders that instructed staff to change the tubing weekly. Additionally, they did not have a policy on accurate documentation and expected nurses follow orders and document accurately and if not completed, would follow the corrective action procedure. During interview on 11/7/24 at 8:50 a.m., the DON stated she expected staff to follow orders and not document if something was not completed and further stated she completed corrective action with their nurse and added the other nurse was an agency nurse.	F 695			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			12/16/24

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F 880	Continued From page 56 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			F 880			

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F 880	Continued From page 57 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented with the use of personal protective equipment (PPE) during high-contact resident care activities for 1 of 1 residents (R39) who had a central line, 1 of 1 residents (R38) who had wound dressings changed, and 1 of 3 residents (R11) observed during personal cares. The facility also failed to ensure appropriate hand hygiene was utilized for 1 of 2 residents (R38) observed during personal cares, and failed to ensure shared resident equipment was disinfected between uses for 1 of 1 residents (R3) observed for shared equipment. Lastly, the facility failed to ensure re-usable ice packs for clinical use were stored separately from food storage in 3 of 3 kitchen refrigerators. Findings include: R39's admission Minimum Data Set (MDS) dated 10/20/24, identified intact cognition, no rejection of care or behaviors, partial/moderate assistance needed for upper body dressing and supervision for personal hygiene. Diagnoses included			F 880	Facility staff educated immediately on EBP x3. All like residents have the potential to be affected by this finding. Facility will audit all resident on Enhanced Barrier Precautions to ensure that signage is posted according to orders. Facility will educate all nursing staff on Enhanced Barrier Precautions, cleaning of shared equipment. Facility will audit 10 EPB x3 weeks, 6 EBP x3weeks, 3 EBP x3weeks, to ensure that all Saff is following EBP. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. DON or Designee to complete audits. Facility will audit 10 cares for hand hygiene weekly x3 weeks, 6 cares for hand hygiene x3weeks, 3 cares for hand hygiene x3weeks, to ensure that all staff are performing hand hygiene between cares. The result of these audits will be		

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F 880	Continued From page 58 extradural and subdural abscesses and type two diabetes mellitus. Injections and antibiotics were received 7/7 days. R39's functional abilities Care Area Assessment (CAA) worksheet dated 10/20/24, identified a history of infection following lumbar spine surgery which required intravenous (IV) antibiotics. The surgical site became reinfected and required additional surgery. Then, he was admitted to the facility on IV antibiotics, wound care and peripherally inserted central catheter (PICC) line (long, thin tube that's inserted through a vein in the arm and passes through to the larger veins near the heart, requires careful care and monitoring for complications, including infection) care. R39's care plan dated 10/17/24, identified contact precautions were in place due to VRE (vancomycin-resistant enterococci which is resistant to antibiotics, in lumbar area due to abscess. The care plan was marked as resolved on 10/25/24. There was no care plan in place for EBP until 11/4/24. R39's orders identified: 10/16/24, flush line (PICC) with 10 milliliters (mL) of normal saline prior to IV drug administration daily. 10/15/24, PICC/midline monitor site, location left arm every shift for s/s of infection and infiltration every shift. 10/21/24, PICC/midline change dressing location left arm using sterile technique weekly and as needed. 10/15/24, complete infection nurses note and document what antibiotics, how long, why, symptoms, side effects, effectiveness every day			F 880	shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. DON or Designee to complete audits. Facility will audit 10 shared equipment uses weekly x3 weeks, 6 shared equipment uses x3weeks, 3 shared equipment uses x3weeks, to ensure that all staff are cleaning shared equipment after use. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. DON or Designee to complete audits.		

