DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
November 7, 2024

Administrator
Episcopal Church Home The Gardens
1860 University Avenue West
Saint Paul, MN  55104

RE: CCN: 245625
Cycle Start Date: September 12, 2024

Dear Administrator:

On November 7, 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.

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

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Electronically delivered

November 7, 2024

Administrator
Episcopal Church Home The Gardens
1860 University Avenue West
Saint Paul, MN  55104

Re: Reinspection Results
Event ID:  6KUB12

Dear Administrator:

On November 7, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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Electronically delivered
September 23, 2024

Administrator
Episcopal Church Home The Gardens
1860 University Avenue West
Saint Paul, MN  55104

RE: CCN: 245625
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 12, 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 12, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 12, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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,

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

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September 23, 2024

Administrator
Episcopal Church Home The Gardens
1860 University Avenue West
Saint Paul, MN  55104

Re: State Nursing Home Licensing Orders
Event ID: 6KUB11

Dear Administrator:

The above facility was surveyed on September 9, 2024 through September 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245625 | A. BUILDING _____ B. WING _____ | C 09/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EPISCOPAL CHURCH HOME THE GARDENS | 1860 UNIVERSITY 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) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 9/9/24 to 9/12/24 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance.<br><br>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<br><br>On 9/9/24 to 9/12/24, 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.<br><br>The following complaints were reviewed:<br>H56257786C MN96771<br>H56257785C MN104776 - Non-compliance cited at F689<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/30/2024

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 659 SS=D | Qualified Persons<br>CFR(s): 483.21(b)(3)(ii)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure unqualified staff did not administer as needed (PRN) medication used for skin rash for 1 of 1 resident (R1) reviewed for qualified staffing.<br><br>Findings include,<br><br>R1's quarterly Minimum Data Set (MDS) dated 7/15/24, indicated R1 was cognitively intact, and had diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) , hypertension (high blood pressure), and diabetes.<br><br>R1's Clinical Diagnoses record printed 9/12/24, indicated diagnoses of local infection of the skin and subcutaneous tissue (under the skin), and irritant contact dermatitis (a skin rash caused by contact with a certain substance) due to fecal and urinary incontinence.<br><br>R1's Clinical Orders record printed 9/12/24, included an order for Nystatin powder (used to treat fungal or yeast infections) 100,000 unit/gm (gram) topical under breast every 12 hours as | F 659 | Plan of correction for residents cited with this survey: R1's nystatin powder was locked up in the medication cabinet during time of survey.<br><br>Plan to address/prevent this deficiency for other residents: Current licensed nurses, TMA's, and CNA's will be educated on PRN medications require a nurse assessment.<br><br>Measures put in place to prevent recurrence: Current licensed nurses, TMA's, and CNA's will be educated on PRN medications require a nurse assessment.<br><br>Plan to monitor: Audits of proper storage of medication and staff competency of PRN medication procedure will be completed 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Director of Nursing or designee. | 11/4/24 |

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| F 659 | Continued From page 2<br>needed (PRN) for skin rash.<br><br>R1's Medication Administration Record (MAR) dated September 2024, indicated a PRN order for Nystatin powder, which had not been documented as being administered to date during the month of September.<br><br>During observation on 9/11/24 at 9:07 a.m., nursing assistant (NA)- G and NA-F provided personal cares to R1. NA-F used a wipe to clean R1's skin under her breast, abdomen, and groin areas. NA-F took a bottle of Nystatin powder from R1's nightstand and administered the medication on R1's skin under her breast and groin areas.<br><br>During interview on 9/11/24 at 2:35 p.m., NA-F stated when she applies the Nystatin powder, she washes the areas, dries the area to ensure it is clean and then she applies the powder. NA-F stated the nurses had talked to her to ensure she understood how to do it, but only the nurses can assess and document.<br><br>During interview on 9/12/24 at 10:08 a.m., registered nurse (RN)-C stated the nursing assistants were not authorized to administer the Nystatin powder or any medicated creams. RN-C stated trained medication aids (TMA) were able to administer scheduled creams and powders to the skin, but the administration of PRN medications required a nursing assessment. RN-C stated nursing assistants were not licensed to do assessments. RN-C stated NA-F had not informed her about administering the Nystatin powder to R1.<br><br>During interview on 9/12/24 at 10:38 a.m., clinical coordinator/licensed practical nurse (LPN)-C | F 659 | | |

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| F 659 | Continued From page 3<br>stated nursing assistants were not trained to do assessments or apply Nystatin powder. LPN-C stated nursing assistants were supposed to report any resident's skin concerns to the nurse. LPN-C stated only the nurses can do an assessment and determine if a PRN needs to be administrated.<br><br>Facility policy on medication administration requested but not received. | F 659 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure assistance with personal hygiene for 2 of 2 residents (R6, R44 ) reviewed for activities of daily living (ADLs) for dependent residents.<br><br>Findings include:<br><br>R6<br><br>R6's annual Minimum Data Set (MDS) dated 7/29/24, identified severe impairment of cognition, diagnoses of Alzheimer's and heart failure, and R6 required extensive assistance with ADL's. In addition, R6 did not display rejection of cares.<br><br>R6's Care Area Assessment (CAA) identified triggers for delirium, cognitive loss/dementia, functional abilities, psychosocial well-being, mood state, and psychotropic drug use (medications | F 677 | Plan of correction for residents cited with this survey: R6 and R44 facial hair was removed during time of survey. R6 and R44 Shahbaz care sheet's updated to reflect shaving support and preferences.<br><br>Plan to address/prevent this deficiency to other residents: Audit completed of all residents to ensure facial hair preferences are being met and reflected on the Shahbaz care sheet.<br><br>Measures put in place to prevent reoccurrence: Current nursing department staff will be educated on elder's facial hair preferences and updating if the care plans.<br><br>Plan to monitor: Audits of dependent resident cares, shaving, will be completed | 11/4/24 |

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| F 677 | Continued From page 4<br>used to treat mental health disorders).<br><br>R6's care plan (CP) dated 8/2/22, and revised 8/21/23 identified, "PERSONAL HYGIENE/ORAL CARE: I require limited to extensive assist of 1 staff for personal hygiene and oral care. "<br><br>R6's nursing assistant (NAR) task form in the electronic medical record (EMR) for dates of 8/12/24 to 9/9/24 identified, "PERSONAL HYGIENE: SUPPORT PROVIDED-How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers" was documented one to two times per day during that period. All entries but one (9/5/24 at 9:02 p.m.) were documented as, "One person physical assist".<br><br>R6's NAR care sheet titled, "Eldershahbaz Care Plan-Gabrielle House-4th Floor" downloaded 9/10/24, had a column with a section titled, "Grooming". The column identified for R6 documented, "Extensive assist 1" with no indication anywhere else on the document for shaving support.<br><br>During observation on 9/9/24 at 1:57 p.m., R6 was observed sitting in a wheelchair in her room. R6 was fully dressed with hair pulled back into ponytail. R6 had several 1.5-inch white hairs noted to left of chin on the face. R6 not interviewable.<br><br>During observation on 9/10/24 at 1:46 p.m., R6 was laying in bed and stated she had finished eating lunch and was resting. R6 was observed with several 1.5-inch white hairs noted on the left side of her chin. R6 touched the chin hairs and | F 677 | weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Director of Nursing or designee. | |

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| F 677 | Continued From page 5 | F 677 | | |

stated, "I don't like that one bit. I want them cut."

During interview with family member (FM)-A on 9/10/24 at 2:00 p.m., FM-A stated, "[R6] would not like to have long facial hair." FM-A stated it was important for [R6] to be well groomed, "so having a long whisker or several of them would be awful for [R6]. I know they [facility] clean [R6] up and shower [R6], but they should at least make sure [R6's] facial hair is trimmed. No one from the facility has reached out to me about [R6] possibly refusing to be shaved or trimmed."

During interview with NA-A on 9/10/24 at 1:49 p.m., NA-A stated all nursing assistants were expected to review the resident care plan, pointing to the "Eldershahbaz Care Plan-Gabrielle House-4th Floor" to "tell us what we need to do for the residents."

During interview with NA-C on 9/10/24 at 3:10 p.m., NA-C stated, "I get the care plan sheet [sic]. It tells me what to do [for each resident]". NA-C stated if a resident refuses care then we are to re-approach the resident." If resident refuses care completely, then NA-C stated the nursing assistants were expected to document refusals in the EMR and notify the nurse. NA-C stated, "women residents should be asked every day if they would like to have their facial hair trimmed. Here, we[staff] have a lot of free time so we can always ask and offer to help to shave them." NA-C stated, nursing assistants were responsible for providing personal hygiene, "including facial hairs".

During interview with NA-B on 9/10/24 at 3:23 p.m., NA- B stated the expectation for nursing assistants was to "always ask. Especially for

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| F 677 | Continued From page 6<br>ladies, we should be offering to shave or trim chin hairs every day if we see long hair on the faces. Most women would not like that at all." NA-B stated all nursing assistants were expected to document in the EMR for tasks assigned to aides per the printed "Eldershahbaz Care Plan-Gabrielle House-4th Floor".<br><br>During observation and interview on 9/11/24 at 8:15 a.m., NA-D stated she was familiar with R6 and had worked at facility for two years. R6 was observed sitting at dining room table alone eating breakfast. R6 was dressed, with hair pulled back into a ponytail. R6 with several 1.5-inch white hairs noted to left of chin on face. NA-D stated, "the hair on [R6] chin is pretty long. Obviously it is not a good thing. I would not like to have hairs like that on my face. It would really bother me."<br><br>During observation and interview with licensed practical nurse (LPN)-A on 9/11/24 at 8:35 a.m., LPN-A stated he worked at facility for three years and was familiar with the 4th floor unit residents. LPN-A stated the expectation of nursing assistants was to review the resident care sheets, pointing to the "Eldershahbaz Care Plan-Gabrielle House-4th Floor" sheet and "prioritize resident needs." LPN-A stated, "shaving is part of personal cares." LPN-A observed R6 and stated, "I can see that it [chin hairs] needs to be shaved. It hasn't been done for a couple weeks. The razors are available on the unit [for aides to use]. We should ask her [R6] and then do it. I would not like it if my mom or loved one had long facial hair like that. It would really bother her. [R6] should at least be asked if she wants it cut off or not."<br><br>During interview with LPN-B on 9/11/24 at 8:55 | F 677 | | |

