Electronically delivered

February 12, 2021

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: January 29, 2021

Dear Administrator:

On January 29, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 28, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 28, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 28, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 28, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Lynnhurst Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 28, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 29, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2021

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Re: Event ID: 693N11

Dear Administrator:

The above facility survey was completed on January 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/28/21 through 1/29/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5304105C (MN00064162); H5394106C (MN00069293); and H5394107C (MN00069294). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245394	A. BUILDING _____ B. WING _____	C 01/29/2021

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THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 1/28/21, and 1/29/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance Because you are enrolled in ePOC, your 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 A COVID-19 Focused Infection Control survey was conducted on 1/28/21 and 1/29/21, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to NOT to be in compliance. In addition, the following complaints were investigaged and found to be UNSUBSTANTIATED: H5394105C (MN00069291) H5394106C (MN00069293) H5394107C (MN00069294) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2021

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 revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		3/17/21

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F 880	Continued From page 2 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program according to Centers for Medicare and Medicaid Services (CMS) guidelines when they failed to include timely	F 880	F880 Residents 2,3, and 7 have been screened for covid-19 and vital signs checked. Orders have been reviewed and updated as necessary.	

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F 880	Continued From page 3 screening of 3 of 6 residents (R2, R3, and R7) for COVID-19 in residents reviewed for screening and they failed to test 3 of 6 residents (R3, R4, and R6) for COVID-19 for residents reviewed for testing. Findings Include: COVID-19 SCREENING R2's admission MDS, dated 12/21/20, indicated R2 was admitted on 12/14/20, with medical diagnoses of diabetes, high blood pressure, and kidney failure requiring dialysis three times a week. R2's orders indicated R2 was monitored for fever, two temperatures > 99.0 Fahrenheit (F), chills, SOB (shortness of breath), new or change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, diarrhea, new or worsening malaise, new dizziness, new confusion, or altered mental status. In the supplementary documentation section, the nurses can enter the temperature and oxygen saturations. If any of the above S/S (signs or symptoms) are noted in progress note, staff are to update clinical leadership, update MD, and initiate droplet precautions. This is to be done for day and evening shifts. R2's January Treatment Administration Record (TAR) indicated R2 was missing symptoms checks on the morning of 1/8/21, 1/18/21, 1/25/21, and on 1/27/21. The TAR indicated R2 was missing symptom checks on both morning and evening on 1/9/21, and 1/26/21. R1 was missing symptom checks for 8 out of 54 opportunities, or 17% of the time for the month of January.	F 880	All residents have the potential to be affected. " QAPI team meeting was held and root cause analysis determined that the division of screening and vital sign tasks would increase documentation compliance for screening. Also two rooms have been selected for new admission quarantine. The following policy and procedures were reviewed: o Influenza and pneumococcal immunization o Cohorting Covid-19 positive residents o Company policy for covid-19 actively screening residents. " Covid-19 testing results, resident PCR results have been scanned into resident files. " Active health screening for fever and symptoms of covid-19 will be done upon admission and twice daily for 14 days. " Education conducted for nurse leadership on use of infection sign and symptom tracking tool and the tracking of transfer to acute care facility. " MDH education on Oximetry and Covid used for training nurses. " Residents were provided education on social distancing, frequent hand hygiene, and wearing masks to prevent droplet spread. Daily audits will be conducted on temperature, oximetry, and screening for residents. Daily audits will be conducted on new admissions for twice daily temperature, oximetry, and screening. Monthly audits will be conducted on surveillance form to ensure tracking of number of residents sent to acute care	

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F 880	Continued From page 4 R3's face sheet indicated an admission date of 2/20/20, and a discharge date of 1/18/21. R3's diagnoses included type 2 diabetes mellitus, atherosclerotic heart disease, and chronic kidney disease. R3's orders section printed 1/28/21, lacked an order to actively screen for fever and respiratory symptoms of illness at least daily. R3's electronic medical record (EMR) dated 11/1/20, through 1/18/21, lacked documentation of daily temperatures or oxygen (O2) saturations and lacked documentation of daily active screening for respiratory symptoms. R3's vital signs summary from 11/1/20, through 1/18/21, lacked documentation of temperature or O2 saturation for 71 out of 78 possible days. R7's face sheet indicated an admission date of 1/15/21, and diagnoses of asthma, muscle weakness and epilepsy. R7's orders section printed 1/28/21, included an order to monitor for fever, chills, SOB (shortness of breath), new change in cough, sore throat, muscle pain, headache, new loss of taste or smell, nausea, vomiting, diarrhea, new or worsening malaise, new dizziness, new confusion, or altered mental status. In the supplementary documentation section, the nurses can enter the temp (temperature) and oxygen sats (saturations). If any of the above s/s (signs/symptoms) are noted, enter progress note, update clinical leadership, update MD (medical	F 880	hospital. Audit findings will be reported to QA/QAPI team monthly. Ongoing audit frequency will be determined by QA/QAPI team. DON/ designee responsible	

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F 880	Continued From page 5	F 880		

doctor) and initiate droplet precautions. The order start date was 1/30/21.