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F 880	Continued From page 59 shift until 11/20/24. There were no orders for EBP until 11/4/24 at 11:00 p.m. During an observation and interview on 11/4/24 at 12:50 p.m., R39's door lacked EBP signage or nearby PPE. R39 was in bed and awake. A PICC line with dressing was observed on his left upper arm. He stated he got IV antibiotics through the PICC line, and he had not noticed staff wearing a gown while providing this care. During an observation on 11/4/24 at 1:50 p.m., registered nurse (RN)-D prepared to give R39 his IV antibiotic. RN-D performed hand hygiene, entered the room, put gloves on, used an alcohol wipe to clean the port of the PICC line and flushed the line with 10 mL of normal saline. He attached the antibiotic to the PICC line and opened (unclamped) the line to start the infusion. RN-D also assisted R39 to put on his back brace. RN-D had not worn a gown in accordance with EBP. During a follow up interview on 11/4/24 at 2:04 p.m., RN-D was not immediately sure if a gown was required for R39 high-contact cares since there was no signage or PPE bin outside. However, he added, he should have due to the PICC line. During an observation and interview on 11/5/24 at 1:52 p.m., R39's door had EBP signage and PPE organizer on the door. EBP signage directed staff to wear gloves and a gown for high-contact resident care activities including dressing, bathing, transfers, hygiene, incontinence care, and device care including lines, catheters, tubes tracheostomy and wound care. The PPE	F 880			

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F 880	Continued From page 60 organizer contained gloves and gowns. RN-E prepared to give R39 his IV antibiotic. RN-E performed hand hygiene, entered the room, put gloves on, opened an alcohol wipe to clean the port of the PICC line, said he was going to start the IV antibiotics, and was stopped by surveyor and asked if EBP were required. RN-E initially had not known what EBP stood for and exited the room to check the orders. RN-E re-entered the room and came back with a gown, put it on and then put on gloves. R39 asked RN-E what the gown was for, and it was explained it was for IV site care and flushed the line with 10 mL of normal saline. RN-E attached the antibiotic to the PICC line and opened the line to start the infusion. After RN-E exited the room he stated for PICC line care staff needed EBP PPE on, he explained he had not thought of it today. R38 EBP R38's significant change MDS dated 9/17/24, indicated R38 had moderate cognitive impairment, was dependent on staff for personal cares, and received hospice services. R38's diagnoses included dementia, mood disturbance, anxiety, and adult failure to thrive. R38's care plan updated 4/8/24 indicated R38 required enhanced barrier precautions (EBP) related to a foley catheter and history of ESBL/MRSA [extended-spectrum beta-lactamase (an enzyme that make bacteria resistant to many antibiotic)]/methicillin-resistant Staphylococcus aureus (a type of staph bacteria that is resistant to many antibiotics)]. R38's provider orders dated 6/5/24, indicated, "Follow EBP while providing wound cares and other high contact care activities."			F 880			

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F 880	Continued From page 61 During observation on 11/7/24 at 8:15 a.m., R38's door had EBP signage on door and PPE organizer outside the door. EBP signage directed staff to wear gloves and a gown for high-contact resident care activities including dressing, bathing, transfers, hygiene, incontinence care, and device care including lines, catheters, tubes tracheostomy and wound care. The PPE organizer contained gloves, masks and gowns. Doctor of Medicine (MD)-A (rounding wound doctor) entered R38's room. MD-A was wearing a mask, and applied gloves, but did not don a gown. MD-A observed R38's coccyx wound , and bilateral heels. MD completed an ultra sound mist treatment to R38's heel, removed her gloves, washed her hands and left the room. Interview on 11/7/24 at 8:30 a.m., MD-A indicated she" missed the sign on the door" that indicated R38 was on Enhanced Barrier Precautions., and indicated if she would have seen the sign, she would have put a gown on. R38 Hand Hygiene R38's significant change MDS dated 9/17/24, indicated R38 had moderate cognitive impairment, was dependent on staff for personal cares, and received hospice services. R38's diagnoses included dementia, mood disturbance and anxiety, and adult failure to thrive. R38's care plan updated 4/8/24 indicated R38 required enhanced barrier precautions (EBP) related to a foley catheter and history of ESBL/MRSA [extended-spectrum beta-lactamase (an enzyme that make bacteria resistant to many antibiotic)]/methicillin-resistant Staphylococcus aureus (a type of staph bacteria that is resistant to many antibiotics)].			F 880			