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| F 677 | Continued From page 7<br>a.m., LPN-B stated, she was employed full time and worked at facility for over a year and a half. LPN-B stated, "personal cares should be every day. Personal cares include washing face, brushing teeth, hair, nails, dressing, and shaving. Shaving should be done on the days it is seen not just on bath days. Facial hair on women is not appealing and long facial hair shows neglect. I would not like if I was left with long facial hair. It is a dignity thing. I would be very angry if my mom was left with long facial hair. That is not ok with me."<br><br>R44<br><br>R44's quarterly Minimum Data Set, dated 7/29/24, indicated R44 was admitted to the care facility on 5/2/22, had moderate cognitive impairment and was dependent on staff for showers and personal hygiene to include shaving.<br><br>R44's care plan, dated 8/15/24, indicated R44 had an "ADL [activities of daily living] self-care performance deficit r/t [related to] right BKA [below knee amputation], diabetes, A fib [atrial fibrillation], HTN [hypertension], anemia, osteoporosis, DM [diabetes mellitus], wounds. Elder is needing more assistance with ADLS and does get irritated when asked if they can help him."<br><br>R44's picture in his electronic medical record (EMR) showed R44 to be clean shaven.<br><br>During observation on 9/9/24 at 4:09 p.m., R44 was sitting in his room. R44 had a full-face beard at least ½ inch long with dried particles stuck in | F 677 | | |

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| F 677 | Continued From page 8<br>his beard. R44 stated he prefers to be clean shaven but does not get help with his beard despite asking.<br><br>During an interview on 9/11/24 at 8:50 a.m., nursing assistant (NA)-N stated the NAs should offer to shave resident on bath days or if they notice a resident is "out of the usual." NA-N stated R44 had his own shaver and at times would shave himself but he did prefer to be clean shaven and staff should be offering to shave him on bath days.<br><br>During interview and observation on 9/11/24 at 9:00 a.m., R44 was out at the breakfast table clean shaven. R44 stated "they just came at me with a shaver and gave me a shave. It was kind of a forced shaving."<br><br>During interview with nurse manager and registered nurse (RN)-A on 9/11/24 at 11:43 a.m., RN-A stated the expectation of staff is to provide personal cares daily. RN-A stated a failure to provide shaving or trimming of facial hair is a "concern for dignity, especially if you are a woman."<br><br>Facility policy titled Standard of Care/Elder Rights revised on 4/2022, documented "Assistance or supervision of shaving as needed to keep clan[sic] and well groomed". | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive | F 684 | | 11/4/24 |

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| F 684 | Continued From page 9<br>assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to assess and implement interventions to assist a resident, who was unable to maintain positioning for 1 of 1 resident (R40) reviewed for positioning.<br><br>Findings include:<br><br>R40's quarterly Minimum Data Set (MDS) indicated R40 was admitted to the care facility on 4/4/22, had severe cognitive impairment, and was dependent on staff for activities of daily living (ADLs). The MDS further indicated R40 had 2 or more falls with injury since the last assessment.<br><br>R40's Diagnoses list, printed 9/12/24, indicated R40 had several medical diagnoses including Parkinson's Disease, vascular dementia, and legal blindness.<br><br>R40's care plan, printed on 9/12/24 lacked interventions to address R40's positioning.<br><br>During observation on 9/9/24 at 1:21 p.m., R40 was in the common area in a black, high back wheelchair. R40 was leaning over at her waist to the right with her right arm hanging over the side of the wheelchair arm. An unnamed nurse approached R40 to ask if she needed toileting, R40 stated "no". The unnamed nurse did not attempt to reposition R40 during the interaction. | F 684 | Plan of Correction for resident cited: R40 positioning was corrected during time of survey. R40 Shahbaz care sheet updated.<br><br>Plan to address/prevent this deficiency for other residents: Current nursing department staff educated on proper body alignment in chair, positioning devices and repositioning residents.<br><br>Measures put in place to prevent recurrence: Current nursing department staff educated on proper body alignment in chair, positioning devices and repositioning residents.<br><br>Plan to monitor: Audits of residents proper body alignment in wheelchairs will be completed 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Director of Nursing or designee. | |

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| F 684 | Continued From page 10<br>During observation on 9/11/24 at 8:21 a.m., nursing assistant (NA)-J was observed transferring R40 to a recliner chair in the common area. R40 immediately started to lean to the right. NA-J placed a pillow under R40's legs but did not attempt to assist R40 with repositioning or sitting upright.<br><br>During observation on 9/11/24 at 11:03 a.m., R40 was sitting with the activities director (AD) out in the common area sitting in a recliner. R40 was leaning over at her waist to the right, with her right arm hanging over the arm of the chair.<br><br>During an interview on 9/11/24 at 11:17 am licensed practical nurse (LPN)-B stated she was aware R40 had "always leaned to the right" and R40 had worked with therapy in the past but was not currently because she was on hospice. LPN-B stated she assumed R40 leaned to the right because she was "uncomfortable sitting there all day."<br><br>During observation on 9/12/24 at 8:10 a.m., R40 was up in a broda chair, leaning over to the right, with her arm hanging over the side and fidgeting with the wheel of the broda chair.<br><br>During an interview on 9/12/24 at 11:51 a.m., nurse manager and registered nurse (RN)-A stated R40 had been leaning in her broda chair "for awhile" stating she had thought staff were using a pillow to help keep R40 upright. RN-A stated it would be expected for staff to reposition R40 if she was leaning over in her chair and to use a pillow to keep her upright if needed. RN-A confirmed the care plan lacked interventions to address R40 positioning, stating it would be good to have. RN-A stated she could reach out to | F 684 | | |

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| F 684 | Continued From page 11<br>hospice about a therapy consult to assist with proper positioning.<br><br>A facility policy titled Standards of Care/Elder Rights, revised 4/2022, indicated "Elders will be provided with the necessary care and services per our policies and procedures to maintain the highest practicable physical, mental, and psychosocial wellbeing in the accordance with their comprehensive assessments, elder rights, needs, preferences and care plan." | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to implement, and care plan, new and appropriate fall interventions to prevent falls for 2 of 2 residents (R40 and R51) reviewed for falls.<br><br>Findings include:<br><br>R40<br><br>R40's quarterly Minimum Data Set (MDS), dated 7/31/24, indicated R40 was admitted to the care facility on 4/4/22, had severe cognitive impairment, and was dependent on staff for | F 689 | 1. Care plans and care sheets were reviewed for R40, R51 and updated to reflect interventions for fall prevention that were appropriate and individualized for each resident.<br>2. 55/55 residents have the potential to be affected by the deficient practice.<br>3. Facilities policy on falls was reviewed and remains current. Facility will continue to determine root cause of falls through completing risk mgmt. Staff will be educated on new fall interventions and follow through.<br>4. Follow up of all falls, interventions | 11/4/24 |

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| F 689 | Continued From page 12<br>activities of daily living (ADLs). The MDS further indicated R40 had 2 or more falls with injury since the last assessment.<br><br>R40's Diagnoses list, printed 9/12/24, indicated R40 had several medical diagnoses including Parkinson's Disease, vascular dementia and legal blindness.<br><br>R40's past two fall assessments, dated 4/27/24 and 7/27/24, indicated R40 has at risk for falls.<br><br>R40's care plan, dated 4/5/22 and revised on 8/2/24, indicated R40 had "behaviors where I try to stand up, wander and occasionally grab at staff during cares." However, the care plan problem lacked any new interventions since 4/5/22. R40's care plan, dated 5/27/24 and revised on 6/18/24, further indicated R40 was at "high risk for falls r/t [related to] Parkinson's [disease], poor vision, hx [history of] UTIs [urinary tract infections], anemia, left MCA [middle cerebral artery] stroke, impaired balance, acute CVA [cerebral vascular accident], I fall frequently, I'm impulsive, I have poor decision making, I don't use my call light or pendant. I sometimes wake up in the middle of the night and wander in my room, in the hallway or I will wander into the room across from my room." The most current fall intervention was dated 2/6/24 and indicated "toilet before and after meals and at bedtime, q2h [every 2 hours] during the night. Say 'lets go to the bathroom'." Other fall interventions included a bed and chair alarm dated 1/18/24, massage abdomen on toilet to encourage voiding dated 5/27/23, anticipate needs dated 4/5/22, ensure call light is within reach, every hour checks, more frequent between 3-5 am, dated 9/20/23, keep walker in front of R40 dated 7/24/23, and provide a safe environment with | F 689 | implemented and follow through of those falls Interventions will be reviewed by the Nurse Managers, DON or designee to ensure they are individualized and appropriate for each elder within a week of a fall and intervention implementation. Audits will be completed of all residents fall care plan and interventions during the MDS assessment period to ensure that interventions remain appropriate and are followed by the staff. Results of findings will be documented and reviewed with IDT and monitored at the facility QA meeting.<br>5. Director of Nursing or designee is responsible for compliance. | |

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| F 689 | Continued From page 13<br>even floors free from spills and clutter, and personal items within reach dated 9/8/23.<br><br>R40's progress notes indicated R40 had 20 falls since a new care plan intervention was put in place on 2/6/24 and documented the following:<br><br>On 3/7/24 it was documented R40 was found on the floor with a scratch on her left lower extremity. Approaches previously care planned were documented as "bed alarm, walker at bedside, wheelchair." Approaches to prevent reoccurrences were documented as "continue bed alarm, monitoring low position of bed, call light within reach, walker at bedside."<br><br>On 3/16/24 it was documented R40 fell in the dining room, sitting in a "regular chair without alarm on" and sustained a skin tear to her forehead.<br><br>On 5/2/24 it was documented R40 was found on the bathroom floor.<br><br>On 5/21/24 it was documented R40 had an unwitnessed fall in the dining room. Approaches previously care planned indicated R40 had "alarms on wheelchair, and walker in front of her while sitting or lying, and toilet the resident as schedule."<br>Approaches to prevent reoccurrences indicated "keep an eye on common area while she appears active, assisting with walk, and continue to monitor by staff."<br><br>On 5/25/24 it was documented R40 had an unwitnessed fall in her room. Approaches previously care planned were documented as "toileting the resident as schedule and put walker | F 689 | | |

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| F 689 | Continued From page 14<br>in front of her." Approaches to prevent reoccurrences were documented as "staff assisting the resident with walking, continue monitoring."<br><br>On 5/27/24 it was documented staff found resident lying on the ground with her walker near by and had hit the back of her head. Approaches previously care planned indicated "toileting as needed, keep wheeled walker in front of her, in living area during the day for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care].<br><br>On 5/28/24 it was documented R40 was found on the floor kneeling over her walker and appeared weak and lethargic. Approaches previously care planned indicated "resident has alarm but they are not available." Approaches to prevent reoccurrences indicated "educated on calling out for help."<br><br>On 6/10/24 it was documented R40 was found in the hallway by her room and had complaints of pain. Approaches previously care planned indicated R40 "has bed alarm and is hourly rounding." Approaches to prevent reoccurrences indicated "told [R40] the risked of not seeking help when needed and told her to pull call light when assistance is needed."<br><br>On 6/15/24 it was documented R40 had an unwitnessed fall in the living room and sustained a four-inch skin tear to her left forearm and one-inch skin tear to her right elbow. Approaches previously care planned indicated "walker in front of her, proper footwear, in living room for close monitoring, alarm pad." Approaches to prevent reoccurrences indicated "continue POC [plan of | F 689 | | |

