Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: October 12, 2022

Dear Administrator:

On November 1, 2022, we notified you a remedy was imposed. On November 22, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 16, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 1, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 16, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 30, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 20, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: Reinspection Results
Event ID: 7H1T12

Dear Administrator:

On November 22, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 12, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 1, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: October 12, 2022

Dear Administrator:

On October 12, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 16, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 16, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 16, 2022.

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

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 16, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Regina Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 16, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

deficient practice.

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 12, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 10/10/222 to 10/12/22, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Regina Senior Living was found to be in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/10/22 to 10/12/22, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Regina Senior Living was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5254058C (MN82682); however, no deficiencies issued due to actions taken prior to survey. H52545005C (MN85643); however, no deficiencies issued due to actions taken prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 11/10/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (dental care) was provided for 1 of 1 residents (R1) reviewed for activities of daily living (ADLs) and who was dependent upon staff for care. Findings include: R1's facesheet printed on 10/11/22, included diagnoses of hemiplegia (paralysis of one side of the body) following a stroke, affecting her dominate hand. R1's quarterly Minimum Data Set (MDS) assessment dated 10/4/22, indicated R1 was cognitively intact, had clear speech, could understand others and was usually understood. R1 required extensive assistance of one staff for most ADL's including hygiene. R1 did not walk.	F 677	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F677 Resident #1 was assessed by RN-C on 11/8/2022 for oral care/hygiene. Plan of care was reviewed and updated to reflect staff assistance required for oral hygiene during AM and HS cares as accepted and	11/18/22

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F 677	Continued From page 2 R1's physician order dated 12/20/18, indicated staff were to assist R1 to brush her teeth twice a day during the morning medication pass between 7:00 a.m. and 10:00 a.m. and the bedtime medication pass from 7:00 p.m. to 10:00 p.m. R1's care plan edited on 7/15/22, indicated R1 required staff assistance with dental care. R1 would be free from tooth decay, swollen or bleeding gums, oral abscesses or ulcers. Staff were to monitor the adequacy of brushing. In addition, R1's care plan edited 8/8/22, indicated R1 was unable to independently perform grooming related to hemiplegia affecting her right dominate side. The care plan indicated R1 would be assisted with brushing her teeth. Staff were to provide R1 with verbal cues to brush teeth once she was set up at the sink. Nursing staff were to encourage R1 to be as independent as possible. During an interview on 10/10/22, at 1:18 p.m., R1 stated no one brushed her teeth and stated she could not do it herself; adding, "I need to brush them." R1 stated if staff brought her the supplies, she thought she could brush her teeth. During an interview on 10/11/22, at 1:15 p.m., nursing assistant (NA)-B stated R1 could brush her teeth with set up help and admitted she did not assist R1 with brushing her teeth that morning, adding she had so much to do. NA-B stated R1 was to receive assistance with brushing her teeth at least once a day. During an interview on 10/11/22, at 1:25 p.m., licensed practical nurse (LPN)-A stated NA's got R1 up in the morning to wash and help her brush her teeth. LPN-A looked in the electronic medical	F 677	tolerated. Residents requiring assistance with oral hygiene have the potential to be affected. Resident receiving oral care assistance were reviewed by Clinical Leadership with no further concerns identified. Review was completed on 11/3/22. Nursing direct care staff were educated by Clinical Leadership in relation to oral cares and hygiene including importance of oral care, assistance to be provided, and reporting resident reluctance or refusal of cares in order to ensure necessary services to maintain personal and oral hygiene. This education will be completed by 12/1/22. Audits including direct observation of oral cares/hygiene will be performed by Clinical Leadership 2x weekly x4 weeks, then as needed to validate ongoing compliance. Audits will be brought through facility QAPI committee for review and further recommendations. Audits will be discontinued only upon QAPI committee determination of sustained compliance.	

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F 677	Continued From page 3 record (EMR) and printed NA documentation for assisting R1 to brush teeth twice a day. Many entries indicated the task was "reviewed," and LPN-A was not sure what that meant. During an interview on 10/11/22, at 3:55 p.m., (NA)-C demonstrated how resident tasks were documented in the NA documentation system called Point of Care (POC). NA-C displayed the five drop-down options to select for dental care for R1: 1) Reviewed 2) Resident sick 3) Resident refused 4) Resident unavailable 5) Completed task as written. NA-C stated "reviewed" meant a NA looked at it but did not complete the task and "completed task as written" meant the task was done. Review of POC records provided by LPN-A, indicated out of 60 opportunities for staff to assist R1 with brushing her teeth twice a day from 9/11/22, to 10/11/22, the task was documented as completed only 50% of the time. The task was never documented as completed on the following 11 dates: 9/11, 9/14, 9/15, 9/21, 9/24, 9/25, 9/27, 9/29, 10/5, 10/8 and 10/9. During an interview on 10/12/22, at 7:29 a.m., the director of nursing (DON) was informed that R1 had not being assisted to brush her teeth 50% of the time over the past month. The DON was unaware of this and stated dental care was important for residents, adding she expected staff to complete tasks as assigned. Facility policy titled Activities of Daily Living (ADL) dated 2021, indicated residents unable to carry out ADL's independently would receive the services necessary to maintain good grooming and personal hygiene. Care and services would	F 677		

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F 677	Continued From page 4 be provided for residents who were unable to carry out ADL's independently, including hygiene such as oral care. If a resident refused care, he/she would be approached at a different time.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure oxygen was delivered according to physician orders and professional standards for 1 of 2 (R15) residents reviewed for respiratory care. Findings include: R15's quarterly minimum data set (MDS) dated 8/6/22, indicated R15 had intact cognition and received oxygen therapy. R15 had diagnoses that included lung cancer, chronic hypoxemic respiratory failure (low oxygen in the blood), abdominal aortic aneurysm without rupture (a ballooning and thinning of the abdominal aortic artery wall), T12 (thoracic vertebra) compression fracture, stroke, macular degeneration (progressive eye disease leading to blindness), and seizures.	F 695	F695 Resident #15□s oxygen concentrator setting was corrected from 3LPM to 2LPM via nasal cannula by staff nurse on 10/10/2022 upon notification of the surveyor. Resident #15 exhibited no adverse effect of oxygen being administered at 3LPM via nasal cannula. Upon review of Resident #15□s TAR, it was confirmed that maintenance orders for oxygen including tubing changes, humidifier fill, and cleaning was documented as being performed as ordered. Residents receiving oxygen therapy have the potential to be affected. Residents receiving oxygen therapy were reviewed by Clinical Leadership on 10/17/22 to	11/18/22

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F 695	Continued From page 5 R15's care plan dated 8/15/22, indicated R15 had an alteration in respiratory status related to chronic respiratory failure as manifested by use of oxygen. Interventions included compliance with oxygen therapy, and administering oxygen as ordered. R15's physician orders dated 10/10/22, indicated R15 received 2 liters per minute (lpm) of oxygen by nasal cannula. The orders also indicated to change R15's humidifying jar weekly and remove and wash the oxygen concentrator filter weekly. R22's quarterly MDS dated 8/30/22, indicated R22 had no cognitive deficits. R22's physician orders dated 10/12/22, indicated to change R22's oxygen tubing and wash R22's oxygen concentrator filter weekly on Mondays and to change R22's humidifying jar weekly on Sundays. During an observation and interview on 10/10/22, at 1:17 p.m. R15's concentrated oxygen machine was set to deliver 3 lpm oxygen through a nasal cannula, the water container (bubbler) for delivery of humidified oxygen was empty, and the oxygen tubing and bubbler lacked a date to indicate when they were last changed. R15 stated they change her oxygen tubing "about once a month". During an interview on 10/10/22, at 1:38 p.m. registered nurse (RN)-A verified there was no water in R15's bubbler. RN-A stated she had not filled the bubbler before and was not sure how to fill it or what kind of water she should use and would need to ask another staff member but that R15's bubbler should be filled to deliver humidified oxygen.	F 695	validate delivery settings were per physician's orders and that maintenance orders for oxygen were being performed per plan of care. No other concerns were identified per review. Nursing direct care staff were educated by Clinical leadership in relation to Oxygen Therapy including importance of following physician orders for rate of delivery, changing of tubing and supplies, and cleaning of filters per facility protocol. This education was completed by 12/1/22. Audits of residents receiving oxygen will be performed 2x weekly x4 weeks, then as needed to validate ongoing compliance. Audits will be brought through facility QAPI committee for review and further recommendations. Audits will be discontinued only upon QAPI committee determination of sustained compliance.	