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F 880	Continued From page 62 During observation on 11/6/24 at 7:43 a.m., Trained medication assistant (TMA)-A washed R38's rectal area, changed her gloves, but did not perform hand hygiene. TMA -A repositioned R38 in bed and removed her gloves and left the room. Interview on 11/06/24 at 07:58 a.m., TMA-A indicated that she should have used hand sanitizer or washed her hands after removing her gloves. Shared Equipment During observation on 11/6/24 at 9:10 a.m. TMA -A and nursing assistant (NA) - A transferred R3 into bed with a Hoyer lift (a lift that helps caregivers safely transfer patients from chair to bed). TMA-A removed the lift from R3's room into the spa room, and walked away. Interview on 11/6/24 at 9:21 a.m., TMA-A stated the lift should be cleaned when brought out of a resident's room, and left the spa room. TMA-A returned to the spa room at 9:30 a.m. and proceeded to clean the lift with wipes that were in the bag on the back of the lift. R11 R11's quarterly MDS dated 9/17/24, indicated R11 had severe cognitive impairment, was frequently incontinent of bowel and bladder, and was dependent on staff for personal cares. R11's diagnoses included dementia, cerebral atherosclerosis (a condition causing plaque buildup in the arteries and decrease blood flow to the brain), and reduced mobility. R11's care plan updated 11/1/24, indicated R11 had a stage II pressure ulcer on sacrum and required enhanced barrier precautions (EBP)			F 880			

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F 880	Continued From page 63 related to the wound. The care plan instructed staff to "don/doff [put on/take off] PPE per [EBP] when providing high contact cares." R11's provider orders dated 11/1/24, indicated, "Follow EBP while providing wound cares and other high contact care activities." During observation on 11/5/24 at 12:55 p.m., nursing assistant (NA)-B and NA-C wheeled R11 into her room to transfer back to bed and complete a brief change. Signage for EBP and all appropriate PPE observed on R11's door. Both NA-B and NA-C donned gloves, but neither donned a gown. R11's sling was attached to the Hoyer lift and R11 was lifted up and transferred to bed. R11's pants removed, and brief checked and found to have bowel movement (BM). Brief removed and dressing noted over the sacral wound. NA-B completed peri care wiping R11's bottom up to and including the bottom edge of the dressing. A new brief placed. R11 positioned and tucked in bed for a nap. During interview on 11/5/24 at 1:16 p.m., NA-B stated was not sure what the signage meant or if it was for R11 or her roommate. NA-B stated did not think he needed to wear a gown for peri care on R11. During interview on 11/5/24 at 1:23 p.m., NA-C stated EBP was for residents with a catheter or wound and that staff need to gown and glove when caring for those residents. NA-C stated R11's precautions must be new this week and did not notice the signage or PPE on her door. NA-C further stated he and NA-B should have donned gowns while performing cares on R11 since she had a wound.	F 880			

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F 880	Continued From page 64 R35's annual MDS dated 10/17/24, indicated intact cognition and diagnoses of chronic kidney disease (CKD) and type II diabetes. It further included R35 required staff assistance with activities of daily living, mobility, had a catheter and was frequently incontinent of bowel. R35's care plan dated 4/1/24, indicated R35 was currently on EBP related to a wound and foley catheter. It further included the following interventions: -staff to follow EBP -explain reason for and use of EBP -staff to don (put on)/doff (take off) personal protective equipment (PPE) when providing high contact cares. During observation on 11/04/24 at 3:02 p.m., R35 put on his call light and the assistant director of nursing (ADON)- entered the room. R35 stated he wanted to be boosted up in bed. The ADON applied gloves and assisted him to roll onto his left side, adjusted his brief, assisted him to roll onto his back, and pulled the trapeze bar down and handed it to him. R35 then used the bar to boost himself up in bed. The ADON then removed her gloves and left the room. The ADON was not wearing a gown while assisting R35. During interview on 11/4/24 at 3:13 p.m., the ADON verified she was not wearing a gown when assisting R35 with cares and was only required to wear a gown for catheter and wound care stating R35's order indicated he only need to be on enhanced barrier precautions (EBP) for catheter and wound care. The ADON also stated EBP was specific to what each resident had for			F 880			