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| F 689 | Continued From page 15<br>care].<br><br>On 6/27/24 it was documented R40 had a fall around 11:50 a.m., and family, DON and hospice was notified. No previously care planned approaches or new approaches to prevent reoccurrence documented.<br><br>On 7/11/24 it was documented R40 had a witnessed fall while sitting in the recliner in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated "the resident [R40] has a bed alarm on the recliner and, put the her bed lowest potion the bed toilet frequently, keep her in common area, keep her walker in front of her." Approaches to prevent reoccurrences indicated to continue R40's care plan.<br><br>On 7/15/24 it was documented R40 fell from her wheelchair in the dining room. Approaches previously care planned indicated "proper footwear, locked wheelchair, keep in common area for close monitoring, chair alarm." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>On 7/18/24 it was documented R40 had an unwitnessed fall in the dining area and sustained a skin tear to her right elbow. Approaches previously care planned indicated "fall alarm in place, frequent visual checks, assistance w/ [with] all transfers and ambulation." Approaches to prevent reoccurrences: indicated "coaching: fall alarm must be placed under elder at all times; attempt regular toileting."<br><br>On 7/19/24 it was documented R40 had an unwitnessed fall in the dining room during dinner. | F 689 | | |

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| F 689 | Continued From page 16<br>Approaches previously care planned indicated "toilet the resident as schedule, and use bed alarm, bed wheelchair, reclined, assisted with walking." Approaches to prevent reoccurrences was not documented.<br><br>On 7/26/24 it was documented R40 fell after several attempts to self-transfer from her recliner in the common area, indicating the "pressure" alarm did not sound. R40 sustained a "raised wound" on her forehead. Approaches previously care planned indicated "pressure/fall alarm in place; routine toileting; assistance with all transfers/ambulation." Approaches to prevent reoccurrences indicated "1:1 care as possible; frequent visual check."<br><br>On 8/3/24 it was documented R40 was found on lying on the floor in the doorway of another room and hit her head. No previously care planned approaches or new approaches to prevent reoccurrence documented.<br><br>On 8/3/24 it was documented R40 had a second fall in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated "assist resident toilet as schedule, bed and chair alarm on, put her walker in front of her while sitting and assist resident with walk." Approaches to prevent reoccurrences indicated "check the elder [R40] alarm functio[n]."<br><br>On 8/31/24 it was documented R40 had a witnessed fall in the common area. Approaches previously care planned indicated "ensure that the alarm is activated, and conduct safety checks every 15 minutes. assist resident with using the toilet as per her scheduled." Approaches to prevent reoccurrences was not documented. | F 689 | | |

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| F 689 | Continued From page 17<br><br>On 9/3/24 it was documented R40 fell in the dining room and sustained a "hematoma to R [right] cheek bone" and a "skin tear under R [right] eyebrow." Approaches previously care planned indicated "proper footwear, chair alarm, walker in front of resident, toileting, keep in common living area for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>On 9/6/24 it was documented R40 was found on the floor in the common area and sustained a "small skin tear on L [left] elbow." Approaches previously care planned indicated "walker in front, proper footwear, chair alarm, keep in living area for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>R40's electronic medical record (EMR) lacked a neuro assessment for R40's falls on 9/3/24 and 9/6/24 with known facial/head trauma.<br><br>During observation on 9/9/24 at 1:20 p.m., R40 was out in the main common area in a black, high back wheelchair. R40's right periorbital skin was black and blue in color and the entire right side of her neck was covered in a black bruise.<br><br>During observation and interview on 9/11/24 at 7:49 a.m., R40 was sitting in a broda chair with cotton socks on her feet. Nursing assistant (NA)-J approached R40 and wheeled her back to her room to transfer her to bed. NA-J stated R40 fell out of bed and her broda chair, stating she was not sure if R40 could use her call light anymore but that it should be placed near her. | F 689 | | |

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During an interview on 9/11/24 at 8:01 a.m., NA-M stated R40 had a "lot of falls" stating, "we basically make sure she always has her alarm on her."

During observation on 9/11/24 at 8:04 a.m., R40 was lying in bed, with her broda chair next to her. R40's call light was observed laying on the floor between the right side of the bed and the wall.

During observation on 9/11/24 at 8:21 a.m., R40 was becoming restless in bed, attempting to get out of bed. NA-J transferred R40 back to the main common area and placed her in a recliner chair. There was no walker left near R40 as care planned.

During an interview on 9/11/24 at 11:17 a.m., licensed practical nurse (LPN)-B stated when a resident fell, they should be assessed for pain or injuries. A neuro assessment should be completed if they resident hit their head for 72 hours post fall. LPN-B stated interventions for R40 to prevent falls were the bed/chair alarm, placing her walker in front of her, keeping R40 in the common area during the day for closer monitoring and staff "keeping as quiet at night as possible."

During an observation on 9/12/24 at 8:37 a.m., R40 was sitting out at the breakfast table without staff or residents nearby. R40 was not wearing her call light pendant around her neck.

During an interview on 9/12/24 at 11:51 a.m., nurse manager and registered nurse (RN)-A stated the expectations when a resident fell was for the nurse to do a full resident assessment and a neuro assessment for 72 hours "if warranted",

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| F 689 | Continued From page 19<br>meaning if the fall was unwitnessed or the resident hit their head. RN-A stated falls were discussed at morning meeting and staff would "brainstorm" to try and "come up with new fall interventions." RN-A stated a risk managemnt note would be put in progress notes. RN-A stated it would be expected for new fall interventions to be put in place with continued falls. Fall interventions for R40 were reviewed and RN-A confirmed R40's fall interventions were outdated and not working. RN-A further stated R40 had slid out of her broad chair "just the other day" and had another fall this morning.<br><br>R51<br><br>R51's annual Minimum Data Set (MDS) dated 7/22/24, identified admission to facility on 7/26/23, intact cognition, had no impairment of upper and lower extremities, was independent with hygiene and mobility. Also, one fall with major injury since prior MDS assessment. In addition, R51 was documented as taking antipsychotics (medications prescribed for mood disorders).<br><br>R51's Care Area Assessment (CAA) dated 7/22/24, identified care plan triggers for delirium, cognitive loss/dementia, communication, functioning abilities, psychosocial well-being, mood state, behavioral symptoms, falls, and psychotropic drug use.<br><br>R51's Medical Diagnoses downloaded from electronic medical record (EMR) on 9/10/24 identified R6 with dementia (group of symptoms affecting memory, thinking and social abilities), bipolar (mental health condition that causes | F 689 | | |

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| F 689 | Continued From page 20<br>extreme mood swings), anxiety, major depression, arthritis, diabetes, heart failure, and history of falling.<br><br>R51's Provider Notes (PPN) for 8/9/23, 10/13/23, 1/18/24, 3/19/24, and 8/9/24 do not mention any falls. However, falls were noted from the following PPNs:<br>* 3/22/24 documented R51 with fall on 3/20/24 with rib injury requiring x-ray.<br>*7/3/24 documented R51 with fall on 6/25/24 with right toe fracture.<br>*9/12/24 documented R51 with fall on 9/11/24 with injury to right arm requiring x-ray.<br><br>R51's Risk Management Reports (RMR) for 10/29/23, 2/7/24, 3/20/24, 3/30/24, 6/25/24, and 9/2/24 identified un-witnessed falls on each of the dates each with a different root cause.<br><br>R51's Care Plan (CP) downloaded 9/11/24, identified of the six RMR's, only one subsequent CP was updated. R51's fall risk CP was updated on 4/1/24 related to the fall on 3/30/24 with a new intervention of "remind me to use my walker when ambulating at all times. I tend to leave it and then attempt to walk without it."<br><br>During interview with Administrator on 9/12/24 at 11:39 a.m., Administrator stated if there is a resident fall or injury the expectation is for staff to ensure safety of the resident first, assess for injury and then fill out a risk management report, update provider, family, director of nursing (DON), and Administrator. Also, staff were expected to update resident care plan and "put in interventions in place right away."<br><br>Facility policy titled Fall (POST) Assessment | F 689 | | |

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| F 689 | Continued From page 21<br>reviewed 11/25/2022 state expectation of staff to document the fall in risk management in the EMR, document the fall in the progress notes, care plan fall and fall prevention measures and update caregivers as warranted. Policy included "Documentation Hints" to include, all interventions and treatments, any fall interventions in place at the time for the fall, and any interventions put in place after the fall. | F 689 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 758 | | 11/4/24 |

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| F 758 | Continued From page 22<br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures during the use of an antipsychotic medication (used to manage delusions, hallucinations, paranoia, or disordered thought) for 1 of 5 residents (R51) reviewed for antipsychotic medications.<br>Findings include:<br><br>R51:<br><br>R51's annual Minimum Data Set (MDS) dated 7/22/24, identified admission to facility on 7/26/23, intact cognition, independence with ambulation, standing and transfers and was taking antipsychotics (medications prescribed for mood disorders). | F 758 | Plan of correction for residents cited in this survey: R51 orthostatic blood pressure was taken and documented in the EMAR.<br><br>Plan to address/prevent this deficiency for other residents: All orthostatic blood pressures for drug monitoring will be scheduled consistent day of month. Current licensed nurses educated on the need for orthostatic BP needs to be completed monthly for anyone on an antipsychotic and documented in the EMAR.<br><br>Measures put in place to prevent recurrence: Current licensed nurses | |

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| F 758 | Continued From page 23<br><br>R51's Care Area Assessment (CAA) dated 7/22/24, identified care plan triggers for delirium, cognitive loss/dementia, communication, functioning abilities, psychosocial well-being, mood state, behavioral symptoms, falls, and psychotropic drug use.<br><br>R51's Medical Diagnoses downloaded from electronic medical record (EMR) on 9/10/24, identified R51 with dementia (group of symptoms affecting memory, thinking and social abilities), bipolar (mental health condition that causes extreme mood swings), anxiety, major depression, arthritis, diabetes, heart failure, and history of falling.<br><br>Orthostatic Blood Pressures<br>Per Centers for Disease Control and Prevention (CDC) Assessment Measuring Orthostatic Blood Pressure tool containing Stopping Elderly Accidents, Deaths & Injuries (STEADI), dated 2017, identified process for obtaining orthostatic blood pressure by: "<br>1. Have the patient lie down for 5 minutes.<br>2. Measure blood pressure and pulse rate.<br>3. Have the patient stand.<br>4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes.<br>A drop in BP of more than or equal to 20 mm Hg [millimeters in Mercury], or in diastolic BP of more than or equal to 10mm Hg, or experiencing lightheadedness or dizziness is considered abnormal. CDC's STEADI tools are resources can help you screen, assess, and intervene to reduce your patient's fall risk."<br><br>A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic | F 758 | educated on the need for orthostatic BP needs to be completed monthly for anyone on an antipsychotic and documented in the EMAR.<br><br>Plan to monitor: Audits orthostatic BPs for residents on antipsychotics will be completed monthly for 3 months. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Director of Nursing or Designee | |

