Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2025

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

RE: CCN: 245071
Cycle Start Date: January 16, 2025

Dear Administrator:

On January 16, 2025, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically 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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 April 16, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

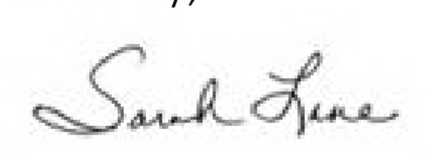
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/13/25-1/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/13/25 - 1/16/25, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H50714660C (MN109392) H50714661C (MN107941) H50714680C (MN106070) H50714681C (MN101097) H50714700C (MN101016) H50714701C (MN099983) 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2025

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		2/28/25

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 1 resident (R14) reviewed for dignity related to unwanted facial hair. Findings include: R14's quarterly Minimum Data Set (MDS) dated 11/20/24, indicated R14 had severe cognitive impairment and diagnoses of peripheral vascular disease (reduced circulation of blood to a body part, such as arms or legs, due to a narrowed or blocked blood vessel), diabetes mellitus, arthritis, dementia, anxiety disorder, depression, and psychotic disorder. R14 had delusions and no behaviors or rejection of cares. R14 required substantial and/or maximal assistance for personal hygiene, which included combing hair, shaving, washing and/or drying face. R14's care plan intervention dated 11/1/22, indicated R14 preferred to be shaved when hair present as needed. R14's care plan did not indicate refusals of care. During observation on 1/13/25 at 1:34 p.m., R14 laid in bed and hair on chin was observed. During interview on 1/14/25 at 10:38 a.m., family	F 550	R14 was assisted by staff with shaving on 1/15/25. R14 continues to be shaved as needed per her care plan. The ADL Policy was reviewed. All other residents will have shaving preferences reviewed and care plans will be updated accordingly. Licensed nurses and nursing assistants will be reeducated on dignity and individualized shaving preferences and practices. The nurse manager/designee will conduct audits weekly on 10% of the facility x 4 weeks, then monthly x 2 months to ensure compliance. The DON is responsible for monitoring and compliance. The results will be shared with QAPI committee. Compliance date 2/28/2025	

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F 550	Continued From page 3 member (FM)-B stated R14 preferred to be shaved and felt better when they didn't have long hairs on their chin. FM-B stated they brought a shaver with when they visited R14 and assisted R14 with shaving. During observation on 1/15/25 at 9:01 a.m., R14 was in their wheelchair in the dining area and had 15 or more grayish colored hairs approximately a half inch or longer on their chin. During interview and observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-K stated residents' preferences to be shaved or not, or if they refused, would be in the care plan. NA-K stated they did not work with R14 often, but R14 let staff know what they did or did not want done. NA-K approached R14 and asked if R14 would allow NA-K to shave them. R14 consented, and NA-K went to find a shaver. NA-K brought R14 to their room and shaved R14. During interview on 1/15/25 at 1:32 p.m., NA-L stated they helped transfer R14 that morning, but the night shift dressed R14. NA-L stated staff shaved residents on their shower day and was not sure when R14's shower day was. During interview on 1/16/25 at 11:04 a.m., registered nurse (RN)-E stated residents' care plans directed whether they wanted to be shaved or not. RN-E stated R14 was already up most of the time when RN-E started their shift. RN-E stated if the staff on the night shift did not shave R14, the morning shift should shave R14. RN-E stated cares were 24 hours and not being shaved could impact R14's dignity. During interview on 1/16/25 at 1:06 p.m., RN-C	F 550		

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F 550	Continued From page 4 stated residents' care plan reflected whether they wanted to be shaved or not. RN-C stated they tell staff to shave all female residents unless they specified they did not want to be shaved. RN-C expected staff on night shift to shave R14 if they got them up in the morning, but any shift could shave R14 as long as it got done. RN-C stated R14 told staff if they did not want something done and thought staff should be able to shave R14. RN-C stated keeping R14 shaved impacted R14's appearance and dignity and was part of keeping R14 clean, happy, and looking nice. During interview on 1/16/25 at 2:46 p.m., the director of nursing (DON) expected staff to offer to shave if care planned and hair visible. If the resident refused, staff should notify the nurse and they resident should be reapproached. DON stated a reasonable person would not want to have facial hair and was a dignity issue. The facility's policy ADL [activities of daily living] Completion / Cares revised 1/11/23, directed staff to be familiar with residents plan of care and follow the care plan. ADL tasks included bathing, dressing, grooming, and oral care. The policy directed staff to treat residents with respect and dignity during cares.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and	F 554	R77 had self-administration of medication	2/28/25

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F 554	Continued From page 5 documentation review, the facility failed to comprehensively assess for safety to determine if self-administration of medication was appropriate for 1 of 2 residents (R77) reviewed for self-administration of medication (SAM). Findings include: R77's quarterly Minimum Data Set (MDS) dated 11/14/24, indicated she had intact cognition and diagnoses of heart failure, high blood pressure, multiple sclerosis (a chronic disease that damages the central nervous system, including the brain, spinal cord, and optic nerves), and muscle weakness. R77's medication administration record (MAR) dated 1/14/25, reflected the following administered medications: - ascorbic acid oral tablet, Give 1000 mg by mouth one time a day for health care maintenance, dated 8/26/24. - cholecalciferol oral tablet, Give 4000 unit by mouth one time a day for Vitamin D def [sic], dated 10/10/23. - docusate sodium oral tablet, Give 100 mg one time a day for constipation, date 9/28/23. - furosemide oral tablet, Give 20 mg by mouth one time a day for edema (swelling), dated 9/13/23. - potassium chloride oral tablet Extended Release (ER), Give 100 milliequivalents (mEq) by mouth two times a day, for low potassium levels, dated 9/13/23. During observation on 1/14/25 at 8:52 a.m., during R77's morning medication pass, trained medication assistant (TMA)-A stated she was alert and "takes her medications by herself."	F 554	assessment completed on 1/14/2025 which stated that resident was competent to administer medications after nurse/TMA set-up. All other residents that are currently self-administering or wish to self-administer medications will be audited to ensure their safety with self-administration. Self-Administration of Medication policy was reviewed. All Licensed nursing staff and TMA's will be re-educated on self-administration of medications. The nurse manager/designee will conduct audits weekly x4 weeks, then monthly x2 months to ensure compliance. The DON is responsible for monitoring the results and audit results will be shared with QAPI committee. Compliance date 2/28/2025	

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F 554	Continued From page 6 TMA-A verified each medication in the morning pass against R77's MAR and placed the potassium chloride tablets into a separate cup per R77's preference. TMA-A walked to her room and introduced self and surveyor, provided the medication cups to R77, and stated, "I will be back to check on you," before leaving the room without ensuring she had taken the medications. Back at the medication cart, TMA-A stated SAM orders were "usually written in the MAR" for residents, and showed an example from an unidentified resident's chart who had an order for "ok to crush medications". TMA-A stated if a resident could take their own medications and had a SAM, it would show up on the MAR like the unidentified resident's MAR. TMA- A was unsure where a SAM assessment was located and indicated the nurse manager would be responsible for assessing a resident's safety to take medications. TMA-A located a physician's order, dated 11/8/23, indicating "ok to self administer [sic] medications after set up" and stated, "registered nurse (RN)-A told me it was written in the care plan, and I just take her word for that." A self-administration of medications assessment dated 11/8/24 indicated R77 did not wish to self-administer any of her medications. Self-administration of medications assessments dated 5/18/24, and 8/9/24, both identified she wished to self-administer oral medications and had a current order to self-administer medications. The assessment lacked documentation on if R77 could state the name and use of each medication; the correct dosage, route, and time of administration; state if she was experiencing any side effects; and if the	F 554		