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F 695	Continued From page 6 During an observation on 10/10/22, at 2:28 p.m. R15's bubbler contained water measuring to the "minimum" line marked on the container. Oxygen was being delivered at a rate of 3 lpm. During an interview on 10/10/22, at 6:53 p.m. R15 stated she was always on 2 lpm of oxygen, but when she came back from the hospital recently the facility increased it to 3 lpm but they didn't tell R15 why it was increased. During an interview on 10/10/22, at 6:57 p.m. licensed practical nurse (LPN)-C stated resident bubblers were filled as needed and the container and oxygen tubing should have been changed weekly. LPN-C stated there was usually a task in the resident's computer to indicate if they had been changed or not. During an observation on 10/11/22, at 11:00 a.m. the water in R15's bubbler was below the "minimum" line marked on the container and the oxygen was being delivered at 3 lpm. During an observation and interview on 10/11/22, at 11:41 a.m. R22 had oxygen being administered humidified oxygen via nasal cannula. The oxygen tubing, cannula tubing, and bubbler lacked a date to indicate when they were last changed. R22 stated she was going on three weeks since the staff last changed her oxygen tubing, although they did clean the humidifier filter the previous week. During an observation and interview on 10/11/22, at 11:30 p.m. RN-C stated the water in a resident's bubbler should have been filled above the "minimum" but below the "maximum" lines	F 695		

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F 695	Continued From page 7 marked on the container to ensure proper delivery of the humidified oxygen. RN-C also stated the resident's oxygen should be delivered at the rate ordered by the physician. RN-C verified the water in R15's bubbler was below the "minimum" line and was being delivered at 3 lpm although R15's physician orders indicated R15 should be receiving oxygen at 2 lpm. During an interview on 10/12/22, at 10:54 a.m. the director of nursing (DON) stated a resident's bubbler should be filled with distilled water and remain between the "minimum" and "maximum" lines marked on the container to maintain moist mucosa and avoid dry nasal passages. The DON also stated a resident's oxygen should be delivered at the rate ordered by the physician. During an interview on 10/12/22, at 12:14 p.m. nurse practitioner (NP)-A stated oxygen bubblers needed to remain appropriately filled to prevent mucous membranes from drying out and causing nose bleeds, particularly in residents who were on continuous oxygen such as R15. NP-A further stated oxygen should be delivered at the rate indicated in the physician orders, and although she did not believe it was required, staff should date the tubing and bubbler when they change them. The facility Cleaning of Oxygen Equipment policy dated June 2017, indicated to replace resident nasal cannulas, oxygen tubing, and humidifier bottle each week. Use tape to place dated and initials on tubing and bottle when replaced. The facility Oxygen Therapy policy dated 2017, indicated oxygen was to be provided in a safe manner as identified by a prescribing physician.	F 695		

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F 695	Continued From page 8 Follow manufacturer recommendations for cleaning, humidification, dispensing, and maintenance of equipment and in accordance with federal, state, and local laws and regulations.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure implemented interventions for pain management were comprehensively reassessed to ensure efficacy and effectiveness for 1 of 2 residents (R32) reviewed for pain management and who expressed ongoing, unrelieved pain. Findings include: R32's admission Minimum Data Set (MDS), dated 9/19/22, identified R32 had moderate cognitive impairment, demonstrated no delusional behavior(s), and required extensive assistance to complete most activities of daily living (ADLs). Further, the MDS outlined R32 received scheduled and as-needed medication for pain in addition to non-pharmacological interventions. R32 reported occasional pain with a recorded intensity of, "Moderate." R32's Clinical Documentation Observation, dated 9/7/22, identified R32 had no memory or recall	F 697	F697 Resident #32 was reassessed by RN-C on 10/17/22 in relation to pain/discomfort, current pain management regime, and resident concerns in relation to taking prescribed pain medications, specifically controlled substances. He has expressed increased control with scheduled medications vs. as needed. Care plan was reviewed and updated to include non-pharmacological interventions as well. Resident will have pain observation assessment completed at regular intervals to analyze responses to promote increased comfort. Resident of the facility experiencing pain have the potential to be affected. Residents were reviewed by Clinical leadership in relation to pain, pain medication regime, current interventions. Care plans were updated as needed to	11/18/22

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F 697	Continued From page 9 concerns. The observation listed a section labeled, "Acute Physical Pain," which identified R32 received scheduled medication, as-needed medication, and non-pharmacological interventions for his pain in the previous five day review period. A pain interview was completed with R32 which recorded him as having moderate pain or hurting with a frequency recorded as, "Frequently." The pain did not impact his sleep, however, did cause limited daily activities. The staff recorded R32 as having vocal complaints of pain in addition to facial expressions indicative of pain (i.e., grimaces); and the observation listed a section labeled, "Assessment," which outlined R32 had pain in his back described as, "Dull." A series of management interventions were selected which included warm compress, rest, along with scheduled and as-needed Tylenol administration. The completed observation lacked evidence R32 consumed or was provided tramadol (a narcotic medication). R32's care plan, dated 10/4/22, identified R32 experienced pain or discomfort related to spinal stenosis, age-related osteoporosis, and compression fractures. A goal was listed for R32 which read, "My pain management goal is to be comfortable as evidence by ability to do my ADL [activities of daily living] without experiencing pain." Further, the care plan listed a single intervention to help R32 meet this goal which read, "Interventions for me when I express pain include: pain medications, rest." On 10/10/22 at 1:47 p.m., R32 was observed seated in a chair in his room, and he appeared comfortable and demonstrated no physical signs or symptoms of pain (i.e., clenched jaw, grimacing). However, when interviewed at this	F 697	reflect current status, goals, and appropriate, individualized interventions. Nursing direct care staff were educated by Clinical Leadership in relation to pain management including assessment, implementation of interventions, comprehensive reassessment to validate efficacy and effectiveness of interventions, and revision of plan of care as needed to promote adequate pain relief and comfort. Audits will be performed by resident interviews and review of Facility activity report by Clinical Leadership to validate ongoing compliance with pain management, interventions implemented, and reassessment of resident 2x weekly x4 weeks, then as needed. Audits will be brought through facility QAPI committee for review and further recommendations. Audits will be discontinued only upon QAPI committee determination of sustained compliance.	