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| F 758 | Continued From page 24<br>Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension [which can] lead to dizziness, syncope, falls." It should be evaluated by both history and routine measurement.<br><br>R51's physician orders (PO) downloaded from EMR on 9/11/24 identified the following:<br><br>"* Risperidone Oral tablet 3 milligrams (MG) orally at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE" with start dated of 7/26/23. "Order type: Antipsychotic Orders-[MAR]". Order was revised 1/3/24 with no changes to dose or diagnoses."<br><br>"*Psychoactive-ortho BPs monthly for Haldol, Clozapine, Seroquel, Risperadal, Compazine, Reglan" with directions of, "one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring sitting AND one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring laying AND one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring standing". Starting date for order was 7/26/23."<br><br>R51's Vital Sign Log (VSL) downloaded from the EMR on 9/11/24, identified blood pressure readings since admission to facility on 7/23/23. The VSL identified orthostatic blood pressures were completed and documented 5 of 13 months.<br><br>During interview with licensed practical nurse (LPN)-A on 9/11/24 at 8:35 a.m., LPN-A stated, he had worked at facility for three years and was | F 758 | | |

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| F 758 | Continued From page 25 | F 758 | | |

familiar with R51. LPN-A reviewed R51's PO for medications and the monthly orthostatic blood pressures and stated the expectation of all vital signs obtained by staff appear in the VSL of the EMR. LPN-A stated, "it is very important to do orthos [orthostatic blood pressures] when ordered because they can tell us if there is variation in vitals from laying, sitting, and standing. If we don't do the orthos [orthostatic blood pressures] then it can be dangerous for the resident because of a fall risk. They could stand and the BP [blood pressure] will bottom out and then they will fall. Those meds (pointing to R51's medication orders) can alter the persons balance and they can fall. They can cause balance and other health problems so that is why we must do them when ordered. The order to do the orthos [orthostatic blood pressures] will show up on the computer for the nurse to tell the nurse to do [them] and document the vitals [signs]. I don't know why it wasn't done for [R51], but it has not been done and it should be done correctly."
During interview with LPN-B on 9/11/24 at 8:55 a.m., LPN-B stated she had worked at facility for year and a half. LPN-B stated the PO for blood pressures "will show up in our tasks pointing to R51's EMR. "This is where the order will tell the nurse to do the orthos [orthostatic blood pressures] and to document it. If [R51] refuses there should be a notation. I don't see anywhere that R51 ever refused it. It is important to do orthos [orthostatic blood pressures] and we want to make sure that they don't get weak and faint. It is a side effect of some of those meds that R51 takes.".

During interview with registered nurse (RN)-A on 9/11/24 at 11:22 a.m., RN-A stated orthostatic blood pressures include, "standing, sitting, and

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| F 758 | Continued From page 26<br>laying. We do that once a month when [residents] are on antipsychotics. It is important to do them because the meds can change the BPs and [leave the residents] prone to falling." RN-A reviewed R51's PO and stated, "The orders say orthos every month on the 26th started July 2023". RN-A also stated, "[R51] is taking Risperdal and has been on it for a long time. 3 mg at bedtime." RN-A reviewed R51's TAR and stated, "it [order] should pop up on the nurse's tasks to remind them to do the orthos on the 26th of each month. I can see that they [nurses] have not been putting in the complete orthos for [R51] and the nurses should ...if resident refuses it should be documented. R51 will agree to anything and would not decline or refuse."<br><br>Facility policy titled Psychoactive Medication, revised 03/01/18 documented, "All elders receiving antipsychotic medication will have monthly orthostatic BP checks documented in the medical record." | F 758 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper | F 761 | | 11/4/24 |

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| F 761 | Continued From page 27<br>temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure mediations were safely and securely stored for 1 of 1 resident (R38) reviewed for medication storage.<br><br>Findings include:<br><br>R38's quarterly Minimum Data Set (MDS) dated 6/17/24, indicated R38 had moderate cognitive impairment, was dependent with dressing, toileting, bathing, transfers, but ate independently. The MDS indicated the following diagnoses, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes (a group of diseases that result in too much sugar in the blood), anxiety, depression, and hyperlipidemia (a condition in which there are high levels of fat particles in the blood).<br><br>R38's care plan printed 9/12/24, indicated R38 was unable to ambulate, transferred with assist of staff and a standing lift, and used a manual wheelchair with brake extenders. The care plan also indicated R38 had poor safety awareness, | F 761 | Plan of correction for residents cited in this survey: R38 medication cabinet was secured at time of survey.<br><br>Plan to address/prevent this deficiency for other residents: Education will be completed with current nursing department proper storage of medications.<br><br>Measures put in place to prevent reoccurrence: Education will be completed with current nursing department proper storage of medications.<br><br>Plan to monitor: Random audits of improperly stored medication will be completed 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: | |

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| F 761 | Continued From page 28<br>and impaired cognitive function related to mild cognitive impairment.<br><br>During observation on 9/9/24 at 12:17 p.m., R38's medication cabinet located in R38's room was observed open and unsecured. The cabinet had 19 cards of medications, about 10 lidocaine patches, and a glucometer. R38 was not in her room.<br><br>During interview on 9/9/24 at 12:24 p.m., registered nurse (RN)-B stated she went to the team's office across from R38's room and forgot to close the cabinet. RN-B stated she needed to grab something and was going to come back right away, but a resident went to the office to talk to her. RN-B acknowledged the office's blinds were closed and she couldn't see if anybody walked by or entered R38's room. RN-C stated the cabinet needed to be locked to prevent resident or other residents from getting the medications or consuming them.<br><br>During interview on 9/12/24 at 12:39 p.m., clinical nurse/licensed practical nurse (LPN)-C stated if the medicaiton cabinet is unsecured, anybody can come along and take the medications. LPN-C added, residents might be allergic to the medication, or have difficulty swallowing, and "it's dangerous". LPN-C stated ,the medications cabinets should always be kept closed.<br><br>Facility policy title Med Storage dated 1/1/15, indicated the facility "maintains equipment and supplies necessary for medication preparation and administration in a manner that is orderly, effective and follows the standards of infection control practice." The policy also indicated the facility will maintain proper storage, preparation | F 761 | Director of Nursing or designee | |

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| F 761 | Continued From page 29<br>and administration of medications including lockable medication carts, medication cabinets, drawers, and rooms with well lit dose preparation areas. | F 761 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to have a process in place to monitor refrigerator, dishwasher and breakfast food temperatures in all six unit kitchens in the care facility. In addition the facility failed to ensure opened food and beverage containers were dated to prevent unsafe consumption by residents. This had the ability to affect all 55 residents residing in the care facility. | F 812 | Plan of Correction for Residents Cited in this Survey: Temp logs were placed on all floors during survey for fridge, dishwasher and freezers on all floors and food opened was labeled and dated during time of survey.<br><br>Plan to address/prevent this deficiency for other residents: Current staff will be educated on labeling and dating opened | 11/4/24 |

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| F 812 | Continued From page 30<br>Findings include:<br><br>During interview and observation on 9/9/24 at 11:45 a.m., the registered dietician (RD) stated there was one central kitchen where lunch and dinner were cooked, and each resident floor (two through seven) had their own full kitchen. Breakfast was cooked to order for each resident on the floors and lunch and dinner were kept warm in a steamer on the floors. Each floor had an industrial refrigerator, one unit residential type refrigerator and a high temperature dishwasher. During observation the second-floor kitchen lacked any temperature logs for the industrial and unit refrigerators and the dishwasher. The industrial refrigerator was showing two different temperatures on different thermometers of 8 degrees Fahrenheit and 50 degrees Fahrenheit. The RD stated, "it feels cold, but I don't think that is right [the temperatures]. The third-floor kitchen also lacked any temperature logs for the industrial and unit refrigerators and dishwasher. The sixth-floor kitchen also lacked any temperature logs for the industrial and unit refrigerators and dishwasher. The RD stated she would assume it should be her that is currently monitoring the temperatures in the kitchen, stating there had been a gap in the position (of kitchen manager) and the unit kitchens were not up to standard yet. The RD stated they were further in a transition from kitchen staff overseeing the unit kitchens to the nursing staff and that the nursing assistants needed training on proper food temperatures and monitoring refrigerator and dishwasher temperatures and their currently was a process in place for checking food temperatures for the breakfast prior to serving.<br><br>During observation on 9/9/24 at 1:23 p.m., the | F 812 | food, taking temperatures of food for the breakfast meal, and keeping log of the freezer, fridge and dishwasher temperatures.<br><br>Measures put in place to prevent reoccurrence: Current staff will be educated on labeling and dating opened food, taking temperatures of food for the breakfast meal, and keeping log of the freezer, fridge and dishwasher temperatures.<br><br>Plan to monitor: Audits will be conducted on fridge, freezer, and dishwasher temperature logs, temps of breakfast food items and labeling and dating of opened food 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Dietitian or designee will monitor compliance. | |

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| F 812 | Continued From page 31 | F 812 | | |

sixth-floor unit refrigerator had a temperature log hung on the side that was dated December 2023 and blank. Inside the refrigerator was an open, undated milk container.

During observation on 9/9/24 at 1:31 p.m., the seventh-floor unit refrigerator had an open, undated milk container and liquid eggs in an opened and undated container.

During interview and observation of the breakfast service on seventh-floor on 9/11/24 at 7:35 a.m., R39 was served a glass of milk out of the unit refrigerator. R39 stated, "I think this milk has turned, it tastes sour."

During an interview at 9/11/24 at 7:47 a.m., nursing assistant (NA)-M they worked with preparing breakfast meals for residents and stated the kitchen staff were responsible for taking food temperatures and was unsure who was responsible for monitoring the refrigerator or dishwasher temperatures.

During an interview on 9/11/24 at 8:50 a.m., NA-N stated the NAs were responsible for making the residents breakfast and that the kitchen staff were responsible for taking all the food temperatures for the other meals, refrigerator temperatures and dishwasher temperatures. NA-N further stated it was expected for all opened food containters to be dated when opened and discarded after seven days.

During an interview on 9/11/24 at 8:18 a.m., a cook (C)-A from the central kitchen stated the kitchen staff were responsible for taking lunch and dinner temperatures before taking the food to the unit kitchens and they did not temp the

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| F 812 | Continued From page 32<br>breakfasts. C-A stated the NAs were responsible for monitoring the temperatures of the refrigerators and dishwashers on the individual floors and for temping any food prepared on the individual floors.<br><br>During observation on 9/12/24 at 8:31 a.m., the second-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened, undated container of half and half inside. The industrial refrigerator had a temperature log hanging on the outside with one temperature recorded for the month on 9/9/24. The dishwasher had a temperature log hanging above it with temperatures recorded on 9/10/24 and 9/11/24 only. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures.<br><br>During observation on 9/12/24 at 8:25 a.m., the third-floor unit fridge did not have a temperature log. The industrial refrigerator had a temperature log hanging on it however lacked any recorded temperatures. The dishwasher had a temperature log hanging above it with temperatures recorded for the month on 9/9/24, 9/10/24, and 9/11/24 only. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures.<br><br>During observation on 9/12/24 at 8:22 a.m., the fourth-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened, undated container of half and half inside. The industrial refrigerator had a temperature log hanging on the outside with one temperature for the month recorded on 9/11/24. The dishwasher had a temperature log hanging above it however lacked any recorded | F 812 | | |

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| F 812 | Continued From page 33 | F 812 | | |

temperatures. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures.