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F 554	Continued From page 7 interdisciplinary team (IDT) deemed her safe to SAM. R77's care plan dated 7/11/24, identified her preference to SAM with a goal to have her preferences respected and followed. The care plan indicated a test was "passed and order to self administer [sic] was placed in chart." During interview on 1/16/25 at 9:12 a.m., RN-A, also the long-term care (LTC) nurse manager, stated the process for residents who wish to SAM was to first assess the resident for safety and if they were deemed successful, an order would be obtained and placed into the chart and the resident's care plan would be updated. RN-A stated staff should not leave oral medications in a resident's room if a resident does not have a SAM and order in place. RN-A stated there had been an error on R77's SAM assessment dated 11/8/24 and the nurse meant to enter "yes" instead of no. RN-A explained there had been conversations with R77 about her medications and "she knows her medications and she understands the meds she gets." RN-A reviewed R77's previous SAM assessments dated 8/9/24 and 5/18/24 and confirmed they lacked documentation if she was safe to SAM. RN-A stated the importance of assessing a resident's safety to SAM was to make sure they understood the implications of their medications, and to ensure "we aren't leaving medications with residents who could potentially hide or stockpile them." Per interview on 1/16/25 at 3:23 p.m., the director of nursing (DON) expected the SAM assessment to be completed by checking the box if it was safe or not for the resident to SAM because that was	F 554		

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F 554	Continued From page 8 what drove the order from the physician, and if it was not checked, "we wouldn't have the order." Per facility policy titled Self Administration of Medication revised 7/3/19, it was the responsibility of the IDT to determine if a resident was safe to self-administer drugs, and the determination would be made would be made before the resident exercised that right. The policy guided nursing staff to complete Self Administration of Medication Data Collection (SAM) for Self-Administration of Medication if/when a resident indicated a desire to do so or when staff identified the need for the resident to be assessed. The policy indicated the assessment must include the resident was competent and safe to proceed with the self-administration of medications before proceeding.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		2/28/25

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	245071	A. BUILDING _____ B. WING _____	C 01/16/2025

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MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

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F 561	Continued From page 9 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food preferences were honored for 1 of 2 residents (R76) reviewed for food choices. Findings include: R76's annual Minimum Data Set (MDS) dated 12/5/24, indicated he had intact cognition and did not have weight loss or gain of during the lookback period. The MDS identified his diagnoses of high blood pressure, diabetes, high cholesterol, and Parkinson's disease (a chronic brain condition that causes movement problems, such as stiffness and tremors). R76's Care Area Assessment (CAA) dated 12/5/24, triggered for nutritional status and identified his potential nutritional problem. The CAA indicated the objective was to avoid complications and minimize risks and guided staff to the care plan. The CAA lacked resident-specific documentation regarding efforts to avoid complications and minimize his risks.	F 561	Dietitian met with R76 on 1/14/2025 to discuss and update meal and snack preferences. Care plan was updated with preferences. All residents will have their care plans reviewed and updated to ensure they match their meal ticket. Person-Centered Care Plan Policy was reviewed by IDT. Culinary staff and nursing staff will be educated on reading the meal ticket and ensuring it matches the food that is served. The nurse manager/designee will conduct audits weekly on 10% of meal services x 4 weeks, then monthly x 3 months to ensure compliance. The DON is responsible for monitoring results and audit results will be shared with QAPI committee. Compliance date 2/28/2025	

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F 561	Continued From page 10 R76's care plan revised on 12/5/24, identified his potential nutritional problem and guided staff to provide his diabetic diet as ordered and it was "OK to request regular foods if desired." Additionally, the care plan identified he should be served the same breakfast items every day, which included Greek yogurt, oatmeal with brown sugar, toast, orange juice and coffee, "unless otherwise preferred." The care plan included his preference for an evening snack of vegetables, however, lacked documentation on his preferences for larger or double portions at meals. A quarterly nutrition assessment for the lookback period of 9/6/24 through 9/12/24, encouraged staff to "continue to provide, offer and encourage meals and snacks as scheduled and throughout the day if indicated or requested." An annual nutrition assessment for the lookback period of 11/29/24 through 12/5/24, indicated R76 should have assorted raw vegetables with ranch for an evening snack every day. The assessment reported he believed he was not eating enough vegetables, which is why the snack was added and staff were encouraged to "continue to provide, offer and encourage meals and snacks as scheduled and throughout the day if indicated or requested." A care conference summary note dated 9/26/24, indicated R76 expressed he was not getting the food he ordered at meals and the dietitian "will follow up with kitchen director." During dining observation on 1/13/25 at 6:41 p.m., R76's meal ticket indicated he should be served "double portions" of the broccoli, tilapia,	F 561		

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F 561	Continued From page 11 and mashed potatoes. He was served a bowl of broccoli and tilapia but no mashed potatoes. R76 stated he did not believe the fish was a double portion and was unsure about the broccoli. Culinary aid (CA)-A confirmed R76 was not served mashed potatoes and should have been as indicated on his meal ticket. CA-A stated the broccoli was a double portion and the "fish was two smaller pieces" and considered it double portion. CA-A stated staff were aware of a resident's menu preferences or special diet by what was identified on the meal ticket as well as during department meetings. CA-A stated residents who had double portions on their meal tickets, like R76, would be served the double portions right away and would not have to request the second portion, and said if the unit ran out of food, staff only needed to call down the main kitchen for more food. During dining observation on 1/14/25 at 9:35 a.m., R76 did not receive the apple fritter he ordered for breakfast along with the usual items he requested. An unidentified nursing assistant (NA) answered his call, verified the missing pastry, and called the kitchen for the missing item. During dining observation on 1/16/25 at 1:09 p.m., R76 was served his meal and was missing mandarin oranges, which was marked on his meal ticket. Licensed practical nurse (LPN)-A verified the missing item and that it was marked on his meal ticket. LPN-A stated, "he should have gotten the oranges. I spoke with the nursing assistant, and he said it was a mistake, it was missed. I educated him that we should be checking the trays."	F 561		

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F 561	Continued From page 12 During interview on 1/16/25 at 9:43 a.m., R76 stated he was not served a double portion of chicken at the previous supper meal and was not served mashed potatoes, rather tater tots. He stated the portions were not enough for him and he still felt hungry after supper. During interview on 1/16/25 at 3:20 p.m., the director of nursing (DON) stated the dietitian interviewed residents and their representatives about their food and menu preferences and was able to update the care plan, meal tickets and resident profiles. The DON expected staff to follow a resident's plan of care, including a resident's care planned preferences. Per facility policy titled Person-Centered Care Planning revised 6/26/19, each resident would be assessed for their individual risk factors, strengths, goals, interventions, and outcomes at the time of admission and throughout their stay, and these would be identified on the care plan. The policy guided the interdisciplinary team (IDT) to collect data via various assessments to contribute to the development of the comprehensive care plan. The policy indicated the care plan would be reviewed throughout the resident's stay and as required for the MDS assessment, as well as at a care planning conference with the resident and their representative. Furthermore, the policy indicated interventions should be written to help meet the goal and they should be individualized to the resident and be person-centered.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		2/28/25