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F 880	Continued From page 65 instance if a resident had a wound staff only needed to follow EBP when caring for the wound. During interview on 11/7/24 at 9:38 a.m., nursing assistant (NA)-C stated if a resident was put on EBP, staff were required to wear a gown and gloves when performing any personal cares. During interview on 11/7/24 at 9:45 a.m., NA-E stated staff were supposed to wear a gown, gloves, and a mask when performing cares on a resident who is on EBP. During interview on 11/7/24 at 9:50 a.m., RN-A stated when a resident was on EBP, staff were required to wear gloves and a gown for all personal cares. During interview on 11/7/24 at 10:00 a.m. RN-C stated staff are supposed to wear gown and gloves when performing any type of cares for a resident on EBP. Ice packs During observation on 11/5/24 at 9:45 a.m., the resident freezer in the third-floor kitchenette contained a reusable blue ice pack. It was touching residents' labeled containers of food. A sign posted on the refrigerator indicated for resident food only. During observation on 11/5/24 at 9:50 a.m., the resident freezer in the second-floor kitchenette contained a blue reusable ice pack, touching residents' labeled items. A sign posted on the refrigerator indicated for resident food only. When interviewed 11/5/24 at 10:00 a.m., registered nurse (RN)-B stated ice packs were not supposed to be in freezer in kitchenettes, and			F 880			

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F 880	Continued From page 66 stated there was a freezer for residents' ice packs in the nursing office. Reusable ice packs were not supposed to be with food for infection control reasons. (RN)-B removed the ice pack from the freezer. During observation on 11/5/24 at 10:13 a.m., the resident freezer in the first-floor kitchenette contained multiple blue reusable ice packs. The ice packs were touching residents' frozen labeled items including ice cream and containers of food. A sign posted on the refrigerator indicated for residents' food only. When interviewed on 11/5/24 at 10:15 a.m., nursing assistant (NA)-D stated ice packs should not be stored in the freezer. At 10:17 a.m., the culinary director (CD)-G entered the kitchenette, removed the reuseable blue ice packs swiftly out of the freezer, and stated they didn't belong there, and stated there was medication freezer for the ice packs. When interviewed on 11/6/24 at 10:29 a.m., director of nursing (DON) stated the reusable ice packs should be stored separately in the medication room freezers and not freezers in the kitchenettes due to infection control concerns, and they expected all staff to know and follow this procedure. During an interview on 11/7/24 at 12:00 p.m., the director of nursing (DON) stated EBP should always be utilized for high-contact resident care activities for residents that meet the requirements, for infecton control purposes, and to help prevent the spread of multi-drug resistant organisms, and signage with directions including the needed supplies should be in place to assist	F 880			

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F 880	Continued From page 67 with staff compliance. The DON stated hand hygiene should be completed between glove changes during major cares such as incontinence care. Shared resident equipment such as transfer lifts should be cleaned between uses, and have the disinfectant wipes in a bag on the lifts. The facility's EBP policy dated 4/1/24, defined EBP as the implementation of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (for example residents with wounds or indwelling medical devices). Indwelling medical devices included central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and wounds including chronic wound such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers. Review of Monarch Healthcare Management Handwashing Policy dated 2/2024 directed staff: "When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves."	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883			12/16/24

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F 883	Continued From page 68 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883			