During observation on 9/12/24 at 8:18 a.m., the fifth-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened and undated liquid eggs container inside. The industrial refrigerator had a temperature log hanging on the outside with two temperatures recorded for the month on 9/10/24 and 9/11/24. The dishwasher had a temperature log hanging above it however lacked any recorded temperatures. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures.

During observation on 9/12/24 at 8:14 a.m., the sixth-floor unit refrigerator did not have a temperature log. The industrial refrigerator had a temperature log hanging on the outside with two temperatures for the month recorded on 9/9/24 and 9/10/24. The dishwasher had a temperature log hanging above it with two temperatures recorded on 9/9/24 and 9/10/24. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures.

During observation on 9/12/24 at b8:15 a.m., the seventh-floor unit refrigerators had a temperature log hanging on the side with one recorded temperature from 9/9/24. The industrial refrigerator had a temperature log hanging on the outside however lacked any recorded temperatures. The dishwasher had a temperature log hanging above it however lacked any recorded temperatures. A food temperature log was also hanging on the refrigerator however it

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| F 812 | Continued From page 34<br>lacked breakfast food temperatures.<br><br>During an interview on 9/12/24 at 10:00 a.m., the RD acknowledged and stated awareness of the temperatures for the refrigerators and dishwashers were not being monitored on the resident floors as well as the temperatures not being monitored for the breakfasts prepared on the individual floors. The RD stated the expectation was for the NAs to monitor breakfast food temperatures and they would need to receive training on that. The RD further stated it was expected for all opened food or drinks to be dated and discarded within seven days or discarded if a food container was in the refrigerators open and undated. The RD stated monitoring of food, refrigerator, and dishwasher temperatures, along with dating opened food or drink containers was important due to the vulnerable state of the population they serve and to prevent any potential food borne illness.<br><br>A facility policy titled Date Marking and Labeling, dated 3/2016, indicated that all food held for more than 24 hours would be labeled. A policy on refrigeration and dishwasher temperature monitoring was requested but not received. | F 812 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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. | F 880 | | 11/4/24 |

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| F 880 | Continued From page 35<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct | F 880 | | |

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| F 880 | Continued From page 36<br>contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to the facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (R35) observed for personal cares. In addition, the facility failed to sanitize a standing lift sling shared by residents for 2 of 2 residents (R35 and R9) observed for infection control practices.<br><br>Findings include:<br><br>Hand Hygiene<br><br>R35's quarterly Minimum Assessment Data (MDS) dated 6/26/24, indicated R35 had moderate cognitive impairment, needed setup to eat, supervision with oral hygiene, and was dependent with bathing, toileting, dressing, bed mobility and transfers. | F 880 | Plan of Correction for Residents Cited in this Survey: R35 and R9 each given their own sling.<br><br>Plan to address/prevent this deficiency for other residents: All residents who use a mechanical lift will be given their own sling. Education will be completed with current staff on sling use and hand hygiene specific to glove use during peri-cares.<br><br>Measures put in place to prevent recurrence: Education will be completed with current staff on sling use and hand hygiene specific to glove use during peri-cares.<br><br>Plan to monitor: Audits will be conducted on cleaning of shared equipment between | |

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| F 880 | Continued From page 37<br>R35's clinical diagnoses record printed 9/12/24, indicated diagnoses of epileptic syndrome (a unique combination of symptoms or by the location in the brain where the seizures originate), malignant neoplasm of the frontal lobe (brain cancer), essential hypertension(abnormally high blood pressure that's not the result of a medical condition), pain, unspecified dementia, type 2 diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), left bundle branch block (a delay or blockage of electrical impulses to the left side of the heart), dysphagia (difficulty swallowing), and erythematous condition (red discoloration of the skin caused by infectious agents, drug hypersensitivity, or underlying disease).<br><br>During observation on 9/11/24 at 7:30 a.m., two nursing assistants (NA)-H and NA-I entered R35's room to assist R35 with personal cares. R35 had used a bed pan to have a bowel movement. After removing the bed pan, R35 laid down on her back. NA-H wore gloves and provided peri-care. NA-I assisted R35 to stay on her side while NA-H used wipes to clean R35's rectal area. When R35 was cleaned NA-H and NA-I put on a clean brief. NA-H did not change her gloves and proceeded to assist resident to get dressed. NA-H and NA-I assisted resident to put on clean pants, a top, and shoes. Still wearing the same gloves, NA-H pulled the standing lift closer to R35's bed, grabbed the stand's sling, and with the help of NA-I they put on sling, connected it to lift, and transferred R35 to her wheelchair. NA-H gathered garbage in a clear plastic bag and removed her soiled gloves. NA-H rubbed her hands with hand sanitizer and left the room. | F 880 | elders and completing proper hand hygiene during peri-cares 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful.<br><br>Responsible for maintaining compliance: Infection Preventionist or designee | |

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| F 880 | Continued From page 38<br><br>During interview on 9/11/24 at 8:17 a.m., NA-H stated she failed to change her gloves or wash her hands and put on new gloves after she provided peri care for R35. NA-H stated she should have changed her gloves to minimize the potential of contaminating R35's clothes with body fluids, her own clothes, and any surface she touched with her dirty gloves.<br><br>During interview on 9/11/24 at 8:24 a.m., clinical coordinator/licensed practical nurse (LPN)-C stated the expectation was for nursing assistants to change their gloves after they provided peri-care. LPN-C stated failure to change gloves after peri-care increased the risk for cross-contamination and was an infection control issue.<br><br>Standing lift slings<br><br>During observation on 9/11/24 at 7:30 a.m., NA-H and NA-I provided personal cares and assisted R35 to get ready for breakfast. NA-H and NA-I moved a standing lift close to R35's bed. The NAs put a sling around R35's lower back, connected it to lift, and transferred R35 to her wheelchair.<br><br>During observation and interview on 9/11/24 at 7:41 a.m., after providing personal cares and using a standing lift to transfer R35, NA-H was observed cleaning the standing lift but not the sling. NA-H stated the standing lift and slings were shared by several residents on the second floor. NA-H stated the standing lifts were cleaned/sanitized after each use but not the slings. NA-H stated the laundry washes the slings, "I think once a week." | F 880 | | |

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| F 880 | Continued From page 39<br><br>During interview on 9/11/24 at 7:43 a.m., NA-I stated staff sanitize the standing lifts after every use, but they did not sanitize the slings between residents.<br><br>R9's quarterly Minimum Assessment Data (MDS) dated 6/5/24, indicated R9 had severe cognitive impairment, was dependent with toileting and transfers, maximal assistance with dressing and bathing, and needed moderate assistance with upper body dressing and personal hygiene. Diagnoses included hypertension, diabetes (A group of diseases that result in too much sugar in the blood), hyperlipidemia (high levels of fat particles in the blood), dementia, hemiplegia (paralysis of one side of the body), anxiety, and depression.<br><br>Nursing Assistants care plan printed on 9/12/24, indicated R9 transferred with staff assistance and a standing lift.<br><br>During continuous observation on 9/11/24 at 7:52 a.m., NA-H and NA-I took standing lift and unsanitized sling from R35's to R9's room. After providing personal cares and dressing R9, NA-H and NA-I used standing lift and the unsanitized sling to transfer resident from her bed to her wheelchair.<br><br>During interview on 9/11/24 at 8:17 a.m., LPN-C stated the standing lifts and the slings needed to be sanitized after every use. LPN-C stated the laundry didn't wash the slings, the NAs wash the slings in the laundry rooms located in each floor. LPN-C stated failure to sanitize slings between residents was an infection control concern. | F 880 | | |

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|---|---|---|---|
| | 245625 | A. BUILDING _____ B. WING _____ | C 09/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EPISCOPAL CHURCH HOME THE GARDENS | 1860 UNIVERSITY 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) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 40<br>Facility policy's titled Standard Precautions dated March 10, 2020, indicated "Gloves are to be worn when contact with blood, body fluids, secretions, excretions, and contaminated items is possible. New clean non-sterile gloves are to be worn immediately after washing hands and just prior to touching mucous membranes and non-intact skin. New gloves will be applied when performing tasks and procedures on the same elder when cross-contamination is possible. Gloves are to be removed immediately after use, and before touching non-contaminated items and environmental surfaces and before going to another elder or different task. Hands are to be washed immediately after gloves are removed. Gloves are to be removed prior to leaving room."<br><br>Facility policy titled Infection Control - Equipment & Care Items (reuse) dated March 2020, indicated "To ensure that all reusable resident/patient equipment is not used by another person until the item has been cleaned and or disinfected according to current Infection Prevention guidelines written in this policy and procedure. This policy also ensures that single use items are disposed of properly." | F 880 | | |

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| | 245625 | A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____ | **09/10/2024** |

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| **EPISCOPAL CHURCH HOME THE GARDENS** | **1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/10/2024. At the time of this survey, EPISCOPAL CHURCH HOME GARDENS 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/03/2024

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<br>IS NOT REQUIRED.<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>EPISCOPAL CHURCH HOME GARDENS is a 7-story building with a lower-level parking garage.<br><br>The original building was constructed in 2012 and was determined to be of Type I (332) construction.<br><br>The facility is fully protected throughout by an | K 000 | | |

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| K 000 | Continued From page 2<br>automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.<br>There are single station smoke alarms in all resident rooms.<br><br>The facility has a capacity of 60 beds and had a census of 54 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 324 SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | K 324 | | 10/30/24 |

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|---|---|---|---|---|
| K 324 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, a review of available documentation, and staff interview, the facility failed to maintain cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.7.6, 4.6.12 and 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1, and NFPA 17A (2009 edition), Standard for Wet Chemical Extinguishing Systems, section 7.3.3. This deficient finding could have an wide impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the facility failed to provide documentation showing that their kitchen hood and fire extinguishing system did not have an inspection completed on it within 6 months after their last inspection dated 11/6/2023 from Summit.<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 324 | Kitchen hood inspection is scheduled to be completed. A task has been created in TELS to ensure compliance within the next 6 months of completion date.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National | K 345 | | 10/30/24 |

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| K 345 | Continued From page 4<br>Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, 9.6.2.10.1.1 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5, 14.4.6. This deficient finding could have a widespread impact on residents within the facility.<br><br>Findings include:<br><br>On09/10/2024 between 9:00 and 1:30 PM, it was revealed by a review of available documentation that the following was found:<br><br>1. The facility fire alarm system was not annual tested. The last annual inspection occurred on 04/12/2023 by IFS.<br><br>2. The resident rooms single-station smoke alarms have not been tested monthly.<br><br>An interview with the Maintenance Manager verified these deficient findings at the time of discovery. | K 345 | Fire alarm system is scheduled to be inspected by IFS. All resident room single station smoke alarms will be tested. A task in TELS will be created to ensure ongoing compliance.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, | K 353 | | 10/30/24 |

