DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 5, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

Re: Reinspection Results
Event ID: 7HDB12

Dear Administrator:

On February 29, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 21, 2023. 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
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 5, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 21, 2023

Dear Administrator:

On February 28, 2024, we notified you a remedy was imposed. On February 29, 2024 the Minnesota Departments 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 February 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 28, 2024, 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 March 21, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 1, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location 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
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 21, 2023

Dear Administrator:

On December 21, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 21, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 21, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

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
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

Re: State Nursing Home Licensing Orders
Event ID: 7HDB11

Dear Administrator:

The above facility was surveyed on December 18, 2023 through December 21, 2023 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 5, 2024

Revised Letter

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 21, 2023

Dear Administrator:

This letter, sent on March 5, 2024, will replace the letter dated February 28, 2024. The effective date of the remedy of DDPNA, should be March 21, 2024.

On January 11, 2024, we informed you that we may impose enforcement remedies.

Compliance with the health deficiencies cited on December 21, 2023 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS location concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 21, 2024. (42 CFR 488.417 (b))

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 21, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 21, 2024. You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, South Shore Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 21, 2024. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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
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
	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 12/18/23 through 12/21/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		2/1/24

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

Electronically Signed | 01/20/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community based excercise, a facility based excercise or a facility drill to test their emergency preparedness (EP) program at least twice per year. This had the potential to affect all 31 residents who currently resided in the facility, along with staff who work in the facility. Findings include: Interview and review of the EP plan and policy on 12/21/23 at 4:00 p.m., with the administrator identified they had not completed or planned a full-scale exercise or table top exercise to test their emergency plan. The administrator agreed the facility had not followed the EP plan or policy.	E 039	E 039 The facility will have a table-top exercise on 2/1/2024. The live drill will take place in tentatively scheduled for May 1, 2024. There were no ill effects experienced by this deficient practice. Future drills and tabletop exercises will be conducted per facility policy. The Maintenance Director will be in-serviced on the Disaster Training Policy with emphasis on item #4 that training exercises are conducted bi-annually to test the emergency plan. Executive Director and/or designee will be responsible for compliance. Audits on completion of the required table-top exercise, employee attendance and mock drill scheduling will begin monthly x3 months then yearly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 10 On 12/18/23 through 12/21/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55965530C (MN92569), H55967817C(MN97909), H55967820C (MN94418), H55967958C (MN96983), and H55967821C (MN97725). The following complaints were reviewed H55968190C (MN99372) with a deficiency cited at F609 and F940. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		1/26/24

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F 609	Continued From page 11 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of potential abuse timely to the facility management staff and the State Agency for 1 of 1 resident (R8) reviewed. Findings include: R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and cares. R8 had impairment bilaterally in her lower extremities. R8 had inattention and disorganized thinking that fluctuated. R8 had verbal behaviors directed towards others 1-3 days and other behaviors not directed towards others such as screaming, 1-3 days. R8 had no toileting program	F 609	F 609 R 8 will have a risk management incident created, a root cause identified, and care plan was updated to include resident preferences and bed mobility assistance. All other residents who require 2 persons assistance with bed mobility, their care plans were reviewed and updated as needed. Future residents who require extensive assistance with bed mobility, will be reviewed for 1- or 2-person assistance upon admission and as needed. Facility staff will be in-serviced on the Abuse, Neglect, and Investigation policy with emphasis on reporting abuse immediately to the administrator and/or	