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F 656	Continued From page 13 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 14 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive and resident-specific care plan for 1 of 1 residents (R76) reviewed for urinary tract infections. Findings include: R76's annual Minimum Data Set (MDS) dated 12/5/24, indicated he had intact cognition, was occasionally incontinent of urine and used an external catheter. The MDS identified his diagnoses of high blood pressure, benign prostatic hyperplasic (BPH, a condition that causes the prostate gland the enlarge), diabetes, Parkinson's disease (a chronic brain condition that causes movement problems, such as stiffness and tremors), and a history of urinary tract infections (UTIs). R76's Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 12/5/24, identified he had a history of chronic UTIs and was followed "closely by Urology" and indicated his urinary incontinence would be addressed in his care plan. R76's care plan, revised 10/4/23, lacked documentation pertaining to his history of chronic UTIs and interventions identifying resident-specific treatment preferences, including his preference to exclude the antibiotic Macrobid	F 656	F656- Develop/Implement Comprehensive Care Plan R76 Care plan was updated to address chronic UTI and antibiotic preferences on 2/7/2025. Other All residents identified to have chronic/hx of UTI's had their care plans audited to ensure care plans were up to date. Comprehensive Care Plan Policy was reviewed and reeducation on the policy will be completed with nurse managers who are responsible for the assessments and care planning. The nurse manager/designee will conduct audits weekly on any new dx of chronic UTI x 4 weeks, then monthly x 2 months to ensure compliance.The DON is responsible for monitoring compliance and the audit results will be shared with QAPI committee. Compliance date 2/28/2025	

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F 656	Continued From page 15 since he stated that antibiotic did not work to treat his UTIs. A provider progress note dated 7/29/24 indicated R76 was seen for a telehealth visit and the Macrobid antibiotic was stopped due to the consideration of a "possible chronic prostatis" component. The recommendation under the "assessment and plan" was to "treat with Cipro" (another type of antibiotic) and consider taking a probiotic. During interview on 1/14/25 at 9:24 a.m., R76 stated he had chronic UTIs and was working with Urology for ongoing management. He stated he had multiple UTIs while staying in the facility and believed his medical record reflected his preference to avoid Macrobid, but a recent UTI with three doses of Macrobid made him question if staff were aware. R76's medication administration record (MAR) dated 1/25 reflected the following order administrations: - Macrobid oral capsule 100 milligrams (mg) Give 100 mg by mouth two times a day for UTI for 5 days", dated 1/9/25, discontinued 1/10/25. - Keflex oral capsule 500 mg, Give 500 mg by mouth two times a day for UTI for 5 days", dated 1/10/25. During interview on 1/16/25 at 1:00 p.m., family member (FM)-A verified ongoing conversations with the facility about R76's chronic UTIs and treatment preferences to avoid Macrobid. Per FM-A, the facility started R76 on Macrobid in July and "it just didn't work, he gets weaker and weaker. I told them back in the summer it just doesn't work but the Keflex does." FM-A stated	F 656		

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F 656	Continued From page 16 when the facility wanted to start him on Macrobid in the beginning of January, "I told him, 'you go tell the charge nurse or manager that Macrobid just doesn't work.'" During interview on 1/16/25 at 3:13 p.m., the director of nursing (DON) reviewed R76's electronic health record (EHR) and verified his admission diagnosis of chronic UTIs. The DON expected his care plan to include documentation pertaining to his history of UTIs and confirmed the care plan lacked this documentation. Per facility policy titled Person-Centered Care Planning revised 6/26/19, each resident would be assessed for their individual risk factors, strengths, goals, interventions, and outcomes at the time of admission and throughout their stay, and these would be identified on the care plan. The policy guided the interdisciplinary team (IDT) to collect data via various assessments to contribute to the development of the comprehensive care plan. The policy indicated the care plan would be reviewed throughout the resident's stay and as required for the MDS assessment, as well as at a care planning conference with the resident and their representative.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		2/28/25

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F 686	Continued From page 17 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify pressure injury, and/or provide preventive care consistent with care planned interventions for residents at risk for pressure injuries for 2 of 5 residents (R28, R45) reviewed for pressure ulcers. Findings include: Pressure ulcer or pressure injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury looks like intact skin and may be painful. A pressure ulcer will look like an open area, the appearance of which will vary depending on the stage and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue. R28's annual Minimum Data Set (MDS) dated 11/28/24, indicated severe cognitive impairment with verbal behaviors direct towards others reported 1 - 3 days during the lookback period. These were not identified as putting the resident at risk for physical injury and did not interfere with	F 686	R28□s skin was assessed by RN on 1/16/2025 and new orders were obtained for skin. Comprehensive skin risk assessment to be completed per policy and Care plan and Kardex will be updated. R45 had a comprehensive skin assessment completed at time of notification. Wound protocol was implemented per policy to include pressure relief interventions. Resident is currently on therapy caseload and therapy is evaluating for appropriate pressure relief footwear. Care plan and Kardex were updated with skin interventions and footwear preferences. Nursing staff to be re-educated on Skin Integrity Management Policy, including ensuring the staff are looking at pressure points during cares and reporting any changes immediately to the nurse. Skin audits will be completed on all residents. Nurse manager/designee will do repositioning audits and random weekly skin assessments audits on 10% of the facility x4 weeks and then x2 months. The DON is responsible for compliance monitoring and the results will be shared with QAPI committee. Date of Completion: 2/28/2025	

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F 686	Continued From page 18 the resident's care. No other behavioral symptoms or rejection of care was reported on the MDS. The MDS indicated R28 required substantial to maximal assistance with bed mobility and was totally dependent on staff for personal and toileting hygiene. The MDS identified diagnoses of heart failure, high blood pressure, coronary artery disease (when arteries that carry blood to the heart narrow), peripheral vascular disease (when blood vessels outside the heart narrow or become blocked, causing circulation problems), diabetes, dementia (a condition that causes a decline in thinking, memory, and reasoning), anxiety, and depression. Furthermore, the MDS identified R28's risk of developing pressure ulcers and listed preventive treatments in place, including a pressure reducing device for the chair and bed, a turning and repositioning program, application of ointments and medications, and nutrition and hydration inventions. R28's Care Area Assessment (CAA) for pressure ulcer/injury dated 11/28/24, identified high risk for skin breakdown and indicated he had a history of pressure injuries. The CAA directed staff to his care plan to minimize risks. A Braden Scale for predicting pressure sore risk assessment dated 1/3/25, evaluated R28 and placed him at moderate risk. A weekly skin check assessment dated 12/13/24 indicated R28's skin was assessed and had "no new skin issues noted." A weekly skin check assessment dated 1/3/25 indicated R28 had "an open coccyx area and irritation to the scrotum."	F 686		

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F 686	Continued From page 19 R28's undated order summary printed 1/16/25, included the following orders: - Monitor wound daily coccyx signs/symptoms of infection, need for PRN dressing change, and pain. Update provider as needed, every day and evening shift, dated 1/3/25. - Reposition every 2 hours for wound healing, dated 11/01/24. - Resident to lay down after break fast [sic] and after lunch to get checked and changed and to off load [sic]. Staff to lay resident side to side to reposition. Document refusals and update nurse manager, two times a day, dated 11/4/24. - Wound: R ischial tuberosity: Cleanse with vashe, pat dry, secure with allevyn dressing. Apply thin layer of calmoseptine to surrounding area of moistures associated skin breakdown, one time a day. Update nursing manager and provider if worsening, dated 1/3/25. Per R28's care plan revised 12/9/24, he had a potential for alteration in skin integrity due to his mobility dependence, diabetes, bowel and bladder incontinence, medication usage, obesity, and peripheral vascular disease (PVD). The care plan identified an open area to his "right inner buttock/coccyx" on 11/1/24 that resolved on 11/12/24 and an open area to his "left rear thigh" that was resolved with an unknown date. The care plan identified a goal to keep his skin intact by directing staff to lay the resident down after breakfast and lunch to get checked and changed and to offload side to side. The care plan guided staff to document and report any refusals to the charge nurse. Additionally, the care plan directed staff to turn and reposition R28 every 2 hours for wound healing and re-approach and re-educate of risks and benefits if he refused.	F 686		