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F 697	Continued From page 10 time, R32 stated he had "chronic pain" in his left side due to a history of osteoporosis and compression fractures. R32 described the pain as being constant in duration and a sensation like "a throbbing " and "aching." R32 explained he took ice packs and pain medication for the pain; however, those never completely relieved the pain adding he had dealt with pain for a long time. R32 stated he was not satisfied with his current pain management program at the nursing home and wanted more done, if possible. R32 expressed nursing home staff were aware of his pain but, "[The staff] don't say too much about it." R32's Discharge Medications listing, undated, identified R32's physician orders when he admitted to the nursing home. The orders included 1) Tylenol 1000 milligrams (mg) by mouth four times daily, and, 2) tramadol (a narcotic medication) 75 mg by mouth every six hours as needed for pain. However, R32's Active Orders listing, printed 10/11/22, identified R32's current physician orders while residing at the nursing home. This listing outlined an order for tramadol 50 mg by mouth every six hours (decreased from 75 mg to 50 mg and now scheduled instead of as-needed) with a listed start date of 9/19/22. R32's Pain Interview 2019, dated 9/18/22 (a day prior to the tramadol being scheduled), identified R32 continued to received scheduled and as-needed medication for pain, along with non-pharmacological interventions. A pain interview was completed with R32 who now reported severe pain, "Almost constantly." In addition, the pain was recorded as impacting his sleep and causing limited day-to-day activities. A section labeled, "Symptom Management	F 697		

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F 697	Continued From page 11 Interventions," identified R32 received cold packs, warm compresses, rest, and tramadol for pain management. R32's progress notes, dated 9/6/22 to 10/10/22, identified the following recorded entries: On 9/18/22, R32 complained of pain between eight to 10 on the pain scale (0-10; 10 being worst). R32 was give ice packs and as-needed tramadol. On 9/21/22, R32 complained of pain and rated it a four out of 10 on the pain scale, however, verbalized his pain seemed to be better compared to the previous few days. R32's scheduled tramadol was given. On 9/30/22, R32 again complained of pain and received scheduled tramadol. R32 rated the pain "at a 7" on the pain scale. On 10/1/22, R32 rated his pain at a six out of 10 but denied needing as-needed medication for it. On 10/8/22, the nurse recorded R32 had no tramadol supply as the pharmacy (Alixa) did not have R32's information in the system. This continued until 5:06 a.m., when another note recorded R32's information still was not entered and the pharmacy IT department was " ... working on the system." The note(s) lacked any recorded pain levels (i.e., one to 10) while his medication supply was unavailable. When interviewed on 10/11/22 at 9:49 a.m., nursing assistant (NA)-A stated they had worked with R32 several times in the past few weeks and described R32 as someone who was usually	F 697		

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F 697	Continued From page 12 "very happy" in demeanor and accepting of care. However, NA-A stated R32 did vocalize pain in his left hip and side and would, at times, ask for ice packs which seemed to help improve his pain some when provided. NA-A stated he last heard R32 vocalize and complain of pain "about a week ago" when he described it as a "shooting" pain in the left side. On 10/11/22 at 11:51 a.m., R32 was interviewed with his family member (FM)-C present. R32 stated his pain was "pretty fair" right then when asked, however, stated he felt his pain was "about the same" since 9/19/22, when the tramadol was scheduled and the per-administration dose reduced. FM-A stated R32 did still complain of pain; however, felt it seemed better and did not get as "out of hand" as it did prior to 9/19/22. When interviewed on 10/11/12 at 12:13 p.m., registered nurse (RN)-A stated R32 would "sometimes" complain of pain which caused him to be "up all night" as reported from the overnight nurses. RN-A explained R32 would complain of "back pain" which she understood to be chronic, so staff applied cream and medications to help promote comfort, with R32's tramadol now given every six hours on a scheduled basis. RN-A stated resident pain was assessed upon admission and with each administration of medication while not always documented. RN-A stated the physician or nurse practitioner would then visit routinely and it was up to them to do the comprehensive pain assessment and adjust medications, if needed. RN-A stated any complete re-evaluation of R32's pain, including comprehensive assessment of the pain after 9/19/22, would be in the progress notes.	F 697		

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F 697	Continued From page 13 R32's medical record, including the physician visit notes, was reviewed and lacked evidence R32 had been comprehensively reassessed to ensure the revised narcotic administration (i.e., as-needed to scheduled with reduced dose) was effective and R32's pain was adequately managed in accordance with his wishes and goals for pain management; despite R32's pain being identified as worsening (i.e., having frequent pain to now 'almost constant' pain) from the initial assessment (dated 9/6/22) to the most recent pain interview (dated 9/18/22), direct care staff having knowledge R32 continued to complain of pain and multiple recorded progress notes which identified R32 continued to have pain after 9/19/22. On 10/11/22 at 3:04 p.m., registered nurse clinical manager (RN)-C was interviewed. RN-C explained the interdisciplinary team (IDT) reviewed as-needed medication use on a routine basis and, as a result, decided to have R32's tramadol scheduled on 9/19/22. RN-C expressed R32 had chronic pain issues and they likely would never be able to totally absolve R32's pain; however, acknowledged the medical record lacked evidence R32 had been comprehensively reassessed after 9/19/22 to ensure the scheduled narcotic pain medication was effective and no further intervention(s) were needed or warranted. RN-C stated the reassessment and follow-up was "something we don't do," however, stated it was important to ensure pain was reassessed after interventions were modified to "make sure he's [R32] happy" and "not in pain." When interviewed on 10/12/22 at 7:55 a.m., the director of nursing (DON) stated a	F 697		

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F 697	Continued From page 14 comprehensive pain assessment was completed upon admission, and pain levels were then tracked and monitored based on the medical record and pharmacy reports for as-needed medication use. If more as-needed medication was used, then the nurses would determine if medications needed to be increased or scheduled. The DON stated if pain medications were adjusted, then the staff need "to be reviewing that" and updating the medical providers, as needed, if pain continued to be an issue. The DON stated she felt the nurses and IDT did routinely assess and evaluate resident's pain after medication changes, however, expressed there was no documentation process to demonstrate such in the medical record. Further, the DON stated it was important to ensure pain was reassessed after interventions, including pain medication use, were adjusted or modified as "pain affects so much" of the residents quality of life. A provided Pain Management policy, dated 1/07, identified pain would be assessed upon admission, readmission, quarterly or with a significant change in condition. The policy outlined, "Pain will be assessed on a weekly basis using functional pain assessment," and a score greater than 0 would be further evaluated. Further, the policy identified unrelieved pain had potential to decline a residents functional ability and added, "Pain Medications prescribed for residents will be assessed for efficacy."	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		11/18/22

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F 757	Continued From page 15 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure a resident with psychotropic medication was monitored for side effects for 1 of 5 residents (R1), who was observed to be somnolent (abnormally drowsy), and reviewed for unnecessary medications. Findings include: R1's facesheet printed on 10/11/22, included diagnoses of hemiplegia (paralysis of one side of the body) following a stroke; depression, insomnia and morbid obesity due to excessive calories. R1 did not have a psychiatric diagnosis. R1's quarterly Minimum Data Set (MDS) assessment dated 10/4/22, indicated R1 was	F 757	F757 Resident #1 was reassessed by medical provider on 10/19/2022. Medications including anti-depressant were reviewed with no changes determined as necessary per provider. Diagnosis for medication include F33.1 Major Depressive Disorder and insomnia. Resident was not exhibiting any adverse side effects of medication during provider visit. Residents receiving psychotropic medications have the potential to be affected. Resident were reviewed by Clinical Leadership by direct observation for side effects of medications received.	