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F 609	Continued From page 12 and was frequently incontinent of bladder and always incontinent of bowel. R8 took a daily anti-psychotic, anti-anxiety, and anti-depressant. R8's 11/30/23, Significant Change MDS assessment identified R8 had severe cognitive deficit. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility and was able to assist with turning by using the grab bars on the bed. Behavioral focused area last revised 9/7/22, identified R8 was found to be verbally aggressive. She yelled out to staff to come to her room. She was to ask staff to come back to her room right after they stepped out even after they asked if there was anything else she needed. R8 was socially inappropriate and was known to undress, bang on the walls, threaten staff, call the facility, and making false accusations against staff. There was no mention what staff were to do if R8 made accusations against them. Interview on 12/18/23 at 12:06 p.m., with R8 identified a "guy" had helped her earlier today and shook her when he rolled her on her side. R8 reported she told the "guy" she was going to report him, and he responded he did not care. R8 stated she told the nurse about him. Interview on 12/18/23 at 5:21 p.m., with licensed practical nurse (LPN)-D identified R8 reported to her a "guy" was rough when rolling her. LPN-D reported she was unaware of who the male staff was and then reported that R8 was sometimes confused. LPN-D said R8's anxiety was high today. LPN-D reported that R8 will report staff so someone goes into talk to her. LPN-D said there	F 609	director of nursing on all allegation of abuse immediately within 2 hours of an allegation. Social Services and/or designee will be responsible for compliance. Audits on reporting abuse timely will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 609	Continued From page 13 were 2 male staff on duty, and she checked to see who had assisted R8 however, everyone on duty had been in to assist R8 during the shift. LPN-D said if there were concerns, she would report them to the director of nursing (DON), but it depended on the circumstance, as sometimes R8 got upset with staff if they did not come fast enough when she wanted help. Today R8 was upset because the "guy" (nurse aide (NA-G), a contracted staff) left the room after R8 was placed on the bedpan and R8 wanted him to stay there. LPN-D revealed R8 liked to report staff for things when things did not "go exactly" as she wanted. LPN-D confirmed she had checked with NA-G and he said he left her room to give her privacy and had visited with R8. LPN-D revealed that R8 had reported her concerns to her around noon-ish that day. LPN-D would not answer if she had reported the allegation of abuse to the DON at that time. Additional interview on 12/18/23 at 5:43 p.m., with LPN-D identified she had followed up again with R8 who advised her she had not wanted to make a "complaint" against NA-G. She then reported the allegation to the DON and thought the DON had went in to talk with R8. She also revealed the social service designee (SSD) had been in to talk to R8 during the day due to R8's anxiety. She was unaware if the SSD had knowledge of the incident. Interview on 12/19/23 at 8:35 a.m., with LPN-B who identified if R8 made a report about a staff member, licensed staff were to make sure R8 was ok and interview the resident to determine as much information about the incident as possible, then interview the staff in question and call the DON for direction before letting the staff proceed	F 609		

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F 609	Continued From page 14	F 609		

with work. LPN-B reported that R8 was known to threaten to "report staff" sometimes but not frequently. She reported R8 yelled out for help a lot.

Interview on 12/19/23 at 10:10 a.m., with R8 identified a guy had rolled her onto her side and shook her. R8 said she told the nurse and the nurse visited with her and then the head nurse came in and visited with her. She later said there was also a girl in with the guy that shook her and stated she will lie for him. R8 then reported she only spoke to the nurse that was helping her and that no one else talked to her yesterday. She confirmed the guy had not been back to assist her as she had told him he could not come back. She reported when he shook her it made her feel like a "pig" and when she was asked if she was afraid of this person she stated, "yes wouldn't you be".

Interview on 12/19/23 at 10:31 a.m., with nursing assistant (NA)-G identified that R8's mood depended on the day and some days R8 was angry and cursed at staff and complained and other days she was fine. NA-G confirmed he was the staff that had assisted R8 yesterday and R8 accused him of being rough when he turned her on her side. NA-G reported he was the only staff member in the room at the time. He reported R8 was mad and cursing saying "this is bullshit" as he assisted her to change her brief. He reported after assisting her with her brief she was fine and asked him to help her call her husband. NA-G reported R8 will call her husband if she feels staff are not helping her fast enough or doing a good enough job. NA-G said yesterday was the first time R8 had complained about how he assisted her, and he had assisted her many times. NA-G

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F 609	Continued From page 15 confirmed that the nurse did speak to him yesterday and asked what had happened and he reported all he had done was turn her on her side to change her brief. Interview on 12/19/23 at 10:45 a.m., with the DON identified she was unaware of any accusation of staff being rough with R8 yesterday. She reported she was in the building into the evening and had no knowledge of an accusation of staff being rough. She revealed the nurse on duty should have interviewed R8 and informed her immediately so she could interview the staff and other residents. The DON noted R8's care plan identified she had previously made false accusations against staff however, that had not meant staff would not report allegations of potential abuse and facility management would investigate all allegations. Interview of 12/20/23 at 11:30 a.m. with the SSD identified she was unaware of the allegation of potential abuse with rough care. R8 never mentioned that when she spoke with R8 on 12/18/23. Review of 10/21/22, Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy identified all reports of abuse would be reported to the state agency and thoroughly investigated by facility management. All reports of abuse must be reported immediately to the administrator and to other officials according to state laws. The administrator will make report to state official immediately within 2 hours of an allegation involving abuse or result in serious bodily injury. Upon receiving an allegation of abuse the administrator was responsible for determining what actions (if any) are needed for	F 609		