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| K 353 | Continued From page 5<br>and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 19.7.6, 4.6.12, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.3.3.1and 8.3.1.2.<br>These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024, between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the following was found:<br><br>1. Unable to provide documentation showing that the quarterly tests have been performed on the fire sprinkler system for 3rd and 4th quarter of 2023. | K 353 | Quarterly sprinkler tests have been scheduled. Monthly fire pump churn test has been scheduled. A task in TELS has been created to ensure ongoing compliance with monthly fire pump churn test and quarterly fire sprinkler system.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | |

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| K 353 | Continued From page 6<br>2. Unable to provide documentation showing that the monthly fire pump churn test have been performed for 2023 and 2024.<br><br>An interview with the Maintenance Manager verified these deficient findings at the time of discovery. | K 353 | | |
| K 355 SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19..7.6, 4.6.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.4.1. This deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024 between 09:00 AM and 1:30 PM, it was revealed by observation and document review that the fire extinguishers have been annually inspected only by the tag on the fire extinguishers. No documentation could be provided with a complete inventory listing and documentation from contractor on how many were done.<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 355 | Documentation from vendor will be obtained for complete inventory listing and include documentation of how many fire extinguishers were inspected.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | 10/30/24 |

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| K 712 | Continued From page 7 | K 712 | | |
| K 712 SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.2, 19.7.1.4, 19.7.1.6, and 19.7.1.8. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024, between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the facility fire drill for 3rd quarter, night shift drill was not documented.<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 712 | A calendar will be created to outline all dates and times that fire drills will occur. A task in TELS will be created to ensure compliance with fire drills.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | 10/30/24 |
| K 761 SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested | K 761 | | 10/30/24 |

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| K 761 | Continued From page 8<br>annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 19.7.6, 4.6.12, 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1 and 5.2.4.2.<br>This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024 between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation and observation that the annual fire and smoke door inspection report did not include all the fire and smoke doors with-in the facility.<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 761 | The annual inspection of fire and smoke rated doors will be completed. The list and locations of fire and smoke doors will be reviewed and updated to ensure each door can be properly inspected.<br><br>A task in TELS will be created to ensure ongoing compliance with annual inspection of fire and smoke rated doors.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing | K 914 | | 10/30/24 |

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| K 914 | Continued From page 9<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings Include:<br><br>On 09/10/2024, between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that the facility has properly tested all electrical receptacles in the resident rooms. | K 914 | The NFPA 99 documentation for patient care receptacle testing will be completed.<br><br>A list of all patient care rooms and receptacles will be created and used to ensure compliance. A task in TELS will be created to ensure ongoing compliance within the annual timeframe.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | |

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| | 245625 | A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____ | **09/10/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **EPISCOPAL CHURCH HOME THE GARDENS** | **1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104** |

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| K 914 | Continued From page 10<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 914 | | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. | K 918 | | 10/30/24 |

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| K 918 | Continued From page 11<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.8, 8.4.1, 8.4.2, 8.4.2.1, and 8.4.2.4. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/10/2024 between 09:00 AM and 1:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they completed the monthly generator testing for October, November, December 2023 and January, February, March 2024.<br><br>An interview with the Maintenance Manager verified this deficient finding at the time of discovery. | K 918 | The monthly inspections and testing of the emergency generator will be completed. A task in TELS will be created and/or updated to ensure ongoing weekly and monthly compliance with generator inspections and testing.<br><br>Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.<br><br>The Director of Facilities or designee will be responsible for compliance. | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 9/9/24 to 9/12/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed:<br><br>H56257786C MN96771<br>H56257785C MN104776 - Licensing order issued at 0830<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the | 2 000 | | |

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| 2 000 | Continued From page 2<br>Minnesota Department of Health.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.<br><br>. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to implement, and care plan, new and appropriate fall interventions to prevent falls for 2 of 2 residents (R40 and R51) reviewed for falls. | 2 830 | Corrected | 11/4/24 |

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| 2 830 | Continued From page 3<br><br>Findings include:<br><br>R40<br><br>R40's quarterly Minimum Data Set (MDS), dated 7/31/24, indicated R40 was admitted to the care facility on 4/4/22, had severe cognitive impairment, and was dependent on staff for activities of daily living (ADLs). The MDS further indicated R40 had 2 or more falls with injury since the last assessment.<br><br>R40's Diagnoses list, printed 9/12/24, indicated R40 had several medical diagnoses including Parkinson's Disease, vascular dementia and legal blindness.<br><br>R40's past two fall assessments, dated 4/27/24 and 7/27/24, indicated R40 has at risk for falls.<br><br>R40's care plan, dated 4/5/22 and revised on 8/2/24, indicated R40 had "behaviors where I try to stand up, wander and occasionally grab at staff during cares." However, the care plan problem lacked any new interventions since 4/5/22. R40's care plan, dated 5/27/24 and revised on 6/18/24, further indicated R40 was at "high risk for falls r/t [related to] Parkinson's [disease], poor vision, hx [history of] UTIs [urinary tract infections], anemia, left MCA [middle cerebral artery] stroke, impaired balance, acute CVA [cerebral vascular accident], I fall frequently, I'm impulsive, I have poor decision making, I don't use my call light or pendant. I sometimes wake up in the middle of the night and wander in my room, in the hallway or I will wander into the room across from my room." The most current fall intervention was dated 2/6/24 and indicated "toilet before and after meals and at bedtime, q2h [every 2 hours] during the night. Say | 2 830 | | |

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| 2 830 | Continued From page 4<br><br>'lets go to the bathroom'." Other fall interventions included a bed and chair alarm dated 1/18/24, massage abdomen on toilet to encourage voiding dated 5/27/23, anticipate needs dated 4/5/22, ensure call light is within reach, every hour checks, more frequent between 3-5 am, dated 9/20/23, keep walker in front of R40 dated 7/24/23, and provide a safe environment with even floors free from spills and clutter, and personal items within reach dated 9/8/23.<br><br>R40's progress notes indicated R40 had 20 falls since a new care plan intervention was put in place on 2/6/24 and documented the following:<br><br>On 3/7/24 it was documented R40 was found on the floor with a scratch on her left lower extremity. Approaches previously care planned were documented as "bed alarm, walker at bedside, wheelchair." Approaches to prevent reoccurrences were documented as "continue bed alarm, monitoring low position of bed, call light within reach, walker at bedside."<br><br>On 3/16/24 it was documented R40 fell in the dining room, sitting in a "regular chair without alarm on" and sustained a skin tear to her forehead.<br><br>On 5/2/24 it was documented R40 was found on the bathroom floor.<br><br>On 5/21/24 it was documented R40 had an unwitnessed fall in the dining room. Approaches previously care planned indicated R40 had "alarms on wheelchair, and walker in front of her while sitting or lying, and toilet the resident as schedule."<br>Approaches to prevent reoccurrences indicated "keep an eye on common area while she appears | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>active, assisting with walk, and continue to monitor by staff."<br><br>On 5/25/24 it was documented R40 had an unwitnessed fall in her room. Approaches previously care planned were documented as "toileting the resident as schedule and put walker in front of her." Approaches to prevent reoccurrences were documented as "staff assisting the resident with walking, continue monitoring."<br><br>On 5/27/24 it was documented staff found resident lying on the ground with her walker near by and had hit the back of her head. Approaches previously care planned indicated "toileting as needed, keep wheeled walker in front of her, in living area during the day for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care].<br><br>On 5/28/24 it was documented R40 was found on the floor kneeling over her walker and appeared weak and lethargic. Approaches previously care planned indicated "resident has alarm but they are not available." Approaches to prevent reoccurrences indicated "educated on calling out for help."<br><br>On 6/10/24 it was documented R40 was found in the hallway by her room and had complaints of pain. Approaches previously care planned indicated R40 "has bed alarm and is hourly rounding." Approaches to prevent reoccurrences indicated "told [R40] the risked of not seeking help when needed and told her to pull call light when assistance is needed."<br><br>On 6/15/24 it was documented R40 had an unwitnessed fall in the living room and sustained | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>a four-inch skin tear to her left forearm and one-inch skin tear to her right elbow. Approaches previously care planned indicated "walker in front of her, proper footwear, in living room for close monitoring, alarm pad." Approaches to prevent reoccurrences indicated "continue POC [plan of care].<br><br>On 6/27/24 it was documented R40 had a fall around 11:50 a.m., and family, DON and hospice was notified. No previously care planned approaches or new approaches to prevent reoccurrence documented.<br><br>On 7/11/24 it was documented R40 had a witnessed fall while sitting in the recliner in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated "the resident [R40] has a bed alarm on the recliner and, put the her bed lowest potion the bed toilet frequently, keep her in common area, keep her walker in front of her." Approaches to prevent reoccurrences indicated to continue R40's care plan.<br><br>On 7/15/24 it was documented R40 fell from her wheelchair in the dining room. Approaches previously care planned indicated "proper footwear, locked wheelchair, keep in common area for close monitoring, chair alarm." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>On 7/18/24 it was documented R40 had an unwitnessed fall in the dining area and sustained a skin tear to her right elbow. Approaches previously care planned indicated "fall alarm in place, frequent visual checks, assistance w/ [with] all transfers and ambulation." Approaches to prevent reoccurrences: indicated "coaching: fall | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>alarm must be placed under elder at all times; attempt regular toileting."<br><br>On 7/19/24 it was documented R40 had an unwitnessed fall in the dining room during dinner. Approaches previously care planned indicated "toilet the resident as schedule, and use bed alarm, bed wheelchair, reclined, assisted with walking." Approaches to prevent reoccurrences was not documented.<br><br>On 7/26/24 it was documented R40 fell after several attempts to self-transfer from her recliner in the common area, indicating the "pressure" alarm did not sound. R40 sustained a "raised wound" on her forehead. Approaches previously care planned indicated "pressure/fall alarm in place; routine toileting; assistance with all transfers/ambulation." Approaches to prevent reoccurrences indicated "1:1 care as possible; frequent visual check."<br><br>On 8/3/24 it was documented R40 was found on lying on the floor in the doorway of another room and hit her head. No previously care planned approaches or new approaches to prevent reoccurrence documented.<br><br>On 8/3/24 it was documented R40 had a second fall in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated "assist resident toilet as schedule, bed and chair alarm on, put her walker in front of her while sitting and assist resident with walk." Approaches to prevent reoccurrences indicated "check the elder [R40] alarm functio[n]."<br><br>On 8/31/24 it was documented R40 had a witnessed fall in the common area. Approaches previously care planned indicated "ensure that the | 2 830 | | |