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F 757	Continued From page 16 cognitively intact, had adequate vision, minimal difficulty hearing, clear speech, could understand others and was usually understood. R1 who did not walk, required extensive assistance of one staff for most ADL's. R1 displayed no behaviors. R1's last four PHQ-9 (Patient Health Questionnaire) screenings dated 10/4/22, 7/12/22, 4/19/22, 1/25/22, indicated a score of either 4 or 5. A score of 4 indicated normal or minimal depression and a score of 5 indicated mild depression. R1's care area assessment (CAA) for psychotropic medication use dated 1/28/22, indicated R1 received trazadone (an antidepressant and sedative medication) which is a psychotropic (medication which affects behavior, mood or perception) medication for depression. The CAA evaluation indicated R1 did not experience any adverse consequences to trazodone, including somnolence, lethargy (lack of energy and enthusiasm), or drowsiness. The CAA indicated R1 had a decline in cognition/communication due to psychotropic drug use. R1's care plan, edited on 7/15/22, indicated R1 was on a psychotropic drug and would not experience any adverse reactions through the review date. (The care plan did not identify for staff what the adverse reations could be, such as unusual tiredness, blurred vision, confusion, dizziness. Interventions included to monitor target behaviors daily, observe and report efficacy (producing the desired effect) of medication use. Further, the care plan indicated R1 had the potential for an activity deficit due to disinterest in group activities and out of room activities, due to	F 757	No other concerns were identified per review. Review was completed on 10/23/22. Residents receiving psychotropic medication had their Medication Administration Records revised to include specific monitoring for side effect that require documentation each shift. This was completed 10/24/22. Nursing staff were educated by Clinical leadership in relation to importance of monitoring side effects of psychotropic medications including: unusual tiredness, drowsiness, lethargy, somnolence and documentation of exhibited or observed side effects; notification of provider of observed or reported side effects. This education was completed by Lisa Heutmaker RN DON. Audits will be performed by Clinical leadership 2x weekly x4 weeks, then as needed via direct observation of residents receiving psychotropic medications as well as review of MARs to validate ongoing compliance of monitoring and documentation of side effects. Audits will be brought through facility QAPI committee for review and further recommendations. Audits will be discontinued only upon QAPI committee determination of sustained compliance.	

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F 757	Continued From page 17 depressive mood and amount of time spent sleeping. The facility monitored R1's target behavior of "depression - isolates self in room and/or withdrawn." From 9/11/22, through 10/11/22, R1 was monitored for this target behavior three times a days. All 90 entries indicated R1 did not experience target behaviors of self-isolation and withdrawal. This was verified by licensed practical nurse (LPN)-A on 10/11/22, at 2:20 p.m. R1's physician order dated 6/5/22, indicated R1 received trazodone 100 mg at 11:00 p.m. each night. A prescription order signed on 9/22/22, indicated R1 had been receiving trazodone 100 mg at bedtime since May 2017. R1's last GDR's (gradual dose reduction) for trazodone: --A pharmacy consult note dated 8/17/20, indicated the nurse practitioner declined pharmacist recommendation from 7/11/20, to perform a GDR but did not provide documentation to support the GDR was clinically contraindicated. --Care plan dated 8/3/21, indicated a GDR was contraindicated per provider note dated 7/21/21. --Provider note dated 5/12/22, indicated R1 had been on trazodone 100 mg for a long time due to insomnia and dysthymia [sic]. The note indicated the provider had been asked by the pharmacist to do a GDR, but declined due to the risk of exacerbating R1's mental health exceeded the benefit of GDR. --A provider noted dated 5/28/22, indicated trazodone would be decreased from 100 mg to 50 mg for 8 days due to trazodone having an interaction with Paxlovid, a medication ordered	F 757		

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F 757	Continued From page 18 for R1 due to testing positive for Covid-19. During a telephone interview on 10/11/22, at 2:54 p.m., pharmacist (PharmD)-D stated reducing trazodone due to potential interaction with Paxlovid would not be considered a GDR attempt. Sleep log monitoring for September and October 2022, indicated no patterns of sleeping and had significant variability. Day shift: R1 slept between zero and six hours. Evening shift: R1 slept between zero and three hours. Night shift: R1 slept between zero and seven hours. During an interview and observation on 10/10/22, at 1:30 p.m., R1 was sitting in a wheelchair in her room, with overbed tray in front of her; TV on. During interview lasting approximately 20 minutes, R1 never opened her eyes. R1 responded slowly to questions, with short replies. R1's voice was monotone. R1 stated she wasn't tired, but couldn't keep her eyes open. R1 stated she was given trazodone to help her sleep, but was still awake at night. During an observation and interview on 10/11/22, at 7:56 a.m., R1 was observed sitting in her wheelchair, overbed table in front of her, TV on and eyes closed. R1 did not reply to questions asked, other than staff did not help her clean up that morning. With eyes closed, R1 fumbled with the call light stating she wanted someone to fix the TV input. During an interview on 10/11/22, at 8:35 a.m., nursing assistant (NA)-B admitted R1 seemed sleepy, adding R1 stayed up really late at night	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 19 watching TV and napped after breakfast. During an interview on 10/11/22, at 8:47 a.m., registered nurse (RN)-D admitted R1 seemed sleepy, adding that was her baseline. RN-D stated R1 was awake during the night and tired in the morning. RN-D confirmed R1 received trazodone for insomnia and depression and didn't know when R1's last GDR was. During an interview on 10/11/22, at 11:16 a.m., (RN)-C provided a document titled "Event Report" and stated this tool was utilized for Minimum Effective Dose (MED) Committee Recommendations. The report indicated R1's last review was 9/20/22. The review was attended by RN-C, a physician and pharmacist. The review indicated R1 received a psychotropic for depression and insomnia. It was determined no pharmacological or non-pharmacological changes were required, and no recommendations were made for a dose adjustment of trazodone. No rationale was listed for these determinations. During intermittent observations on 10/11/22, at 10:36 a.m. and 12:57 p.m., R1 was observed sleeping in bed with the TV on. At 3:41 p.m. R1 was observed sleeping in her wheelchair. During an observation on 10/12/22, at 8:55 a.m., R1's was sitting in her wheelchair, eyes closed, head bowed, TV on. At 11:13 a.m., R1 was asleep in bed. During an interview on 10/11/22, at 10:37 a.m., the director of nursing (DON) stated R1 was up at night and slept during the day. The DON was asked for the names and telephone numbers of two night staff to contact in order to verify this.	F 757		

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F 757	Continued From page 20 Names and numbers were received. During an interview on 10/11/22, at 12:29 p.m., (NA)-A who worked the night shift three times in a two week period, stated R1 usually went to bed at 8:00 p.m., and might watch TV until about 2 a.m., then slept till about 5 a.m. During a telephone interview on 10/11/22, at 1:51 pm., (LPN)-B who worked the night shift two to four nights a week, stated R1 typically slept quit a bit of the night, adding R1 turned her call light on once or twice a night usually asking to put in a movie. LPN-B was not aware R1 was excessively sleepy during the day, adding R1 seemed to get okay sleep at night. LPN-B stated R1 was not monitored for side affects from trazodone, and that one side effect could be excessive sleepiness. During a telephone interview on 10/11/22, at 3:15 p.m., nurse practitioner (NP)-G stated she concurred with PharmD-D that a dose reduction of trazodone in May 2022 when R1 had Covid-19 would not be considered a GDR, adding it would not have been long enough to determine if a reduction was effective, and since R1 had an acute illness, would not have been an appropriate time to do a GDR. NP-G stated she was unaware of R1's somnolence, but would discuss it with staff the next time she was in the facility. During a telephone interview on 10/11/22, at 4:10 p.m., family member (FM)-B stated he didn't see R1 very often but excessive sleepiness was a concern shared among his siblings. FM-B stated, "She is always asleep when I get there. I can't recall a time when she wasn't." FM-B did not	F 757		