R7's EMR lacked documentation of daily temperatures and lacked documentation of daily active screening for respiratory symptoms.

R7's vital signs summary for temperature recordings was requested but not provided.

R7's progress notes lacked documentation of temperature recordings for 6 out of 13 possible days.

R7's progress notes and O2 saturations vital signs summary lacked documentation of O2 saturations for 2 out of 13 possible days.

During interview on 1/28/21, at 9:53 a.m. licensed practical nurse (LPN)-A stated for COVID-19 monitoring the residents had their temperature, O2 saturations and symptom screening documented in their EMR daily. LPN-A stated if a resident was newly admitted, such as R7, they would have taken their vital signs and symptom screening twice daily and documented in the EMR. LPN-A reviewed R7's medical record and stated was unsure why R7 lacked regular documentation of temperature or O2 sats, and lacked documentation of symptom screening.

During interview on 1/28/21, at 2:38 p.m. the director of nursing (DON) stated the expectation was for COVID-19 screening, temperature and O2 saturation to be checked once a shift. An order should be placed in the residents EMR which would trigger the task for nursing to complete. DON stated the expectation was for nursing to have documented their findings in the

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EMR.

During an interview on 1/28/21, at 3:20 p.m., the DON stated she knew they weren't always recording symptoms of COVID-19.

The facility policy titled "Coronavirus (COVID-19)" dated 1/25/21, directed staff to monitor residents daily for potential symptoms of COVID-19 which include fever, chills, shortness of breath, new or change in cough, sore throat, muscle pain, headache, new loss or taste or smell, nausea, vomiting, diarrhea. Less common symptoms can include new or worsening malaise, new dizziness, new confusion or altered mental status. More than two temperatures greater than 99.0 degrees Fahrenheit might also be a sign of fever in this population. Document the resident's temperature, oxygen saturation and the absence or presence of symptoms in the residents electronic medical record at least daily (twice daily is best practice).

COVID-19 TESTING
CMS memo reference number 20-38-NH dated 8/26/20, indicated facilities must conduct testing in a manner consistent with current standards of practice for COVID-19 tests. For each instance of testing, facilities are to have documented in the residents' records that testing was offered, completed (as appropriate to the residents testing status) and the results of each test. Additionally, facilities must have procedures in place to address residents who refuse testing.

R3's face sheet indicated an admission date of 2/20/20, and a discharge date of 1/18/21. R3's diagnoses included type 2 diabetes mellitus, atherosclerotic heart disease, and chronic kidney

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disease.

R3's medical record was reviewed from 12/1/20, through 1/18/21, and lacked documentation of COVID-19 testing.

During interview on 1/28/21, at 3:38 p.m. the administrator stated the COVID-19 testing had been done weekly and was not in the resident's record yet. The administrator would have to go find the files.

R3's files were then reviewed and lacked documentation of testing for COVID-19 on 2 out 6 weekly opportunities.

R3's medical record lacked documentation of refusals for testing.

R4's admission MDS, dated 12/29/20, indicated R4 had medical diagnoses of tongue cancer and kidney failure requiring dialysis three times a week.

R4's record indicated R4 tested negative for COVID-19 on 12/2/20, 12/9/20, 12/16/20, and 12/23/20. The record lacked documentation of COVID-19 testing after 12/23/20.

R6's face sheet indicated an admission date of 12/10/20. R6's diagnoses included pelvic fracture, type 2 diabetes mellitus and seizures.

R6's medical record was reviewed from 12/10/20, through 1/28/20, and lacked documentation of COVID-19 testing.