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F 686	Continued From page 20 R28's kardex printed 1/16/25, indicated he was to lay down after breakfast and lunch to get checked and changed and to offload. A task record dated 1/2025, reflected the order to lay R28 down after breakfast and lunch for wound healing and lacked documentation for the dates 1/2/25, 1/4/25, 1/10/25, 1/12/25, and 1/14/25. A PointofCare (POC) task sign-off with a lookback period from 12/18/24 - 1/15/25, for the task to lay the resident down after breakfast and after lunch to get checked and changed and to offload lacked documentation for the dates of 1/2/25, 1/4/25, 1/10/25, 1/12/25, and 1/14/25. R28's progress notes were reviewed on 1/16/25, and lacked documentation of refusals to be offloaded, repositioned, or checked/changed. A progress note dated 11/4/24, indicated staff discussed the risks and benefits of repositioning, offloading and incontinence cares for wound healing "due to history of noncompliance". The progress note indicated R28 responded and stated, "I will do as you said because I want the wound to heal." During observation on 1/15/25 at 9:01 a.m., R28 was sitting in his wheelchair in the dining room for breakfast and had a clothing protector on. During observation on 1/15/25 at 11:26 a.m., R28 was sitting in his wheelchair in the lounge area participating in activities. During observation on 1/15/25 at 11:58 a.m., R28 was sitting in his wheelchair.	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 During interview on 1/15/25 at 2:12 p.m., NA-H confirmed working with R28 that shift and stated R28 laid down "about 9" and was seen by the wound nurse during rounds before they assisted him to get back up for lunch. NA-H stated it was important to help him reposition every 2-3 hours to protect the safety of his skin, and if he refused to lay down, "we would document that." NA-H stated they also re-approach if a resident refused repositioning, "because we want to keep trying to help them." During continuous observation on 1/16/25 between 8:42 a.m. and 1:41 p.m., R28 remained upright in his wheelchair and was not offered to offload or reposition. The following observations were made: - 8:42 a.m.: R28 was sitting in his wheelchair at the dining room table for breakfast. - 9:58 a.m.: R28 was sitting in his wheelchair in the lounge area participating in group activities. - 11:11 a.m.: R28 remained in the lounge area for group activities, his condition unchanged. - 11:44 a.m.: Activities (A)-A pushed R28 in his wheelchair out of the lounge area and offered him a choice of going back to his room or the dining room. R28 requested to sit in the dining room. Per interview with (A)-A, R28 did not leave the group throughout the morning. "He was sitting here with us through both morning activities." - 12:01 p.m.: Nursing assistant (NA)-A and NA-B brought other residents into the dining room and NA-B set up the dinging room tables for the noon meal. There was no offer to reposition or offload R28. - 12:15 p.m.: NA-B stood beside R28 and discussed the newspaper he was reading. NA-B did not offer to reposition, check and change or	F 686		

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F 686	Continued From page 22 offload R28. - 12:28 p.m.: NA-E walked over to R28's table and asked him what he wanted to eat for lunch. NA-E took his lunch order and walked away without offer to reposition or offload him. - 12:45 p.m.: Various staff served meals to residents in the dining room, brought trays to residents in their rooms, and answered call lights. R28's condition remained unchanged. - 12:53 p.m.: NA-B assisted another resident with ambulation in the hallway adjacent to the dining room. R28's condition remained unchanged. - 1:33 p.m.: R28's condition remained unchanged. - 1:36 p.m.: Per interview with R28, he had been up all morning and had not laid down since he woke up. He stated he was feeling "a little tired now." - 1:41 p.m.: NA-A, trained medication assistant (TMA)-B, and NA-C brought R28 to his room and told him they were going to lay him down in bed and he replied, "very, very soon." NA-A, NA-C, and TMA-B assisted R28 with incontinence cares and R28 stated he had "very little soreness" to his backside. The dressing on his coccyx was not intact, and the nursing assistants left the bedside to notify the charge nurse. - 2:03 p.m.: licensed practical nurse (LPN)-A and registered nurse (RN)-B, who was also the long-term care nurse manager, entered the room and approached R28's bedside. RN-B confirmed R28 should be offloaded after breakfast and lunch to promote skin integrity as indicated on his care plan. RN-B confirmed being involved in wound rounds on 1/15/25 and denied seeing R28. RN-B stated he was not on the wound rounds list. RN-B assessed R28's coccyx and stated the area was reddened but blanchable and explained he had a previous pressure ulcer to the area that	F 686		

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F 686	Continued From page 23	F 686		

healed and "has some tenderness." RN-B assessed and found no open areas to R28's coccyx and stated they would still protect the area with barrier cream.

Per subsequent interview on 1/16/25 at 2:03 p.m., LPN-A stated assessed R28's coccyx during morning cares and stated the area was not open as previously documented in the skin assessment dated 1/3/25. LPN-A stated there had not been time to discontinue the previous wound orders or enter a progress note or new skin assessment from the morning.

During interview on 1/16/25 at 3:09 p.m., the director of nursing (DON) stated residents are assessed for their risk for skin breakdown and if identified to be at risk, interventions to reduce their risks are care planned and put on the kardex. The DON expected staff to read the kardex before caring for residents and expected intervention to be implemented. The DON stated the implications for not following interventions to reduce the risk of skin breakdown included putting a resident at risk for skin breakdown or a worsening of skin breakdown.

R45's admission Minimum Data Set (MDS) dated 11/11/24, indicated R45 was cognitively intact, had delusions, daily behavioral symptoms not directed toward others (such as scratching self, rummaging, throwing or smearing food or bodily wastes, or screaming), and did not reject cares.

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F 686	Continued From page 24 R45 required partial and/or moderate assistance with toileting hygiene, substantial and/or maximal assistance with upper body dressing, and was dependent for lower body dressing and footwear. R45 needed partial and/or moderate assistance with rolling left and right and other mobility. R45 had diagnoses which included hypertension (high blood pressure), coronary artery disease (narrowing or blocking of coronary arteries, which supplies oxygen-rich blood to the heart), peripheral vascular or arterial disease (blood vessels narrow or become blocked and reduces blood flow to the body), arthritis, anxiety, depression, psychotic disorder, and schizophrenia. R45 was at risk for pressure ulcers and did not have any pressure ulcers. R45 was to have a pressure reducing device for chair, pressure reducing device for bed, and turning and/or repositioning program. R45's Braden scale (a tool used to assess a patient's risk of developing pressure ulcers, or pressure injuries) dated 11/19/24, indicated a score of 16, which indicated R45 was at risk to develop a pressure area. R45's care plan printed 1/15/25, indicated R45 had a care focus area of Mobility/Ambulation, which was revised 11/11/24, and indicated R45 required assistance for positioning, locomotion, and transfers. An intervention indicated R45 required assistance to turn and reposition every two to three hours and as needed, and assistance of two staff with bed mobility. The care plan indicated R45 had potential for pressure ulcer development related to morbid obesity, anemia, peripheral vascular disease, osteoporosis, incontinence, and limited mobility, and was revised on 11/18/24. Interventions	F 686		