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F 757	Continued From page 21 know why R1 was sleepy and had not asked anyone about it. During an interview on 10/12/22, at 7:16 a.m., the DON stated R1 took joy in eating and watching old movies, and slept during the day and was up all night. Even though R1 preferred staying in her room watching old movies, the DON was asked if the dose of trazodone could be affecting R1's quality of life. The DON stated excessively sleepiness during the day was a new finding she was not aware of, and acknowledged a trazodone side effect was sleepiness. Facility policy titled Psychotropic Medication Use, dated 2020, indicated psychotropic medications were given upon medical provider order. Nursing associates collaborated with the provider to ensure the lowest possible dose is given for the shortest period of time and were subject to gradual dose reductions. When psychotropic medications are ordered the interdisciplinary team (IDT) identified target behaviors and medication side effects and implemented a resident centered care plan with both non-pharmacological and pharmacological interventions. Providers were do document why any attempted dose reduction would impair a residents function, or cause psychiatric instability by exacerbating underlying psychiatric disorder. The IDT monitored the resident condition and target behaviors for efficacy of the medication and clinically significant adverse reaction.	F 757		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		11/18/22

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F 880	Continued From page 22 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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	F 880		

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F 880	Continued From page 23 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper glove use and hand hygiene was performed during incontinence care for 1 of 1 (R30) residents reviewed for incontinence care and for 2 of 10 (R8 and R14) residents reviewed for medication administration. Findings include: Observation on 10/11/22, at 9:38 a.m., registered nurse (RN)-A was observed to administer oral medications to R14 and walked back to medication cart without performing hand hygiene.	F 880	F880 Facility staff were educated by Clinical Leadership & Facility management in relation to hand hygiene and glove use including proper technique, hand washing, hand sanitizer, and use of gloves. This education was validated by hand washing competency. Education will be completed by 12/1/22. Audits will be performed by Facility Management staff 2x weekly x4 weeks,	

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F 880	Continued From page 24 RN-A then gathered all oral medications for R8 without washing or sanitizing her hands. RN-A then walked to R8's room and was stopped from entering R8's room and interviewed. RN-A stated she forgot to wash or sanitize her hands after administering oral medication to R14 and preparing oral medications for R8. RN-A stated, "I should always wash or sanitize my hands after I leave a resident room". Observation on 10/11/22, at 9:47 a.m., RN-A was observed to administer an as needed oral medication to R17 and walked back to medication cart without performing hand hygiene. RN-A then gathered a scheduled nebulizer medication for R8 without washing or sanitizing her hands. RN-A then walked to R8's room and was stopped from entering R8's room and interviewed again. RN-A stated she forgot again to wash or sanitize her hands after administering the medication to R17 and obtaining medication for R8. During interview with director of nursing (DON) on 10/11/22, at 10:11 a.m., DON stated the expectation was staff should sanitize or wash their hands before and after resident contact including passing medications. During observation and interview on 10/10/22, at 1:52 p.m. nursing assistant (NA)-B and NA-D entered R30's room wearing gloves, to provide incontinence care. NA-B removed R30's brief, wiped R30's peri-area and buttocks with a cleaning wipe, and discarded R30's dirty brief. NA-B applied a clean brief to R30, pulled R30's bedding up to R30's chin and used R30's electronic bed controller to raise the head of R30's bed without changing gloves or performing hand hygiene. NA-B then discarded her dirty	F 880	then as needed to validate ongoing compliance with hand hygiene and glove use during cares and medication administration. Audits will be brought through facility QAPI committee for review and further recommendations. Audits will be discontinued only upon QAPI committee determination of sustained compliance.	

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F 880	Continued From page 25 gloves into R30's trash can, removed the full trash bag without donning gloves and proceeded to leave R30's room carrying the dirty trash bag in her ungloved hand. Upon interview, NA-B stated she should have changed her gloves and performed hand hygiene after providing incontinence care to R30 and before touching his bedding and bed controller to avoid cross contamination. During an interview on 10/12/22, at 11:02 a.m. the DON stated staff should remove their gloves and perform hand hygiene after providing incontinence care and prior to moving to a clean environment such as the resident's bedding and bed controller to avoid cross contamination. Facility policy titled, Hand Hygiene dated June 2017, indicated staff must perform hand hygiene before and after direct resident contact, upon and after coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting.	F 880		

Electronically delivered
November 1, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: State Nursing Home Licensing Orders
Event ID: 7H1T11

Dear Administrator:

The above facility was surveyed on October 10, 2022 through October 12, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/10/22 to 10/12/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the Minnesota State Licensure requirements. In addition, mulitple complaint investigations were completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5254058C (MN82682) H52545005C (MN85643) As a result of the survey, the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (dental care) was provided for 1 of 1 residents (R1) reviewed for activities of daily living (ADLs) and who was dependent upon staff for care. Findings include: R1's facesheet printed on 10/11/22, included diagnoses of hemiplegia (paralysis of one side of	2 920	Corrected	11/18/22

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2 920	Continued From page 3 the body) following a stroke, affecting her dominate hand. R1's quarterly Minimum Data Set (MDS) assessment dated 10/4/22, indicated R1 was cognitively intact, had clear speech, could understand others and was usually understood. R1 required extensive assistance of one staff for most ADL's including hygiene. R1 did not walk. R1's physician order dated 12/20/18, indicated staff were to assist R1 to brush her teeth twice a day during the morning medication pass between 7:00 a.m. and 10:00 a.m. and the bedtime medication pass from 7:00 p.m. to 10:00 p.m. R1's care plan edited on 7/15/22, indicated R1 required staff assistance with dental care. R1 would be free from tooth decay, swollen or bleeding gums, oral abscesses or ulcers. Staff were to monitor the adequacy of brushing. In addition, R1's care plan edited 8/8/22, indicated R1 was unable to independently perform grooming related to hemiplegia affecting her right dominate side. The care plan indicated R1 would be assisted with brushing her teeth. Staff were to provide R1 with verbal cues to brush teeth once she was set up at the sink. Nursing staff were to encourage R1 to be as independent as possible. During an interview on 10/10/22, at 1:18 p.m., R1 stated no one brushed her teeth and stated she could not do it herself; adding, "I need to brush them." R1 stated if staff brought her the supplies, she thought she could brush her teeth. During an interview on 10/11/22, at 1:15 p.m., nursing assistant (NA)-B stated R1 could brush her teeth with set up help and admitted she did not assist R1 with brushing her teeth that	2 920		