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F 883	Continued From page 69 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R5 and R20) were offered and/or provided updated vaccinations for pneumococcal disease in accordance with the Centers for Disease Control (CDC) vaccination recommendations. Findings include: R5's Resident Information form dated 11/7/24, identified she was admitted on 9/7/24, and was currently 93 years old with diagnoses which increased the risk of pneumococcal disease including chronic obstructive pulmonary disease, heart failure and history of acute respiratory failure. R5's undated Immunizations form identified the PCV-13 and PPSV23 were given on 2/23/15. R5's vaccine consent form dated 9/7/24, identified she consented to receive the pneumococcal vaccines per primary care provider order and CDC guidelines. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 9/12/24, identified based on R5's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least	F 883	R5 and R20 were offered vaccinations. All residents have the potential to be affected by this. Facility to audit all residents for immunizations per consent and CDC application. Facility to utilize CDC application for shared clinical decision-making process regarding vaccinations. Facility will audit 10 residents' immunizations weekly x3 weeks, 6 residents' immunizations x3weeks, 3 residents' immunizations x3weeks, to ensure that residents are up to date per CDC recommendations or have record of declination. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. DON/IP to complete audits.		

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F 883	Continued From page 70 5 years after the last pneumococcal vaccine dose. R5's medical record lacked a discussion of shared clinical decision making regarding additional pneumococcal vaccines. R20's Resident Information form dated 11/7/24, identified she was admitted 11/12/22, and was currently 82 years old with diagnoses increasing the risk of pneumococcal disease including pulmonary embolism, dyspnea (difficulty breathing), chronic heart failure and obstructive sleep apnea. R20's vaccine consent form dated 11/12/22, identified she already had the PPSV23 and PCV-13 but there was a question mark by the date. R20's undated Immunizations form identified no history of the pneumococcal vaccinations. R20's medical record lacked follow up regarding declination or administration of the pneumococcal vaccines. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 9/12/24, identified based on R20's age and vaccine history: give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. During an interview on 11/7/24 at 12:00 p.m. the director of nursing (DON) who was also the infection preventionist, stated shared clinical	F 883			

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F 883	Continued From page 71 decision making for additional pneumococcal vaccines was not completed with R5 because her vaccines were considered complete according to the Minnesota Immunization Information Connection (MIIC). The DON had not reviewed the vaccines in accordance with updated CDC recommendations. The DON stated no one had followed up to verify R20's vaccine history and should have. The facility's Pneumococcal Policy dated 2/2024, identified the current practice was to offer all residents the vaccines to aid in the prevention of pneumococcal/pneumonia infections. Within 30 days of admission, the resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. If the immunization status was unknown, staff would contact the physician to determine record of immunization status or verify using MIIC. The facility would refer to the current CDC Recommended Adult Immunization Schedule.	F 883			
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi-resident shower room ceiling exhaust fan was cleaned. This had the potential to affect all residents on the third floor who used the shower room.	F 921	Vents were cleaned immediately after brought to attention of maintenance and housekeeping director. All facility vents have the potential to be affected by this finding. Facility audited all vents, in residents' room and spa rooms alike to		12/16/24

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F 921	Continued From page 72 Findings include: R71's quarterly Minimum Data Set (MDS) dated 9/5/24, indicated intact cognition. A Monthly Deep Clean Schedule form undated, indicated the 3rd floor long-term care north and south unit spa/bathrooms were deep cleaned on day 6 of the month. A Deep Clean Calendar dated October 2024, indicated spas were scheduled to be cleaned on 10/6/24. A November 2024 Deep Clean Calendar form was not provided. A procedure, undated, Deep Clean Procedures, indicated to check the posted deep clean schedule and clean the scheduled deep clean room. Further, the procedure directed staff to wipe the top and all sides of heating units and check top vents for accumulation of dust or other debris for resident rooms and to use a high duster to clean vents in restrooms. During interview and observation on 11/4/24 at 12:09 p.m., R71 stated he previously worked as a janitor and staff should dust the vents in the room by the window. R71's vent in the room contained dark colored debris and gray particles hanging off the grates and vent and R71 stated the common shower room vent was worse. During observation on 11/4/24 at 12:54 p.m., the shower room located across from room 312 had a vent on the ceiling that was coated with gray debris and some of the debris was hanging off of the vent. During interview and observation on 11/7/24 at	F 921	ensure cleanliness. Facility to implement cleaning of vents on a bi-weekly basis and bi-weekly check. Facility will audit 10 vents weekly x3 weeks, 6 vents x3weeks, 3 vents x3weeks, to ensure that air vents are safe from debris. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Administrator/Housekeeping Director to complete audits.		