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F 686	Continued From page 25 included daily skin observation with cares and report new or worsening concerns to nurse immediately, house lotion to dry skin with cares as needed, inform resident/family/caregivers of any new area of skin breakdown, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bath or daily care, pressure reducing and/or relieving cushion in wheelchair and/or chair, and pressure reducing and/or relieving mattress. R45's Weekly Skin Check assessment dated 1/10/25, indicated R45's skin color, turgor, and temperature where within normal limits and noted a bruise on the back of R45's right arm and red area on R45's right knee. During observation on 1/15/25 at 10:36 a.m., R45 was in bed with no pants or incontinence product and nothing on their feet. Nursing assistant (NA)-I entered the room and started to assist R45 with incontinence cares, covered R45 with linen, and left to get another staff member. At 10:44 a.m., NA-I and NA-L assisted R45 to get pants on. When NA-I and NA-L assisted R45 to roll in bed, an area of purplish to reddish discoloration was observed on R45's right heel. NA-I- and NA-L assisted R45 to sit up on the side of the bed and applied R45's shoes without socks. NA-L removed R45's shoes when prompted, and NA-I and NA-L stated they had not seen the discolored area before. NA-L went to get a nurse when prompted. Registered nurse (RN)-C entered R45's room and observed the area. R45 stated their right heel did not hurt when asked. RN-C asked if staff could assist R45 to put socks on and R45 declined socks. NA-I could not find socks in R45's room. RN-C gathered supplies to	F 686		

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F 686	Continued From page 26 take a picture, measure, and dress the discolored area. RN-C stated R45's right heel felt "boggy", took a picture of the area through a wound app, applied skin prep on both of R45's heels, and placed a 3M Tegaderm dressing on R45's right heel. Staff found and applied shoes without a backing which slipped on instead of the shoes R45 wore previously which had a heel backing. R45's Skin and Wound Evaluation on 1/15/25 at 10:59 a.m., indicated R45 had a deep tissue injury on the right heel. The length was measured as 1.9 cm by 2.3 cm, had no signs on infection, and surrounding tissue was calloused, dry/flaky, fragile, intact, and normal in color and temperature. The wound note indicated R45's shoes were snug to the area and staff requested R45's responsible party bring different shoes. Other interventions included air mattress, repositioning, and foam boots in bed. The nurse practitioner, therapy, and dietician were notified. During interview on 1/15/25 at 1:25 p.m., NA-L stated they normally did not dress R45 and mostly helped R45 to the bathroom and had not noticed the discolored area before. NA-L stated they reported skin concerns to the nurse if they observed an area of concern while helping residents with showers and other cares. During interview on 1/15/25 at 1:57 p.m., RN-F stated they assessed, treated and covered if needed, documented, and measured new skin concerns. RN-F stated they would notify the charge nurse, family, and doctor. RN-F was not aware of R45's skin discoloration on their right heel. RN-F stated nurses document skin assessment weekly with showers and as needed. RN-F stated R45 was not "bedridden", but R45's	F 686		

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F 686	Continued From page 27	F 686		

mobility seemed to decline within the past few days. RN-F stated R45 needed more staff assistance with transfers compared to moving in bed.

During interview on 1/16/25 at 10:35 a.m., NA-I stated R45 used to living in the assisted living area of the building and did not wear socks then either. NA-I stated R45 was already in a sitting position when assisting R45 earlier yesterday morning so did not notice the area on R45's heel. NA-I stated they checked residents' skin when helping with cares and reported to the nurse if they noticed something new.

During interview on 1/16/25 at 10:57 a.m., RN-E stated R45 was at risk for pressure injuries and did not know R45 refused to wear socks with shoes, and it would have been important to have been aware of. RN-E was not aware of R45's right heel prior to 1/15/25.

During follow-up interview on 1/16/25 at 12:37 p.m., NA-L stated they have seen R45 lay in bed a lot, and they required assistance of two staff when in bed and to the bathroom, but R45 was also able to move in bed by themselves.

During interview on 1/16/25 at 12:53 p.m., RN-C expected NAs to report skin concerns to nurses immediately, and nurses were to complete risk management and update supervisor, provider, and family. Staff were to monitor residents' skin during baths or showers or anytime they noticed something new to residents' skin. RN-C stated staff knew who was at high risk for pressure ulcers or skin alterations by the care plan and resident diagnoses. Staff were to report if residents refused care planned interventions, so

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F 686	Continued From page 28	F 686		

the nurse could chart about it. RN-C did not know R45 did not wear socks and considered R45 at risk for pressure injuries. RN-C stated R45 slept in during the mornings and was up during the day. RN-C stated R45 could move themselves in bed and had self-transferred before but was not sure if R45 moved themselves less now. RN-C stated they were not aware of the suspected deep tissue injury before, and stated the sooner skin changes were identified, the easier they were to heel.

During interview on 1/16/25 at 2:42 p.m., the director of nursing (DON) expected staff to bring new skin concerns to the nurse and skin checks to be completed with morning and evening cares. DON stated pressure areas could worsen if not identified timely to implement interventions. DON stated staff should identify new areas of concern on heels when assisting residents with dressing and application of socks and shoes.

During interview on 1/17/25 at 10:55 a.m., nurse practitioner (NP)-D stated R45 was at risk for pressure injuries and skin alteration related to their size and immobility. R45 moved slowly and was mostly wheelchair bound. NP-D did not think R45 not wearing socks was a concern and stated R45's heel sitting in one place for an extended period could cause a pressure injury within hours. NP-D stated it was important for nurses to complete diligent skin assessments and look at the pressure points. NP-D stated it was good the area was identified before it got worse.

The facility's Skin Integrity Management Policy dated 8/27/24, indicated the Braden Scale was used to identify residents at risk for impaired skin integrity. The policy directed staff to individually

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F 686	Continued From page 29 review and implement interventions for each risk factor regardless of the resident's total skin risk score. The policy directed skin to be inspected minimally weekly by a nurse and with daily cares. The areas to be observed during a skin assessment include coccyx, ischial/scrum, trochanter, spine, scapula, heels, elbows, back of head, shoulders, and ears. It was the facility's policy to implement preventative measures and provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care. The policy indicated the care planned interventions would be communicated to the appropriate staff via the nursing assistant assignment sheet or Kardex and/or through report. Further, the policy guided staff to encourage mobility as tolerated and establish and individualized turning and repositioning schedule if the resident is immobile. The policy directed staff to discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment for residents that wish to exercise their right to refuse.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement care	F 689	R34 was comprehensively assessed for falls care plan and Kardex was reviewed,	2/28/25

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F 689	Continued From page 30 planned fall interventions for 1 of 7 residents (R34) who had history of repeated falls and remained at risk for falls. Findings include: R34's quarterly Minimum Data Set (MDS) dated 10/23/24, indicated R34 had severe cognitive impairment and diagnoses of hypertension (high blood pressure), arthritis, dementia, and depression, and required partial and/or moderate assistance for transfers. The MDS identified no falls since the last assessment. R34's fall risk assessment dated 10/18/24, indicated R34 had one fall with no injury and one fall with injury (except major injury) since prior assessment. R34 had weakness, cognitive delay/impairment that affects judgement, incontinence. R34 was at risk for falls due to self-transfers. R34's care plan printed 1/15/25, had a focus area Fall/Risk, which was revised 9/14/23, and indicated R34 was at risk for falls related to dementia, impaired memory/cognition, inability to appropriately use call light, poor safety awareness, impulsivity, impaired gait/mobility, generalized weakness, h/o [history of] falls, h/o fall related fractures, attempts to self-transfer/ambulate, refuses to stay out in common area for supervision frequently, difficult to distract/redirect at time, anemia, incontinence, high risk medication use. Interventions included all staff to observe and identify for possible hazards in environment to prevent avoidable accidents/falls, auto lock brakes on wheelchair and ensure functioning properly, commonly used items within reach, purposeful rounding at 11:00	F 689	updated and replaced in closet on 1/17/25. All other resident□s care plan/kardexes were reviewed to ensure that they are available and up to date in residents closets. The Risk Management Program: Falls and Injuries Program policy was reviewed. Fall intervention education with all staff will be completed. The nurse manager/Designee will conduct audits weekly on 10% of residents in the facility x4 weeks, then monthly x 3 months to ensure fall interventions are in place per policy. The DON is responsible for compliance monitoring and the results will be shared with QAPI committee. Date of Compliance: 2/28/2025	