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2 920	Continued From page 4 morning, adding she had so much to do. NA-B stated R1 was to receive assistance with brushing her teeth at least once a day. During an interview on 10/11/22, at 1:25 p.m., licensed practical nurse (LPN)-A stated NA's got R1 up in the morning to wash and help her brush her teeth. LPN-A looked in the electronic medical record (EMR) and printed NA documentation for assisting R1 to brush teeth twice a day. Many entries indicated the task was "reviewed," and LPN-A was not sure what that meant. During an interview on 10/11/22, at 3:55 p.m., (NA)-C demonstrated how resident tasks were documented in the NA documentation system called Point of Care (POC). NA-C displayed the five drop-down options to select for dental care for R1: 1) Reviewed 2) Resident sick 3) Resident refused 4) Resident unavailable 5) Completed task as written. NA-C stated "reviewed" meant a NA looked at it but did not complete the task and "completed task as written" meant the task was done. Review of POC records provided by LPN-A, indicated out of 60 opportunities for staff to assist R1 with brushing her teeth twice a day from 9/11/22, to 10/11/22, the task was documented as completed only 50% of the time. The task was never documented as completed on the following 11 dates: 9/11, 9/14, 9/15, 9/21, 9/24, 9/25, 9/27, 9/29, 10/5, 10/8 and 10/9. During an interview on 10/12/22, at 7:29 a.m., the director of nursing (DON) was informed that R1 had not being assisted to brush her teeth 50% of the time over the past month. The DON was unaware of this and stated dental care was important for residents, adding she expected staff	2 920		

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2 920	Continued From page 5 to complete tasks as assigned. Facility policy titled Activities of Daily Living (ADL) dated 2021, indicated residents unable to carry out ADL's independently would receive the services necessary to maintain good grooming and personal hygiene. Care and services would be provided for residents who were unable to carry out ADL's independently, including hygiene such as oral care. If a resident refused care, he/she would be approached at a different time. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures related to oral care hygiene and completion to ensure accuracy; then educate staff on expectations for oral care, including documentation; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper glove use and hand hygiene was performed during incontinence care for 1 of 1 (R30) residents	21375	Corrected	11/18/22

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21375	Continued From page 6 reviewed for incontinence care and for 2 of 10 (R8 and R14) residents reviewed for medication administration. Findings include: Observation on 10/11/22, at 9:38 a.m., registered nurse (RN)-A was observed to administer oral medications to R14 and walked back to medication cart without performing hand hygiene. RN-A then gathered all oral medications for R8 without washing or sanitizing her hands. RN-A then walked to R8's room and was stopped from entering R8's room and interviewed. RN-A stated she forgot to wash or sanitize her hands after administering oral medication to R14 and preparing oral medications for R8. RN-A stated, "I should always wash or sanitize my hands after I leave a resident room". Observation on 10/11/22, at 9:47 a.m., RN-A was observed to administer an as needed oral medication to R17 and walked back to medication cart without performing hand hygiene. RN-A then gathered a scheduled nebulizer medication for R8 without washing or sanitizing her hands. RN-A then walked to R8's room and was stopped from entering R8's room and interviewed again. RN-A stated she forgot again to wash or sanitize her hands after administering the medication to R17 and obtaining medication for R8. During interview with director of nursing (DON) on 10/11/22, at 10:11 a.m., DON stated the expectation was staff should sanitize or wash their hands before and after resident contact including passing medications. During observation and interview on 10/10/22, at 1:52 p.m. nursing assistant (NA)-B and NA-D	21375		

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21375	Continued From page 7 entered R30's room wearing gloves, to provide incontinence care. NA-B removed R30's brief, wiped R30's peri-area and buttocks with a cleaning wipe, and discarded R30's dirty brief. NA-B applied a clean brief to R30, pulled R30's bedding up to R30's chin and used R30's electronic bed controller to raise the head of R30's bed without changing gloves or performing hand hygiene. NA-B then discarded her dirty gloves into R30's trash can, removed the full trash bag without donning gloves and proceeded to leave R30's room carrying the dirty trash bag in her ungloved hand. Upon interview, NA-B stated she should have changed her gloves and performed hand hygiene after providing incontinence care to R30 and before touching his bedding and bed controller to avoid cross contamination. During an interview on 10/12/22, at 11:02 a.m. the DON stated staff should remove their gloves and perform hand hygiene after providing incontinence care and prior to moving to a clean environment such as the resident's bedding and bed controller to avoid cross contamination. Facility policy titled, Hand Hygiene dated June 2017, indicated staff must perform hand hygiene before and after direct resident contact, upon and after coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures related to hand hygiene and to ensure accuracy; then	21375		

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21375	Continued From page 8 educate staff on expectations for hand hygiene with or during resident care; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure baseline tuberculosis (TB) screening components were completed for 3 of 5 newly admitted residents (R15, R32, R294) per	21426	The facility program was assessed by RNS, Director, Clinical Manager IP by 10/18/22. Resident face sheets/charts reviewed to assure all TB tests	11/18/22

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21426	Continued From page 9 current Center for Disease Control and Prevention (CDC) recommendations and facility policy. This had the potential to affect all 48 residents residing in the facility. Findings include: R15's facesheet printed on 10/12/22, indicated admission date of 5/6/22. R15's TB screening tool printed on 10/12/22, indicated TB skin testing or a TB blood test should be administered. During an interview on 10/12/22, at 10:30 a.m., licensed practical nurse (LPN)-A stated there was no documentation that a TB skin test or a TB blood test had been administered. R32's facesheet printed on 10/12/22, indicated admission date of 9/6/22. R32's TB screening tool printed on 10/12/22, indicated TB skin testing or a TB blood test should be administered. During an interview on 10/12/22, at 10:35 a.m., LPN-A stated TB skin testing was appropriately performed on both 7/12/22, and 9/18/22, and stated the date the results were read (to ensure results were read within the required 48-72 hours) were not documented. R294's facesheet printed on 10/12/22, indicated admission date of 9/28/22. R294's TB screening tool printed on 10/12/22, indicated TB skin testing or a TB blood test should be administered. During an interview on 10/12/22, at 10:40 a.m., LPN-A stated R294 received the first TB skin test on 9/28/22, but the results had not been documented. Further, LPN-A stated R294's second TB skin test was to be administered on 10/10/22, but had not been administered. LPN-A stated there was no documentation as to why it was not administered.	21426	completed/documented and reconciled by IP for current residents. Documentation was corrected to assure proper recording of results in necessary area of chart. Based on the immediate audit performed the needed tests are administered and appropriate documentation is in patient charts to support the program requirements. Charts of all new admits are being regularly monitored by IP and Nursing Leadership to assure compliance per regulations. Staff education will occur by 11/18/2022 for all facility staff to assure that the proper process and charting is followed to be in compliance with requirement. Training will be facilitated by DON/IP and Clinical Manager. Audits will by performed on all new admit charts for 4 weeks by IP to assure compliance as outlined in requirement. Audits will be brought through the facility QAPI committed for further review and further recommendations. Audits will be discontinued upon QAPI determination of sustained compliance.	