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F 880	Continued From page 8 R6's files were requested and reviewed. R6's files lacked documentation of testing for COVID-19 on 4 out of 7 weekly opportunities. R6's medical record lacked documentation of refusals for testing. During an interview on 1/29/21, at 3:19 p.m., the DON stated the facility followed the point prevalent testing (PPS) protocol of testing all residents until there were two weeks without a positive test results. After that, the facility tested residents with symptoms of COVID-19. The DON verified COVID-19 testing occurred weekly during December of 2020 and January of 2021. The facility's COVID-19 Testing Policy, dated 9/14/20 indicated residents who have signs or symptoms of COVID-19 would be tested. The policy further indicated upon identification of a single new case of COVID-19 infection residents would be tested and any resident tested negative would be retested every 3 days to 7 days until testing identified no new cases of COVID-19 infection for a period of at least 14 days after the most recent positive result.	F 880		
F 883 SS=E	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; (ii) Each resident is offered an influenza	F 883		3/17/21

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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 and potential side effects of pneumococcal

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F 883	Continued From page 10 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 offer and/or provide the annual influenza vaccine and/or pneumococcal vaccinations for 5 of 5 residents (R4, R5, R6, R7, and R9) reviewed for vaccinations. Findings include: R4's admission Minimum Data Set (MDS), dated 12/21/20, identified R4 had a brief interview for mental status (BIMS) score of 14 indicating mildly impaired cognition and a medical diagnosis of kidney failure requiring dialysis. R4's MDS lacked documentation about influenza or pneumococcal vaccinations. R4's facility Immunization Report dated 1/28/21, lacked documentation of influenza or pneumococcal vaccinations. R4's medical record lacked documentation of education, contraindication, consent or refusal for influenza or pneumococcal vaccinations. R5's admission MDS dated 1/21/21, indicated R5 was 74 years old with intact cognition and a medical diagnosis of diabetes. R5's MDS section on influenza and pneumococcal vaccinations was blank. R5's facility Immunization Report dated 1/28/21,	F 883	F883 Residents 4,5,6, and 7 Immunization records have been updated. All residents have the potential to be affected. " Current resident records have been reviewed and records updated as needed. " QAPI team reviewed company Influenza and pneumococcal policy. " Prevnar 13 vaccine added to standing orders for residents under 65 years of age. Education conducted for licensed staff reviewing company Influenza and pneumococcal policies. Weekly Audits will be conducted on new admission immunization records. Audit findings will be reported monthly to the QA/QAPI team. The frequency of audits will be determined by the QA/QAPI team. DON/ Desgnee responsible	

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lacked documentation regarding the influenza or pneumococcal vaccinations.

R5's medical record lacked documentation of education, contraindication, consent, or refusal for the current influenza vaccination or pneumococcal vaccinations.

R6's admission Minimum Data Set (MDS) dated 12/17/20, identified R6 had mildly impaired cognition. The MDS lacked documentation regarding influenza or pneumococcal vaccinations.

R6's facility Immunization Report dated 1/28/21, lacked documentation of influenza or pneumococcal vaccination.

R6's medical record lacked documentation of education, consent or refusal for influenza or pneumococcal vaccinations.

R7's admission MDS dated 12/15/20, identified R7 had intact cognition. The MDS indicated R7 had not received the influenza vaccine for this year's influenza season due to "not eligible-medical contraindication."

R7's facility Immunization Report dated 1/25/21, lacked documentation regarding the influenza vaccination.

R7's medical record lacked documentation of education, consent or refusal for the current influenza vaccinations.

R9's admission MDS, dated 11/20/20, identified

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R7 had intact cognition and a medical diagnosis of encephalopathy. The MDS indicated R9 did not receive the influenza vaccine for the current influenza season with the stated reason "none of the above."

R9's facility Immunization Report, dated 1/28/21, lacked documentation regarding the influenza vaccination.

R9's medical record lacked documentation of education, contraindication, consent, or refusal for the current influenza vaccination.

When interviewed on 1/28/21, at 2:38 p.m. the director of nursing (DON) stated upon admission either the nurse manager, assistant director of nursing or director of nursing would look up a resident's immunization history in Minnesota Immunization Information Connection (MIIC) as well as review Epic EMR (Electronic Medical Records). Based on that review they would make arrangements for the resident to get vaccines and would do a consent form. The DON reviewed the medical record for R6 and R7 and confirmed documentation was lacking for education, consent or refusal of the vaccinations. The DON confirmed that they needed to update their immunizations.

Facility policy titled, "Influenza Vaccine" dated 8/16, indicated that residents admitted between October 1st and March 31st would be offered the vaccine within five (5) working days of the resident's admission. Prior to the vaccination, the resident or legal representative would be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education would be

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F 883	Continued From page 13 documented in the resident's medical record. A residents' refusal of the vaccine would be documented on the Informed Consent for Influenza Vaccine form and placed in the residents' medical record. Facility policy titled "Pneumococcal Vaccine" dated 8/16, indicated that prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, would be offered the vaccine series within thirty (30) days of admission unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status would be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Before receiving the pneumococcal vaccine, the resident or representative would have received information and education regarding the benefits and potential side effects of the vaccine. Provision of such education would be documented in the resident's medical record. If refused, appropriate entries would be documented in the resident's medical record.	F 883		