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F 921	Continued From page 73 9:02 a.m., social worker (SW)-A stated it was maintenance's responsibility to clean the vents and viewed the vent on the ceiling in the community shower room on the third floor and stated it looked like it contained lint or dust and stated there was a lot of it and thought it was possible it had been there more than a couple of months and further stated they used to have another maintenance person who covered the building and would check with M-A or M-B to see when it was last cleaned. During interview and observation on 11/7/24 at 9:13 a.m., maintenance (M)-A stated he worked for the facility for 14 years and stated vents were cleaned monthly when they changed the filters and vents on the ceiling were cleaned by housekeeping. M-A stated this was a new company and further if they deep cleaned, cleaning was done when people were moved and housekeeping completed the shower room deep cleaning. M-A viewed the vent in the 3rd floor shower room and stated it was an exhaust fan and when residents showered, the room became a rain forest and stated the vent had been wetter than wet and it looked like there was fuzzy fuzz on the vent and did not know how long it had been there and then checked the light fixture for dust, which did not contain any and stated that was housekeeping's responsibility and added they would get that cleaned up. During interview on 11/7/24 at 9:32 a.m., housekeeping (H)-A stated she had been at the facility since 7/2024 and stated the shower room was cleaned daily from top to bottom and included dusting, cleaning mirrors, the sink, toilet, and stated the vents, grab bars, and shower head were all cleaned daily.	F 921			

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F 921	Continued From page 74 During interview on 11/7/24 at 9:37 a.m., H-B stated shower rooms were cleaned daily as part of a routine as well as if needed and entailed the showers, tubs, toilets, sink, stocking, sweeping, mopping and dirty linen. H-B stated they did a deep cleanings monthly. At 9:42 a.m., H-B stated staff should have looked at the vent as part of a daily cleaning and expected the vent to be cleaned. A policy for cleaning schedules for deep cleaning and daily cleaning was requested. During interview on 11/7/24 at approximately 10:57 a.m. M-A stated he cleaned the bathroom exhaust fan in the 3rd floor shower room and had not spoken to the administrator. During interview on 11/7/24 at 11:03 a.m., with the administrator, a policy or check list for daily cleaning was requested.	F 921			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on November 5, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Maplewood Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

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

Electronically Signed

TITLE

(X6) DATE
12/02/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Maplewood Care Center is a 3-story building was constructed in 1969 and was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout The facility has a capacity of 105 beds and had a census of 97 at the time of the survey.	K 000			

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K 000	Continued From page 2	K 000			
K 293 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 11/05/2024, between 9:30 AM and 12:00 PM, it was revealed by observation that there was no exit signs in exit passage ways by room 315 and 110. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 293		12/20/24	
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	K 345	Signs ordered, delivery date set for 12/16/24	12/6/24	

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K 345	Continued From page 3 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 maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 9:30 AM and 12:00 PM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. An interview with the Director of Maintenance and the Administrator verified this deficient finding at the time of discovery.	K 345	Sensitivity test scheduled for 12/6/2024.		
K 351 SS=F	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	K 351		12/6/24	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 351	Continued From page 4 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 sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. Thia deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 9:30 AM and 12:00 PM, it was revealed by observation that there were wires in contact with the sprinkler pipe above the ceiling near room 314, 300, Nursing Services on the 1st floor and in the basement by Therapy . An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 351	Completed by end of week.		
K 363 SS=F	Corridor - Doors	K 363			12/2/24

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K 363	Continued From page 5 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363			

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K 363	Continued From page 6 etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 9:30 AM and 12:00 PM, it was revealed by observation the fire doors separating the building and the access tunnel to an adjacent occupancy failed to properly latch when tested. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 363	Completed		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire	K 521	To be completed prior to 12/20/2024.	12/20/24	

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K 521	Continued From page 7 dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 9:30 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 521			