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21426	Continued From page 10 Facility policy titled Tuberculosis Infection Prevention & Control Plan, dated 2014, indicated all residents must receive baseline TB screening within 72 hours of admission, or within three months prior to admission. Baseline TB screening components included: 1) assessing the residents's risk factors for TB. 2) Assessing for current symptoms of active TB disease. 3) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or a single TB blood test. TST documentation would include date, the number of millimeters of induration and interpretation (i.e., positive or negative). Suggested Method of Correction: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components for tuberculosis identification and control. The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		11/18/22

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21535	Continued From page 11 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure a resident with psychotropic medication was monitored for side effects for 1 of 5 residents (R1), who was observed to be somnolent (abnormally drowsy), and reviewed for unnecessary medications. Findings include: R1's facesheet printed on 10/11/22, included diagnoses of hemiplegia (paralysis of one side of the body) following a stroke; depression, insomnia and morbid obesity due to excessive calories. R1 did not have a psychiatric diagnosis. R1's quarterly Minimum Data Set (MDS) assessment dated 10/4/22, indicated R1 was cognitively intact, had adequate vision, minimal difficulty hearing, clear speech, could understand others and was usually understood. R1 who did not walk, required extensive assistance of one staff for most ADL's. R1 displayed no behaviors.	21535	Completed	

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21535	Continued From page 12 R1's last four PHQ-9 (Patient Health Questionnaire) screenings dated 10/4/22, 7/12/22, 4/19/22, 1/25/22, indicated a score of either 4 or 5. A score of 4 indicated normal or minimal depression and a score of 5 indicated mild depression. R1's care area assessment (CAA) for psychotropic medication use dated 1/28/22, indicated R1 received, trazadone (an antidepressant and sedative medication) which is a psychotropic (medication which affects behavior, mood or perception) medication for depression. The CAA evaluation indicated R1 did not experience any adverse consequences to trazodone, including somnolence, lethargy (lack of energy and enthusiasm), or drowsiness. The CAA indicated R1 had a decline in cognition/communication due to psychotropic drug use. R1's care plan, edited on 7/15/22, indicated R1 was on a psychotropic drug and would not experience any adverse reactions through the review date. (The care plan did not identify for staff what the adverse reations could be, such as unusual tiredness, blurred vision, confusion, dizziness. Interventions included to monitor target behaviors daily, observe and report efficacy (producing the desired effect) of medication use. Further, the care plan indicated R1 had the potential for an activity deficit due to disinterest in group activities and out of room activities, due to depressive mood and amount of time spent sleeping. The facility monitored R1's target behavior of "depression - isolates self in room and/or withdrawn." From 9/11/22, through 10/11/22, R1	21535		

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21535	Continued From page 13 was monitored for this target behavior three times a days. All 90 entries indicated R1 did not experience target behaviors of self-isolation and withdrawal. This was verified by licensed practical nurse (LPN)-A on 10/11/22, at 2:20 p.m. R1's physician order dated 6/5/22, indicated R1 received trazodone 100 mg at 11:00 p.m. each night. A prescription order signed on 9/22/22, indicated R1 had been receiving trazodone 100 mg at bedtime since May 2017. R1's last GDR's (gradual dose reduction) for trazodone: --A pharmacy consult note dated 8/17/20, indicated the nurse practitioner declined pharmacist recommendation from 7/11/20, to perform a GDR but did not provide documentation to support the GDR was clinically contraindicated. --Care plan dated 8/3/21, indicated a GDR was contraindicated per provider note dated 7/21/21. --Provider note dated 5/12/22, indicated R1 had been on trazodone 100 mg for a long time due to insomnia and dysthymia [sic]. The note indicated the provider had been asked by the pharmacist to do a GDR, but declined due to the risk of exacerbating R1's mental health exceeded the benefit of GDR. --A provider noted dated 5/28/22, indicated trazodone would be decreased from 100 mg to 50 mg for 8 days due to trazodone having an interaction with Paxlovid, a medication ordered for R1 due to testing positive for Covid-19. During a telephone interview on 10/11/22, at 2:54 p.m., pharmacist (PharmD)-D stated reducing trazodone due to potential interaction with Paxlovid would not be considered a GDR attempt.	21535		

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21535	Continued From page 14 Sleep log monitoring for September and October 2022, indicated no patterns of sleeping and had significant variability. Day shift: R1 slept between zero and 6 hours. Evening shift: R1 slept between zero and three hours. Night shift: R1 slept between zero and 7 hours. During an interview and observation on 10/10/22, at 1:30 p.m., R1 was sitting in a wheelchair in her room, with overbed tray in front of her; TV on. During interview lasting approximately 20 minutes, R1 never opened her eyes. R1 responded slowly to questions, with short replies. R1's voice was monotone. R1 stated she wasn't tired, but couldn't keep her eyes open. R1 stated she was given trazodone to help her sleep, but was still awake at night. During an observation and interview on 10/11/22, at 7:56 a.m., R1 was observed sitting in her wheelchair, overbed table in front of her, TV on and eyes closed. R1 did not reply to questions asked, other than staff did not help her clean up that morning. With eyes closed, R1 fumbled with the call light stating she wanted someone to fix the TV input. During an interview on 10/11/22, at 8:35 a.m., nursing assistant (NA)-B admitted R1 seemed sleepy, adding R1 stayed up really late at night watching TV and napped after breakfast. During an interview on 10/11/22, at 8:47 a.m., registered nurse (RN)-D admitted R1 seemed sleepy, adding that was her baseline. RN-D stated R1 was awake during the night and tired in the morning. RN-D confirmed R1 received trazodone for insomnia and didn't know when R1's last GDR was.	21535		

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21535	Continued From page 15 During an interview on 10/11/22, at 11:16 a.m., (RN)-C provided a document titled "Event Report" and stated this tool was utilized for Minimum Effective Dose (MED) Committee Recommendations. The report indicated R1's last review was 9/20/22. The review was attended by RN-C, a physician and pharmacist. The review indicated R1 received a psychotropic for depression and insomnia. It was determined no pharmacological or non-pharmacological changes were required, and no recommendations were made for a dose adjustment of trazodone. No rationale was listed for these determinations. During intermittent observations on 10/11/22, at 10:36 a.m. and 12:57 p.m., R1 was observed sleeping in bed with the TV on. At 3:41 p.m. R1 was observed sleeping in her wheelchair. During an observation on 10/12/22, at 8:55 a.m., R1's was sitting in her wheelchair, eyes closed, head bowed, TV on. At 11:13 a.m., R1 was asleep in bed. During an interview on 10/11/22, at 10:37 a.m., the director of nursing (DON) stated R1 was up at night and slept during the day. The DON was asked for the names and telephone numbers of two night staff to contact in order to verify this. Names and numbers were received. During an interview on 10/11/22, at 12:29 p.m., (NA)-A who worked the night shift three times in a two week period, stated R1 usually went to bed at 8:00 p.m., and might watch TV until about 2 a.m., then slept till about 5 a.m. During a telephone interview on 10/11/22, at 1:51 pm., (LPN)-B who worked the night shift two to	21535		

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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) COMPLETE DATE
21535	Continued From page 16 four nights a week, stated R1 typically slept quit a bit of the night, adding R1 turned her call light on once or twice a night usually asking to put in a movie. LPN-B was not aware R1 was excessively sleepy during the day, adding R1 seemed to get okay sleep at night. LPN-B stated R1 was not monitored for side affects from trazodone, and that one side effect could be excessive sleepiness. During a telephone interview on 10/11/22, at 3:15 p.m., nurse practitioner (NP)-G stated she concurred with PharmD-D that a dose reduction of trazodone in May 2022 when R1 had Covid-19 would not be considered a GDR, adding it would not have been long enough to determine if a reduction was effective, and since R1 had an acute illness, would not have been an appropriate time to do a GDR. NP-G stated she was unaware of R1's somnolence, but would discuss it with staff the next time she was in the facility. During a telephone interview on 10/11/22, at 4:10 p.m., family member (FM)-B stated he didn't see R1 very often but excessive sleepiness was a concern shared among his siblings. FM-B stated, "She is always asleep when I get there. I can't recall a time when she wasn't." FM-B did not know why R1 was sleepy and had not asked anyone about it. During an interview on 10/12/22, at 7:16 a.m., the DON stated R1 took joy in eating and watching old movies, and slept during the day and was up all night. Even though R1 preferred staying in her room watching old movies, the DON was asked if the dose of trazodone could be affecting R1's quality of life. The DON stated excessively sleepiness during the day was a new	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/12/2022