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F 689	Continued From page 31 p.m. and offer toileting and ensure all apparent needs were met, encourage resident to call for assist with transfers and ambulation, encourage resident to sit in common areas when awake for closer supervision as much as possible, ensure soft touch call light is in place on right side while in bed, ensure resident has proper and non-slip footwear, ensure w/c [wheelchair] was next to bed while R34 in bed to reduce fall risk if resident tries to self-transfer, keep bed at appropriate transfer height at all times, keep walkways clean and clutter free, assist with evacuation in case of emergency, MD/NP [doctor and nurse practitioner] and consulting pharmacist to review medications with regulatory visits with dose reductions as indicated, need to assist with evacuation in case of emergency, provide adequate lighting at all times, re-orient resident to call light and remind how to use as needed, visual safety checks hourly while in bed and toilet resident when awake at NOC and PRN [night and as needed]. R34's Kardex Report printed 1/17/25, directed for R34's wheelchair to be next to bed while resident in bed to reduce fall risk if resident tried to self-transfer. During observation on 1/15/25 at 9:28 a.m., R34 was in bed with wheelchair facing away from resident and away from the bed, out of R34's reach. During observation on 1/15/25 at 10:04 a.m., the wheelchair was in the same position. During observation and interview on 1/15/25 at 10:10 a.m., nursing assistant (NA)-I stated staff had daily meetings to talk about fall interventions	F 689		

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F 689	Continued From page 32 and looked on residents' care plans to know their specific interventions. NA-I stated R34 used to be more stable and needed the bed at transferable height. NA-I observed the wheelchair placement and stated they turned the wheelchair away from the R34, so R34 was not "tempted" to get out of bed. NA-I checked R34's closet to view R34's care plan and the clear, plastic paper protector was empty. During observation and interview on 1/15/25 at 11:13 a.m., NA-K stated they checked the care plan to know how to prevent residents from falling and checked on them. NA-K stated they did not work with R34 often but had seen R34 wandering around before and R34 could fall if no one was around. NA-K was not sure about R34's fall history. NA-K verified placement of the wheelchair facing away from R34 in bed and was not sure what the appropriate wheelchair placement was for R34. During interview on 1/16/25 at 10:50 a.m., registered nurse (RN)-E stated staff completed a risk management after a fall to see what caused the fall, and care planned fall interventions related to the root cause of the fall. RN-E stated staff knew fall interventions based on the care plan and communication. RN-E stated R34's wheelchair and bed should be at transferable height and would not be appropriate or safe for R34's wheelchair to face away from them. During interview on 1/16/25 at 12:45 p.m., RN-C stated they reviewed falls with staff in "huddles" and updated the care plan. RN-C stated R34's wheelchair should be next to them while R34 was in bed and at risk for self-transferring. R34 had days where they were in bed and would not speak	F 689		

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F 689	Continued From page 33 a word and other days where they talked a lot and roamed around in their wheelchair. R34 was at risk for falls when fall interventions were not followed. During interview on 1/16/25 at 2:45 p.m., the director of nursing (DON) expected staff to look at the Kardex for fall interventions, and residents were at risk for further falls and injury when fall interventions were not followed. The facility policy Risk Management Program: Falls and Injuries Program dated 1/24/23, indicated residents who were identified "at risk" would have care plans which reflected interventions used to minimize falls.	F 689		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria.	F 811		2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245071	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 811	Continued From page 34 (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R112) who had complicated feeding problems received feeding assistance from qualified staff. This had the potential to affect all residents who required feeding assistance. Findings include: During entrance conference on 1/13/25 at 12:44 p.m., the director of nursing (DON) identified there were no paid feeding assistants utilized in the facility. An undated form titled Paid Feeding Assistants in the survey readiness binder presented to the survey team at entrance identified the facility, "does not use Paid Feeding Assistants." R112's quarterly Minimum Data Set (MDS) dated 10/31/24, indicated moderately impaired cognition and did not identify any signs or symptoms of a possible swallowing disorder or a therapeutic diet. The MDS indicated R112 required supervision or touching assistance in which the helper provides verbal cues or touching/steadying assistance	F 811	Environmental services staff member that was assisting with feeding was reeducated on feeding practices in the facility and is no longer assisting residents to eat. All staff to be educated that only nursing personnel will be allowed to assist residents at meal time with eating. The nurse manager/designee will conduct audits weekly on 10% of meal services x4 weeks, then monthly x2 to ensure compliance. The DON is responsible for monitoring compliance monitoring and the results will be shared with QAPI committee. Compliance date 2/28/2025	

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F 811	Continued From page 35 during eating. A Centrex Rehab therapy to nursing communication form dated 9/13/24, recommended R112 have a visual aid of safe swallowing strategies on the table for meals. Per her care plan revised on 6/28/22, R112 required set-up/supervision with some feeding assistance needed, depending on the meal. Additionally, the care plan identified her risk for altered nutrition status related to her self-feeding difficulties and history of taking food from others' plates after meals. The care plan directed staff to provide adaptive equipment for meals, serve food in individual dishes if not on a divided plate, cut up foods, discourage her from taking food from others' plates and encourage healthier snacks, monitor/document/report to the nurse/dietitian/physician signs or symptoms of difficulty swallowing, holding food in her mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, or pocketing food in her mouth. R112's Kardex printed 1/17/25, indicated she required set-up/supervision with some feeding assistance needed, depending on the meal. During a dining observation on 1/15/25 at 12:07 p.m., environmental services (ES)-A was sitting beside R112 in the dining room at the table. ES-A was assisting R112 with her meal. There was a piece of cheesecake sitting on the table in front of R112 and ES-A was feeding her using a fork. At 12:09 p.m., registered nurse (RN)-A walked into the dining room and over to R112's table and stated she would "take over" and sat down next to R112 and continued assisting with the meal. ES-A	F 811		

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F 811	Continued From page 36 got up from the table and walked out of the dining room. During interview on 1/15/25 at 1:58 p.m., ES-A confirmed assisting R112 with her meal and stated, "I like to help the residents." ES-A indicated they had received some prior training, but it was unclear during the interview due to language barriers if the training had been at the current facility or a previous employer. ES-A explained their job duties included cleaning the assigned floor and the resident's rooms on the assigned floor, as well as restocking some supplies. During interview on 1/16/25 at 9:21 a.m., RN-A confirmed ES-A was assisting R112 and stated, "I had not seen that happen before, that was a first. I went over there and took over the assistance." RN-A stated they would be discussing disciplinary action or "performance management", including counseling and education but not termination, with ES-A and ES-A's supervisor. RN-A stated there had not been conversations with nursing staff on the floor about what to do in situations where they witnessed an unqualified individual assisting a resident during a meal because "I've never seen that happen before so now I will be having that conversation." RN-A confirmed the facility did not employ paid feeding assistants. Per interview on 1/16/25 at 3:20 p.m., the DON stated the facility had provided feeding assistance training to some staff previously, including ES-A. The DON confirmed, however, the facility did not currently employ paid feeding assistants and stated, "we have enough nursing staff to help with dining on the floor, I don't think we need ES-A to continue helping."	F 811		