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| 2 830 | Continued From page 8<br><br>alarm is activated, and conduct safety checks every 15 minutes. assist resident with using the toilet as per her scheduled." Approaches to prevent reoccurrences was not documented.<br><br>On 9/3/24 it was documented R40 fell in the dining room and sustained a "hematoma to R [right] cheek bone" and a "skin tear under R [right] eyebrow." Approaches previously care planned indicated "proper footwear, chair alarm, walker in front of resident, toileting, keep in common living area for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>On 9/6/24 it was documented R40 was found on the floor in the common area and sustained a "small skin tear on L [left] elbow." Approaches previously care planned indicated "walker in front, proper footwear, chair alarm, keep in living area for close monitoring." Approaches to prevent reoccurrences indicated "continue POC [plan of care]."<br><br>R40's electronic medical record (EMR) lacked a neuro assessment for R40's falls on 9/3/24 and 9/6/24 with known facial/head trauma.<br><br>During observation on 9/9/24 at 1:20 p.m., R40 was out in the main common area in a black, high back wheelchair. R40's right periorbital skin was black and blue in color and the entire right side of her neck was covered in a black bruise.<br><br>During observation and interview on 9/11/24 at 7:49 a.m., R40 was sitting in a broda chair with cotton socks on her feet. Nursing assistant (NA)-J approached R40 and wheeled her back to her room to transfer her to bed. NA-J stated R40 fell out of bed and her broda chair, stating she was | 2 830 | | |

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| 2 830 | Continued From page 9<br><br>not sure if R40 could use her call light anymore but that it should be placed near her.<br><br>During an interview on 9/11/24 at 8:01 a.m., NA-M stated R40 had a "lot of falls" stating, "we basically make sure she always has her alarm on her."<br><br>During observation on 9/11/24 at 8:04 a.m., R40 was lying in bed, with her broda chair next to her. R40's call light was observed laying on the floor between the right side of the bed and the wall.<br><br>During observation on 9/11/24 at 8:21 a.m., R40 was becoming restless in bed, attempting to get out of bed. NA-J transferred R40 back to the main common area and placed her in a recliner chair. There was no walker left near R40 as care planned.<br><br>During an interview on 9/11/24 at 11:17 a.m., licensed practical nurse (LPN)-B stated when a resident fell, they should be assessed for pain or injuries. A neuro assessment should be completed if they resident hit their head for 72 hours post fall. LPN-B stated interventions for R40 to prevent falls were the bed/chair alarm, placing her walker in front of her, keeping R40 in the common area during the day for closer monitoring and staff "keeping as quiet at night as possible."<br><br>During an observation on 9/12/24 at 8:37 a.m., R40 was sitting out at the breakfast table without staff or residents nearby. R40 was not wearing her call light pendant around her neck.<br><br>During an interview on 9/12/24 at 11:51 a.m., nurse manager and registered nurse (RN)-A stated the expectations when a resident fell was | 2 830 | | |

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| 2 830 | Continued From page 10<br><br>for the nurse to do a full resident assessment and a neuro assessment for 72 hours "if warranted", meaning if the fall was unwitnessed or the resident hit their head. RN-A stated falls were discussed at morning meeting and staff would "brainstorm" to try and "come up with new fall interventions." RN-A stated a risk managemnt note would be put in progress notes. RN-A stated it would be expected for new fall interventions to be put in place with continued falls. Fall interventions for R40 were reviewed and RN-A confirmed R40's fall interventions were outdated and not working. RN-A further stated R40 had slid out of her broad chair "just the other day" and had another fall this morning.<br><br>R51<br><br>R51's annual Minimum Data Set (MDS) dated 7/22/24, identified admission to facility on 7/26/23, intact cognition, had no impairment of upper and lower extremities, was independent with hygiene and mobility. Also, one fall with major injury since prior MDS assessment. In addition, R51 was documented as taking antipsychotics (medications prescribed for mood disorders).<br><br>R51's Care Area Assessment (CAA) dated 7/22/24, identified care plan triggers for delirium, cognitive loss/dementia, communication, functioning abilities, psychosocial well-being, mood state, behavioral symptoms, falls, and psychotropic drug use.<br><br>R51's Medical Diagnoses downloaded from electronic medical record (EMR) on 9/10/24 identified R6 with dementia (group of symptoms affecting memory, thinking and social abilities), bipolar (mental health condition that causes extreme mood swings), anxiety, major | 2 830 | | |

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| 2 830 | Continued From page 11<br><br>depression, arthritis, diabetes, heart failure, and history of falling.<br><br>R51's Provider Notes (PPN) for 8/9/23, 10/13/23, 1/18/24, 3/19/24, and 8/9/24 do not mention any falls. However, falls were noted from the following PPNs:<br>* 3/22/24 documented R51 with fall on 3/20/24 with rib injury requiring x-ray.<br>*7/3/24 documented R51 with fall on 6/25/24 with right toe fracture.<br>*9/12/24 documented R51 with fall on 9/11/24 with injury to right arm requiring x-ray.<br><br>R51's Risk Management Reports (RMR) for 10/29/23, 2/7/24, 3/20/24, 3/30/24, 6/25/24, and 9/2/24 identified un-witnessed falls on each of the dates each with a different root cause.<br><br>R51's Care Plan (CP) downloaded 9/11/24, identified of the six RMR's, only one subsequent CP was updated. R51's fall risk CP was updated on 4/1/24 related to the fall on 3/30/24 with a new intervention of "remind me to use my walker when ambulating at all times. I tend to leave it and then attempt to walk without it."<br><br>During interview with Administrator on 9/12/24 at 11:39 a.m., Administrator stated if there is a resident fall or injury the expectation is for staff to ensure safety of the resident first, assess for injury and then fill out a risk management report, update provider, family, director of nursing (DON), and Administrator. Also, staff were expected to update resident care plan and "put in interventions in place right away."<br><br>Facility policy titled Fall (POST) Assessment reviewed 11/25/2022 state expectation of staff to document the fall in risk management in the | 2 830 | | |

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| 2 830 | Continued From page 12<br><br>EMR, document the fall in the progress notes, care plan fall and fall prevention measures and update caregivers as warranted. Policy included "Documentation Hints" to include, all interventions and treatments, any fall interventions in place at the time for the fall, and any interventions put in place after the fall.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 850 | MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving<br><br>Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:<br>D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record | 2 850 | Corrected. | 11/4/24 |

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| 2 850 | Continued From page 13<br><br>review the facility failed to ensure assistance with personal hygiene for 2 of 2 residents (R6, R44 ) reviewed for activities of daily living (ADLs) for dependent residents.<br><br>Findings include:<br><br>R6<br><br>R6's annual Minimum Data Set (MDS) dated 7/29/24, identified severe impairment of cognition, diagnoses of Alzheimer's and heart failure, and R6 required extensive assistance with ADL's. In addition, R6 did not display rejection of cares.<br><br>R6's Care Area Assessment (CAA) identified triggers for delirium, cognitive loss/dementia, functional abilities, psychosocial well-being, mood state, and psychotropic drug use (medications used to treat mental health disorders).<br><br>R6's care plan (CP) dated 8/2/22, and revised 8/21/23 identified, "PERSONAL HYGIENE/ORAL CARE: I require limited to extensive assist of 1 staff for personal hygiene and oral care. "<br><br>R6's nursing assistant (NAR) task form in the electronic medical record (EMR) for dates of 8/12/24 to 9/9/24 identified, "PERSONAL HYGIENE: SUPPORT PROVIDED-How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers" was documented one to two times per day during that period. All entries but one (9/5/24 at 9:02 p.m.) were documented as, "One person physical assist".<br><br>R6's NAR care sheet titled, "Eldershahbaz Care Plan-Gabrielle House-4th Floor" downloaded | 2 850 | | |

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| 2 850 | Continued From page 14<br><br>9/10/24, had a column with a section titled, "Grooming". The column identified for R6 documented, "Extensive assist 1" with no indication anywhere else on the document for shaving support.<br><br>During observation on 9/9/24 at 1:57 p.m., R6 was observed sitting in a wheelchair in her room. R6 was fully dressed with hair pulled back into ponytail. R6 had several 1.5-inch white hairs noted to left of chin on the face. R6 not interviewable.<br><br>During observation on 9/10/24 at 1:46 p.m., R6 was laying in bed and stated she had finished eating lunch and was resting. R6 was observed with several 1.5-inch white hairs noted on the left side of her chin. R6 touched the chin hairs and stated, "I don't like that one bit. I want them cut."<br><br>During interview with family member (FM)-A on 9/10/24 at 2:00 p.m., FM-A stated, "[R6] would not like to have long facial hair." FM-A stated it was important for [R6] to be well groomed, "so having a long whisker or several of them would be awful for [R6]. I know they [facility] clean [R6] up and shower [R6], but they should at least make sure [R6's] facial hair is trimmed. No one from the facility has reached out to me about [R6] possibly refusing to be shaved or trimmed."<br><br>During interview with NA-A on 9/10/24 at 1:49 p.m., NA-A stated all nursing assistants were expected to review the resident care plan, pointing to the "Eldershahbaz Care Plan-Gabrielle House-4th Floor" to "tell us what we need to do for the residents."<br><br>During interview with NA-C on 9/10/24 at 3:10 p.m., NA-C stated, "I get the care plan sheet [sic]. | 2 850 | | |

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| 2 850 | Continued From page 15<br><br>It tells me what to do [for each resident]". NA-C stated if a resident refuses care then we are to re-approach the resident." If resident refuses care completely, then NA-C stated the nursing assistants were expected to document refusals in the EMR and notify the nurse. NA-C stated, "women residents should be asked every day if they would like to have their facial hair trimmed. Here, we[staff] have a lot of free time so we can always ask and offer to help to shave them." NA-C stated, nursing assistants were responsible for providing personal hygiene, "including facial hairs".<br><br>During interview with NA-B on 9/10/24 at 3:23 p.m., NA- B stated the expectation for nursing assistants was to "always ask. Especially for ladies, we should be offering to shave or trim chin hairs every day if we see long hair on the faces. Most women would not like that at all." NA-B stated all nursing assistants were expected to document in the EMR for tasks assigned to aides per the printed "Eldershahbaz Care Plan-Gabrielle House-4th Floor".<br><br>During observation and interview on 9/11/24 at 8:15 a.m., NA-D stated she was familiar with R6 and had worked at facility for two years. R6 was observed sitting at dining room table alone eating breakfast. R6 was dressed, with hair pulled back into a ponytail. R6 with several 1.5-inch white hairs noted to left of chin on face. NA-D stated, "the hair on [R6] chin is pretty long. Obviously it is not a good thing. I would not like to have hairs like that on my face. It would really bother me."<br><br>During observation and interview with licensed practical nurse (LPN)-A on 9/11/24 at 8:35 a.m., LPN-A stated he worked at facility for three years and was familiar with the 4th floor unit residents. | 2 850 | | |