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21535	Continued From page 17 finding she was not aware of, and acknowledged a trazodone side effect was sleepiness. Facility policy titled Psychotropic Medication Use, dated 2020, indicated psychotropic medications were given upon medical provider order. Nursing associates collaborated with the provider to ensure the lowest possible dose is given for the shortest period of time and were subject to gradual dose reductions. When psychotropic medications are ordered the interdisciplinary team (IDT) identified target behaviors and medication side effects and implemented a resident centered care plan with both non-pharmacological and pharmacological interventions. Providers were do document why any attempted dose reduction would impair a residents function, or cause psychiatric instability by exacerbating underlying psychiatric disorder. The IDT monitored the resident condition and target behaviors for efficacy of the medication and clinically significant adverse reaction. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures related to medication side effect monitoring to ensure accuracy; then educate staff on expectations for medication management, including side effect monitoring and required documentation; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days	21535		

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	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

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REGINA SENIOR LIVING	**1175 NININGER ROAD HASTINGS, MN 55033**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/11/2022. At the time of this survey, REGINA SENIOR LIVING 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 | 11/08/2022

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

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K 000	Continued From page 1 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. REGINA SENIOR LIVING is a 1 story building with full basement. The original building was constructed at 2 different times. The original building, 1 story with basement, was constructed in 1965 and was determined to be of Type II (111) construction. In 2012, a 1 story addition (TCU) was constructed and was determined to be of Type II (111) construction.	K 000		

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	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

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K 000	Continued From page 2 Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6, 7.2.5, 7.2.5.2(b). This deficient condition could have a patterned impact on the residents within the facility. Findings include:	K 271	Facility's preferred vendor came out to inspect the uneven surfaces adjacent to the 1st floor day room egress exit on 11/11/2022. Temporary solution recommendations will be completed at that time by vendor. Due to scheduling and weather conditions, new concrete will be scheduled to be poured early spring 2023.	11/30/22

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K 271	Continued From page 3 On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during the walk-through of the facility that the egress exit adjacent to the 1st Floor Day Room had concrete slabs the changed in elevation more than ½ inch slab-to-slab along the path of travel from the building to the public way An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed during documentation review that the documents presented for review did not identity or confirm when the 90 minute annual testing was completed. An interview with the Maintenance Director verified this deficient finding at the time of	K 291	After further review, facility's 90-minute annual testing was completed on 07/29/2022 as evidenced by facilities TELS program. 90 Minute testing will be continued to be scheduled in TELS annually, with testing performed in July. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	11/30/22

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K 291	Continued From page 4 discovery.	K 291		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5, 19.7.6, 4.6.12, 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.7, 4.3, 5.2, 5.2.1.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 353	After further review, the annual inspection of the fire system was completed on 07/19/2022 per the documented report provided by facility's preferred vendor – Viking Sprinkler. Annual inspections will be continued to be scheduled in TELS annually, with testing performed in July. Serving kitchen closets ceiling tiles were repaired on 11/2/22. Basement dishwasher rooms ceiling tiles were repaired on 11/2/22.	11/30/22

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K 353	Continued From page 5 1. On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed during documentation review that no documentation was available to review to confirm last annual inspection of the fire sprinkler system 2. On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that floor level visual assessment revealed the following: a. Serving Kitchen Closet - missing ceiling tiles b. Basement - Dishwashing Room - missing ceiling tiles c. Basement - Dishwashing Room, sprinkler heads exhibited signs of oxidation 3. On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that location of the shut-off valves was not identified An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Viking Sprinkler replaced the powder coated sprinkler heads. Sprinkler heads will be blown off with compressed air on a quarterly basis, starting in January 2023. Task will be managed and tracked using the facility's TELS program. Complete Date: 11/30/22. Shut-off vales were properly identified by new signage posted on 11/2/22. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		11/30/22

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K 363	Continued From page 6 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 install corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3, and 7.2.1.5 This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/11/2022 between 09:00 AM to 04:00 PM, it	K 363	Clasp and padlocked used on office adjacent to the nurse's station was removed 11/8/22. Staff were educated on corridor requirements on 11/16/22. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be	

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K 363	Continued From page 7 was revealed by observation during walk-through of the facility that an office, located adjacent to the Nurses Station, had a sliding door and was implementing a clasp and padlock to secure the room An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	determined through analysis of results.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 374	Basement's smoke door was adjusted by Maintenance to ensure no gap greater than 1/8 inch. Complete Date: 11/30/22 Smoke door will be audited weekly X 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with	11/30/22

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K 374	Continued From page 8 On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that upon testing the smoke barrier doors, located mid-corridor in the basement, that the assembly exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	ongoing frequency and duration to be determined through analysis of results.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 511	New hardware was added to the electrical panel on 10/13/22 to ensure panel is secured. Electrical panel will be audited weekly X 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be	11/30/22

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K 511	Continued From page 9 On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that in Basement Physical Therapy Area - an electrical panel (PNL 112) was found to be unsecured and readily accessible to unqualified individuals An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	determined through analysis of results.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect decorative materials prior to install per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5, 19.7.5.6. This deficient condition could have an isolated impact on the residents within the facility.	K 753	7. K753 = Combustible · Room 107 – door was found to be covered with seasonal decorative material of unknown fire rating	11/30/22

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K 753	Continued From page 10 Findings include: On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that resident RM 107 was found to be 100% covered with seasonal decorative material of unknown fire rating. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 753	Decorative material was removed from Room 107 fire door on 10/12/22. Staff were provided education on combustible decorations on 11/16/22. All resident fire doors will be audited weekly X 4 weeks to ensure free of combustible decorations. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2, 6.1.4.3.1 This	K 761	All fire doors were inspected by Maintenance Personnel. Fire door inspections was added to TELS for every 6-month completion. All maintenance personnel were educated on fire door	11/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD HASTINGS, MN 55033**

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K 761	Continued From page 11 deficient finding could have an widespread impact on the residents within the facility. Findings include: 1. On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed during documentation review that door inspection documents presented for review were missing signatures, records were missing who completed the inspection(s), and it was unclear as to whether the annual inspection had been completed. 2. On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that the fire door assembly located at the entry to the skilled nursing facility did not self-close and latch upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	inspection procedure and proper documentation. Completion date: 11/30/22. Entry door to skilled nursing had new hinges installed, to ensure door self closes and latch. Door will be audited weekly X 4 weeks. Completion date: 11/30/22. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		11/30/22

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	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

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K 920	Continued From page 12 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during walk-through of the facility that in the exit vestibule, across from RM 133, a power-strip with the corded end of the device rising up and through the ceiling. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 920	Power strip was removed by Maintenance personnel on 10/14/22. Maintenance personnel received training on power cord requirements on 11/16/22. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		11/30/22

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	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

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K 923	Continued From page 13 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to identify locations of medical gas	K 923	Cardboard was removed from oxygen storage room on 10/11/22.	

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	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**10/11/2022**

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K 923	Continued From page 14 storage locations per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3 This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/11/2022 between 09:00 AM to 04:00 PM, it was revealed by observation during a walk-through of the facility that the Med Gas Storage Room was storing e-cylinders and 3 liquid oxygen units. The room also contained combustible storage in the form of cardboard positioned less-than 5 feet from the O2 storage vessels. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	Staff received education on oxygen storage room requirements on 11/16/22. Oxygen storage room will be audited weekly X 4 weeks for continued compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis of results.	