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F 811	Continued From page 37 An EduCare Skill Competency Paid Feeding Assistant Series form dated 10/14/20, indicated ES-A completed infection prevention and control and dining, nutrition and food safety. Per facility policy titled Feeding Assistant Policy dated 10/30/20, the facility would ensure a feeding assistant (non-nursing staff) feed only those residents who have no complicated eating problems that may include, but are not limited to, difficulty swallowing, recurrent lung aspirations or tube or parenteral/IV feedings. Feeding assistants may not feed any resident who 1.) is at risk of choking while eating or drinking; 2.) presents significant behavior management challenges while eating or drinking; or 3.) presents other risk factors that may require emergency intervention. The facility would base resident selection on the resident's latest assessment and plan of care and the RN assessment of the resident's current condition.	F 811		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		2/28/25

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F 880	Continued From page 38 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 39 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to use proper infection control practices to prevent and/or mitigate the risk of a potential infection outbreak for 3 of 12 residents (R42, R57, R118) observed for respiratory precautions, and 1 of 4 residents (R138) observed for enhanced barrier precautions. Findings include: PPE FOR COVID-19 R42's quarterly Minimum Data Set (MDS) 10/23/24, indicated R42 had severe cognitive impairment, was dependent on staff for most activities of daily living (ADL's) and required supervision or touching assistance with eating. R42's physician order dated 1/7/25, indicated R42 had an active COVID-19 infection in the contagious stage and required transmission-based precautions for ten days. R57's quarterly MDS dated 12/18/24, indicated	F 880	PPE for COVID-19: Staff immediately upon notification of surveyor concern, were reeducated and given direction to use the N95 per policy. For all residents on Covid precautions including R57, R118, R42. Facility is no longer in COVID-19 outbreak. All staff were reeducated on PPE practices regarding what to wear in a COVID-19 room. PPE for EBP: R138's supplies were replaced in the cart, an in-house audit of supplies for all residents on EBP was completed to ensure supplies were available. All Nursing staff will be educated on Enhanced Barrier Precautions and Covid precautions and the appropriate PPE to wear for residents on these precautions. Audits for COVID-19 PPE/EBP PPE precautions will be conducted if/when there is a COVID-19 outbreak. The Infection Preventionist/Designee will conduct audits weekly on 10% of EBP and COVID residents (if applicable) x4 weeks, then monthly x2 to ensure compliance. DON/designee is responsible for	

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F 880	Continued From page 40 R57 had severe cognitive impairment, required substantial and/or maximal assistance, and was dependent on staff for ADLs. R57's progress note on 1/4/25 at 3:26 p.m., indicated R57 tested positive for COVID and would be on isolation for ten days. R57's treatment administration record (TAR) dated 1/1/25-1/31/25, indicated staff completed a rapid COVID-19 test for R57 and had positive results on 1/6/25. R118's quarterly MDS dated 12/11/24, indicated R118 had severe cognitive impairment, was independent with most mobility, and required setup/clean-up to partial and/or moderate assistance for other ADLs. R118's progress note on 1/5/25 at 7:51 p.m., indicated R118 had COVID-19 symptoms and tested positive and would be on isolation precautions for ten days. R118's TAR dated 1/1/25 to 1/31/25, indicated staff completed a rapid COVID-19 test for R118 and had positive results on 1/7/25. During observation on 1/13/25 at 6:41 p.m., NA-D entered R57's room with a meal tray and wore gloves, a gown, eye protection, and a regular mask instead of an N95 mask. R57's door had a sign which directed staff to wear a gown, gloves, eye protection, and an N95 mask. During observation on 1/13/25 at 6:43 p.m., NA-F entered R42's room with a meal tray and wore gloves, a gown, eye protection, and a regular mask instead of an N95 mask. NA-F exited the	F 880	compliance monitoring and results will be shared with QAPI committee. Date of Completion: 2/28/2025	

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F 880	Continued From page 41 room and removed their PPE other than the regular mask. R42's door had a sign which read Enhanced Respiratory Precautions and directed staff to wear a gown, facemask or N95, eye protection, gloves, and an optional hair cover. During observation and interview on 1/13/25 at 6:43 p.m., NA-G entered R118's room with a meal tray and wore gloves, a gown, and a regular mask. NA-G exited the room and removed their PPE besides the regular mask. R118's door had a sign which read Enhanced Respiratory Precautions and directed staff to wear a gown, gloves, and facemask or N95 mask, and eye protection. NA-G stated the sign meant the resident had an illness which could spread. NA-G stated they did not need to wear an N95 mask to deliver food to R118 and needed an N95 mask if they stayed longer in R118's room, such as if R118 needed help with cares. During an observation on 1/13/25 at 6:55 p.m., surveyor entered R57's room and observed nursing assistant, (NA)-D wearing a blue standard mask, eye shield, gown, and gloves while feeding and repositioning R-57 in their wheelchair. NA-D was not wearing an N95 mask. During interview on 1/13/25 at 6:58 p.m., NA-F stated R42 was on precautions for COVID-19 and they were supposed to use an N95 mask to deliver meal trays but forgot. NA-F stated they didn't change their regular mask when they exited the room. During observation on 1/13/25 at 7:03 p.m., NA-D exited R57's room. During an interview on 1/13/25 at 7:35 P.M.,	F 880		

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F 880	Continued From page 42 NA-D stated the correct PPE for COVID positive rooms was an N95 mask, eye shield, gown, and gloves as identified on the sign on the door, and was worn to protect the residents from disease and infections. NA-D stated they had on the N-95 mask but removed it. During interview on 1/14/25 at 1:50 p.m., the infection preventionist expected staff to follow the signs on residents' doors and wear an N95 mask in residents' rooms who had COVID. During an interview on 1/16/25 at 11:26 A.M., registered nurse (RN)-C stated the process for proper infection control was hand hygiene and proper PPE. If a resident had signs or symptoms of COVID or tested positive, the resident was placed on respiratory contact precautions, correct signage was posted on door, garbage can was places in the room, and a bin was placed outside of room containing N-95 masks, gowns, gloves, and eye shields. RN-C expected all staff to wear proper PPE when in resident's rooms and to dispose of items per ongoing education and signage to prevent the spread of infections. During further interview on 1/16/25 at 1:15 p.m., registered nurse (RN)-C verified R42, R57, and R118 were on precautions for COVID and expected staff to wear an N95 mask whenever they entered their rooms. During interview on 1/16/25 at 2:48 p.m., the director of nursing (DON) expected staff to wear the appropriate PPE, which included an N95 mask, to enter rooms under COVID and respiratory precautions to prevent the spread of the illness to other residents.	F 880		

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F 880	Continued From page 43 Facility policy Mount Olivet Careview Homes Infection Control dated 5/11/23, indicated residents placed on transmission-based precautions will have signage on their doors to indicate the type of precautions. The policy indicated PPE should be available near the entrance of the resident room, and precautions would be maintained for the length of time necessary to prevent transmission of infection by proximity. R138's admission Minimum Data Set (MDS) dated 11/24/24, included R138 was severely cognitively impaired, dependent on staff for toileting, bed mobility, and transfers, and had a diagnoses of cancer and malnutrition. The MDS indicated R138 received 51% or more of their nutrition through a feeding tube. During observation on 1/13/25 at 6:41 p.m., nursing assistant (NA)-J was observed changing R138's wet brief and repositioning R138 in bed wearing gloves without a gown. During an interview on 1/13/25 at 7:10 p.m., NA-J explained that R138 needed to be changed and repositioned. NA-J stated they had several residents in the facility on EBP and the normal practice for the facility was to place a small orange magnet outside of the door, and to keep PPE in a cart inside of each resident's room. NA-J pointed to a cart in the room by the residents door. A sign with correct use of PPE was placed on top of the cart upside down, and the cart did not contain gowns.	F 880		