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| 2 850 | Continued From page 16<br><br>LPN-A stated the expectation of nursing assistants was to review the resident care sheets, pointing to the "Eldershahbaz Care Plan-Gabrielle House-4th Floor" sheet and "prioritize resident needs." LPN-A stated, "shaving is part of personal cares." LPN-A observed R6 and stated, "I can see that it [chin hairs] needs to be shaved. It hasn't been done for a couple weeks. The razors are available on the unit [for aides to use]. We should ask her [R6] and then do it. I would not like it if my mom or loved one had long facial hair like that. It would really bother her. [R6] should at least be asked if she wants it cut off or not."<br><br>During interview with LPN-B on 9/11/24 at 8:55 a.m., LPN-B stated, she was employed full time and worked at facility for over a year and a half. LPN-B stated, "personal cares should be every day. Personal cares include washing face, brushing teeth, hair, nails, dressing, and shaving. Shaving should be done on the days it is seen not just on bath days. Facial hair on women is not appealing and long facial hair shows neglect. I would not like if I was left with long facial hair. It is a dignity thing. I would be very angry if my mom was left with long facial hair. That is not ok with me."<br><br>R44<br><br>R44's quarterly Minimum Data Set, dated 7/29/24, indicated R44 was admitted to the care facility on 5/2/22, had moderate cognitive impairment and was dependent on staff for showers and personal hygiene to include shaving.<br><br>R44's care plan, dated 8/15/24, indicated R44 had an "ADL [activities of daily living] self-care performance deficit r/t [related to] right BKA | 2 850 | | |

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| 2 850 | Continued From page 17<br><br>[below knee amputation], diabetes, A fib [atrial fibrillation], HTN [hypertension], anemia, osteoporosis, DM [diabetes mellitus], wounds. Elder is needing more assistance with ADLS and does get irritated when asked if they can help him."<br><br>R44's picture in his electronic medical record (EMR) showed R44 to be clean shaven.<br><br>During observation on 9/9/24 at 4:09 p.m., R44 was sitting in his room. R44 had a full-face beard at least ½ inch long with dried particles stuck in his beard. R44 stated he prefers to be clean shaven but does not get help with his beard despite asking.<br><br>During an interview on 9/11/24 at 8:50 a.m., nursing assistant (NA)-N stated the NAs should offer to shave resident on bath days or if they notice a resident is "out of the usual." NA-N stated R44 had his own shaver and at times would shave himself but he did prefer to be clean shaven and staff should be offering to shave him on bath days.<br><br>During interview and observation on 9/11/24 at 9:00 a.m., R44 was out at the breakfast table clean shaven. R44 stated "they just came at me with a shaver and gave me a shave. It was kind of a forced shaving."<br><br>During interview with nurse manager and registered nurse (RN)-A on 9/11/24 at 11:43 a.m., RN-A stated the expectation of staff is to provide personal cares daily. RN-A stated a failure to provide shaving or trimming of facial hair is a "concern for dignity, especially if you are a woman." | 2 850 | | |

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| 2 850 | Continued From page 18<br><br>Facility policy titled Standard of Care/Elder Rights revised on 4/2022, documented "Assistance or supervision of shaving as needed to keep clan[sic] and well groomed".<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 850 | | |
| 21385 | MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance<br><br>Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to the facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (R35) observed for personal cares. In addition, the facility failed to sanitize a standing lift sling shared by residents | 21385 | Corrected | 11/4/24 |

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| 21385 | Continued From page 19<br><br>for 2 of 2 residents (R35 and R9) observed for infection control practices.<br><br>Findings include:<br><br>Hand Hygiene<br><br>R35's quarterly Minimum Assessment Data (MDS) dated 6/26/24, indicated R35 had moderate cognitive impairment, needed setup to eat, supervision with oral hygiene, and was dependent with bathing, toileting, dressing, bed mobility and transfers.<br><br>R35's clinical diagnoses record printed 9/12/24, indicated diagnoses of epileptic syndrome (a unique combination of symptoms or by the location in the brain where the seizures originate), malignant neoplasm of the frontal lobe (brain cancer), essential hypertension(abnormally high blood pressure that's not the result of a medical condition), pain, unspecified dementia, type 2 diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), left bundle branch block (a delay or blockage of electrical impulses to the left side of the heart), dysphagia (difficulty swallowing), and erythematous condition (red discoloration of the skin caused by infectious agents, drug hypersensitivity, or underlying disease).<br><br>During observation on 9/11/24 at 7:30 a.m., two nursing assistants (NA)-H and NA-I entered R35's room to assist R35 with personal cares. R35 had used a bed pan to have a bowel movement. After removing the bed pan, R35 laid down on her back. NA-H wore gloves and provided peri-care. NA-I assisted R35 to stay on her side while NA-H used wipes to clean R35's | 21385 | | |

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| 21385 | Continued From page 20<br><br>rectal area. When R35 was cleaned NA-H and NA-I put on a clean brief. NA-H did not change her gloves and proceeded to assist resident to get dressed. NA-H and NA-I assisted resident to put on clean pants, a top, and shoes. Still wearing the same gloves, NA-H pulled the standing lift closer to R35's bed, grabbed the stand's sling, and with the help of NA-I they put on sling, connected it to lift, and transferred R35 to her wheelchair. NA-H gathered garbage in a clear plastic bag and removed her soiled gloves. NA-H rubbed her hands with hand sanitizer and left the room.<br><br>During interview on 9/11/24 at 8:17 a.m., NA-H stated she failed to change her gloves or wash her hands and put on new gloves after she provided peri care for R35. NA-H stated she should have changed her gloves to minimize the potential of contaminating R35's clothes with body fluids, her own clothes, and any surface she touched with her dirty gloves.<br><br>During interview on 9/11/24 at 8:24 a.m., clinical coordinator/licensed practical nurse (LPN)-C stated the expectation was for nursing assistants to change their gloves after they provided peri-care. LPN-C stated failure to change gloves after peri-care increased the risk for cross-contamination and was an infection control issue.<br><br>Standing lift slings<br><br>During observation on 9/11/24 at 7:30 a.m., NA-H and NA-I provided personal cares and assisted R35 to get ready for breakfast. NA-H and NA-I moved a standing lift close to R35's bed. The NAs put a sling around R35's lower back, connected it to lift, and transferred R35 to her | 21385 | | |

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| | 30004 | A. BUILDING: _____ B. WING _____ | C 09/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EPISCOPAL CHURCH HOME THE GARDENS | 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104 |

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| 21385 | Continued From page 21<br>wheelchair.<br><br>During observation and interview on 9/11/24 at 7:41 a.m., after providing personal cares and using a standing lift to transfer R35, NA-H was observed cleaning the standing lift but not the sling. NA-H stated the standing lift and slings were shared by several residents on the second floor. NA-H stated the standing lifts were cleaned/sanitized after each use but not the slings. NA-H stated the laundry washes the slings, "I think once a week."<br><br>During interview on 9/11/24 at 7:43 a.m., NA-I stated staff sanitize the standing lifts after every use, but they did not sanitize the slings between residents.<br><br>R9's quarterly Minimum Assessment Data (MDS) dated 6/5/24, indicated R9 had severe cognitive impairment, was dependent with toileting and transfers, maximal assistance with dressing and bathing, and needed moderate assistance with upper body dressing and personal hygiene. Diagnoses included hypertension, diabetes (A group of diseases that result in too much sugar in the blood), hyperlipidemia (high levels of fat particles in the blood), dementia, hemiplegia (paralysis of one side of the body), anxiety, and depression.<br><br>Nursing Assistants care plan printed on 9/12/24, indicated R9 transferred with staff assistance and a standing lift.<br><br>During continuous observation on 9/11/24 at 7:52 a.m., NA-H and NA-I took standing lift and unsanitized sling from R35's to R9's room. After providing personal cares and dressing R9, NA-H and NA-I used standing lift and the unsanitized | 21385 | | |

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| 21385 | Continued From page 22<br><br>sling to transfer resident from her bed to her wheelchair.<br><br>During interview on 9/11/24 at 8:17 a.m., LPN-C stated the standing lifts and the slings needed to be sanitized after every use. LPN-C stated the laundry didn't wash the slings, the NAs wash the slings in the laundry rooms located in each floor. LPN-C stated failure to sanitize slings between residents was an infection control concern.<br><br>Facility policy's titled Standard Precautions dated March 10, 2020, indicated "Gloves are to be worn when contact with blood, body fluids, secretions, excretions, and contaminated items is possible. New clean non-sterile gloves are to be worn immediately after washing hands and just prior to touching mucous membranes and non-intact skin. New gloves will be applied when performing tasks and procedures on the same elder when cross-contamination is possible. Gloves are to be removed immediately after use, and before touching non-contaminated items and environmental surfaces and before going to another elder or different task. Hands are to be washed immediately after gloves are removed. Gloves are to be removed prior to leaving room."<br><br>Facility policy titled Infection Control - Equipment & Care Items (reuse) dated March 2020, indicated "To ensure that all reusable resident/patient equipment is not used by another person until the item has been cleaned and or disinfected according to current Infection Prevention guidelines written in this policy and procedure. This policy also ensures that single use items are disposed of properly." | 21385 | | |

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| 21385 | Continued From page 23<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure infection control polices are implemented, monitored and provided for all residents.<br>The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.<br>The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21385 | | |
| 21610 | MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage<br><br>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure mediations were safely and securely stored for 1 of 1 resident (R38) reviewed for medication storage.<br><br>Findings include:<br><br>R38's quarterly Minimum Data Set (MDS) dated 6/17/24, indicated R38 had moderate cognitive impairment, was dependent with dressing, toileting, bathing, transfers, but ate independently. The MDS indicated the following diagnoses, | 21610 | Corrected | 11/4/24 |

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| 21610 | Continued From page 24<br><br>peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes (a group of diseases that result in too much sugar in the blood), anxiety, depression, and hyperlipidemia (a condition in which there are high levels of fat particles in the blood).<br><br>R38's care plan printed 9/12/24, indicated R38 was unable to ambulate, transferred with assist of staff and a standing lift, and used a manual wheelchair with brake extenders. The care plan also indicated R38 had poor safety awareness, and impaired cognitive function related to mild cognitive impairment.<br><br>During observation on 9/9/24 at 12:17 p.m., R38's medication cabinet located in R38's room was observed open and unsecured. The cabinet had 19 cards of medications, about 10 lidocaine patches, and a glucometer. R38 was not in her room.<br><br>During interview on 9/9/24 at 12:24 p.m., registered nurse (RN)-B stated she went to the team's office across from R38's room and forgot to close the cabinet. RN-B stated she needed to grab something and was going to come back right away, but a resident went to the office to talk to her. RN-B acknowledged the office's blinds were closed and she couldn't see if anybody walked by or entered R38's room. RN-C stated the cabinet needed to be locked to prevent resident or other residents from getting the medications or consuming them.<br><br>During interview on 9/12/24 at 12:39 p.m., clinical nurse/licensed practical nurse (LPN)-C stated if the medicaiton cabinet is unsecured, anybody can come along and take the medications. LPN-C | 21610 | | |

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| 21610 | Continued From page 25<br><br>added, residents might be allergic to the medication, or have difficulty swallowing, and "it's dangerous". LPN-C stated ,the medications cabinets should always be kept closed.<br><br>Facility policy title Med Storage dated 1/1/15, indicated the facility "maintains equipment and supplies necessary for medication preparation and administration in a manner that is orderly, effective and follows the standards of infection control practice." The policy also indicated the facility will maintain proper storage, preparation and administration of medications including lockable medication carts, medication cabinets, drawers, and rooms with well lit dose preparation areas.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications are stored and locked.<br>The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.<br>The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21610 | | |