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F 880	Continued From page 44 During an interview on 1/14/25 at 1:50 p.m., the infection preventionist (IP) stated the facility tracked residents who were on EBP, and they were identified by placement of an orange magnet on the doorframe of their rooms. IP indicated staff received education regarding EBP requirements, and all staff were expected to use a gown and gloves while providing certain cares for residents who had an indwelling tubes such as a catheter or G-tube (feeding tube). IP stated PPE carts were placed either inside or outside resident rooms, and staff were expected to re-stock the supplies as needed. During an interview on 01/16/25 at 11:25 a.m., registered nurse manager (RN-D) explained the infection preventionist, administration or nursing supervisors helped with initiating EBP when needed. RN-D stated staff were provided education regarding EBP, and indicated a gown and gloves was required when performing cares with a resident with a chronic wound, indwelling catheter, or a G-tube (feeding tube). During the interview, RN-D identified a resident who was on EBP, and upon observation, RN-D verified an EBP sign was hanging inside their door, but found it to be covered with a large family picture. RN-D explained that they would take down the family picture or relocate the EBP sign. RN-D explained that the facility had some problems with the process, and some new staff found it challenging to understand why specific precautions were needed. RN-D confirmed one resident room had a droplet precautions sign on the door, while another only had a small orange magnet to identify EBP. RN-D confirmed there was inconsistency in signage, and it was difficult to explain to a family member or staff person the difference especially with so many precaution	F 880		

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F 880	Continued From page 45 signs. During follow-up interview on 1/16/25 at 12:55 p.m., IP verified the different process for EBP precautions. When interviewed specifically about the EBP inconsistency with the signs, the IP stated the facility used an orange magnet on the door to identify residents who were on EBP for dignity purposes, and they did not want to post EBP signs so as not to expose residents' information. They stated they understood the inconsitent signage could be confusing for family and staff, and indicated EBP was challenging. During an interview on 1/16/25 at 10:30 a.m., DON explained they expected staff to follow the facility policy and continued to work with the IP for ongoing training to keep the residents safe. The facility wide policy stated Outbreak Management dated 3/12/2020 was reviewed for EBP precautions. The policy provided information that included information from the CDC on what EBP precautions include when working in long term care centers. The policy went on to state that residents with colonization of a CDC targeted infection maybe placed in EBP precautions. Nursing home residents with chronic wounds and indwelling medical devices are at a high risk for possible colonization may be placed in EBP. Staff caring for residents with these conditions will need to wear a gown and gloves during contact high contact activities (see Enhanced Barrier Precaution Sign). See MDRO policy. The facility wide policy named Caring for Residents with Multi Drug Resistant Organisms (MDRO) dated 9/16/24 was reviewed for further indication of EBP information. The policy	F 880		

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	245071	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET CAREVIEW HOME	5517 LYNDALE AVENUE SOUTH MINNEAPOLIS, MN 55419

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F 880	Continued From page 46 specified that residents that are on EBP precautions staff will wear proper PPE. Some examples of activities that this would be expected include dressing, bathing/showering/transferring, changing linens, changing briefs or assisting with toileting, wound care, device care- central line, urinary catheter, feeding tube, and tracheostomy. Resident who requires EBP will be communicated with staff. Supplies will be available for easy accessibility. Family and visitors should be educated about MDRO, and precautions taken that include hand antisepsis and ways to limit environmental control. The policy did not further explain the process that was described by the IP and or staff upon interview for consistency on EBP precautions.	F 880		

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	245071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/14/2025. At the time of this survey, Mount Olivet Careview Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/07/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Mount Olivet Careview Home Building 01 is a 5-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the Northside of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The	K 000		

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K 000	Continued From page 2 new addition, Building 02, will be surveyed separately as new construction. The building is fully protected throughout by an automatic fire sprinkler system and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 155 beds and had a census of 147 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.1.3.2.1, 7.1.3.2.3, 7.2.2.5.3, and 7.2.2.5.3.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 225	1. It is the policy of Mount Olivet to comply with the Life Safety Code, Fire Protection and physical environment requirements. The items under the stairways were removed on 2/10/25, and the storage door and wall were also removed to not allow the space to be used as a storage unit in the future. 2. Education was performed with the environmental services team on 2/5/25.	2/28/25

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K 225	Continued From page 3 1. On 01/14/2025 at 11:31 AM, it was revealed by observation that there was a storage room at the bottom of stairwell C with the entrance being in the stairwell. 2. On 01/14/2025 at 11:57 AM, it was revealed by observation that there was a penetration into stairwell B on the fourth floor caused by a black coax cable. An interview with the Directors of Engineering, Healthcare Operations, and Facility Management verified these deficient findings at the time of discovery.	K 225	3. The Director of Engineering or designee will audit stairwells weekly for one month, and then monthly for 2 months to ensure compliance. 4. The Director of Engineering will be responsible for these corrective actions. 5. Audit results will be brought to QAPI for review. Date of completion 2/28/25.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		2/28/25

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K 353	Continued From page 4 Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 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, 5.2.1.4, 5.2.2.2, 5.3.2.1, 5.4.1.4, and 5.4.1.4.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/14/2025 at 11:26 AM, it was revealed by observation that a florescent light fixture was hanging on the sprinkler pipe in the boiler room in the basement. 2. On 01/14/2025 at 12:43 PM, it was revealed by observation that the gauge on the sprinkler riser in the computer lab/ training room was dated 2017. 3. On 01/14/2025 at 12:43 PM, it was revealed by observation that there were sprinklers in a plastic bag hanging from the sprinkler riser located in the computer lab/ training room. An interview with the Directors of Engineering, Healthcare Operations, and Facility Management verified these deficient findings at the time of discovery.	K 353	1. It is the policy of Mount Olivet to comply with the Life Safety Code, Fire Protection and physical environment requirements. The florescent light fixture was removed from sprinkler pipe on 1/17/2025 and installed correctly. The sprinkler system had a 5-year inspection, all gauges replaced, and sprinkler heads put away in the correct manor by LVC on 1/22/2025 & 1/23/2025. 2. Education was performed with the environmental services team on 2/5/25. 3. The Director of Engineering will schedule LVC for fire protection and sprinkler related needs and audits. 4. The Director of Engineering or designee will audit fire sprinkler maintenance bi-annually to make sure the proper 5-year inspection tags are present, all gauges are replaced, and sprinkler heads are stored properly. 5. Audit results will be brought to QAPI for review. Date of completion 2/28/25.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		2/28/25

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K 363	Continued From page 5 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section	K 363	1. It is the policy of Mount Olivet to comply with the Life Safety Code, Fire Protection and physical environment	

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K 363	Continued From page 6 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/14/2025 at 12:02 PM, it was revealed by observation that the door to resident room 326 did not latch when tested. 2. On 01/14/2025 at 12:23 PM, it was revealed by observation that the door to resident room 228 did not latch when tested. An interview with the Directors of Engineering, Healthcare Operations, and Facility Management verified these deficient findings at the time of discovery.	K 363	requirements. On 2/4/25 resident room doors 326 and 288 were repaired, the doors now latch correctly. 2. Education was performed with the environmental services team on 2/5/25. 3. The Director of Engineering will be responsible to ensure resident doors are latching. 4. The Director of Engineering or designee audited doors on MOCV 4E, 3E, and 2E weekly for one month, then bi-annually to ensure compliance. 5. Audit results will be brought to QAPI for review. Date of completion 2/28/25.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 7, 2025

Administrator
Mount Olivet Careview Home
5517 Lyndale Avenue South
Minneapolis, MN 55419

RE: CCN: 245071
Cycle Start Date: January 16, 2025

Dear Administrator:

On March 6, 2025, 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.

Sincerely,

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