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F 609	Continued From page 16 the protection of the residents. All reports would be thoroughly investigated. Employees who have been accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. A follow up 5-day report of the investigation with sufficient information to describe the results of the investigation and any corrective action taken if allegation was verified.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status and needs for 1 of 1 resident (R9) for depression. Findings include: R9's undated, current care plan identified R9 would be free from discomfort or adverse reactions to antidepressant medication through the review date. Staff were to administer antidepressant medication as ordered by physician. Staff were to monitor and document side effects and effectiveness of medication every shift and report adverse reactions of medications and consult Southwest Mental Health for services. The care plan identified side effects for antidepressant medication but lacked identification of target symptoms that were to be monitored for effectiveness.	F 641	F 641 R 9 antidepressant and antipsychotic medication orders was updated to include resident target behavior, the behavior module activated, the care plan updated to reflect resident target behavior for use of antidepressant or antipsychotic medication, the diagnosis listed updated and appropriate interventions initiated. R 9 s MDS diagnosis list will include major depression for the next quarterly assessment. All existing and future residents will have their medications, diagnosis and care plan include the target behavior and interventions initiated. The MDS coordinator will be in-serviced on the RAI Manual Section I pages 7-11 which the IDT team will review the resident diagnosis list and physician documented diagnosis in the last 60 days that have a direct relationship with the	1/26/24

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F 641	Continued From page 17 R9's 10/02/23 Southwestern Mental Health Center Standard Diagnostic Assessment identified R9 had a depression disorder. R9's 11/09/23, quarterly Minimum Data Set (MDS) assessment identified R9 had no cognitive impairment. R9 had little interest in doing things, feeling down, depressed, or hopeless, trouble concentrating on things, and feeling tired or having little energy for 12 to 14 days. R9 took a daily antidepressant and antipsychotic. R9 had a diagnosis of anxiety but did not indicate a diagnosis of depression. R9 had cerebral infarct of right middle cerebral artery (stroke occurs when blood flow from the main carotid artery of the brain suddenly stops), peripheral vascular disease, nicotine dependence, and anxiety. R9's 12/21/23, physician Order Summary Report identified the following medication orders: 1) mirtazapine 15 milligrams (mg) at night for depression 2) risperidone (used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder) 1 mg at night for depression disorder 3) clonidine 0.1 mg three times a day for anxiety and depression The physician Order summary had no indication of target symptoms ordered to treat with use of the antidepressants. Interview on 12/20/23 at 5:13 p.m., with registered nurse (RN)-A stated R9's depression diagnosis was not listed on his current medical record or in the MDS. Interview on 12/21/23 at 9:02 a.m., with DON-A	F 641	resident s functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look-back period. Social Services and/or designee will be responsible for compliance. Audits on physician diagnosis list matching the resident electronic diagnosis list and this information correctly submitted into the MDS will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 641	Continued From page 18 stated R9's depression diagnosis wasn't identified and had no behavior monitoring in place for R9's depression. A policy was requested but none provided by the end of the survey.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have an integrated hospice care plan for 1 of 1 resident (R27). Findings include: R27's 12/6/23, Significant Change Minimum Data Set (MDS) assessment, identified diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), required oxygen therapy and was admitted to hospice care. R27's current, undated care plan identified there was no mention R27 was on hospice services, what services the facility was to provide, nor services the hospice agency was to provide.	F 684	F 684 R 27 will have a thorough care plan review, the hospice care plan updated with all hospice interventions initiated including hospice staff visits and services that will be provided. R 27 hospice company plan of care will also be uploaded into the resident electronic medical record. All existing and future hospice residents will have an integrated care plan initiated with a listing of hospice services being provided per facility policy. Social services along with the DON and ADON will be in-serviced on the Hospice Program policy with emphasis on item #13 that a coordinated care plan will be initiated. Social Services and/or designee will be	1/26/24

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F 684	Continued From page 19 Interview and document review on 12/19/23 at 10:02 a.m., with LPN-A identified R27's care plan failed to contain documentation of any hospice services, R27's oxygen use, or use of a Foley catheter which should have been documented and included ont he facility care plan. LPN-A agreed it was not documented on what services hospice was to provide. Interview on 12/19/23, at 10:14 a.m., with the director of nursing (DON) confirmed her expectation for coordination of services between hospice providers and the facility. She confirmed the information on hospice and facility provided services had not been included in R27's current care plan. Interview and document review on 12/19/23 at 2:25 p.m., with the hospice registered nurse (RN)-B reported she had previously visited R27 weekly, but following a discussion on the evening of 12/18/23 the decision was made to decrease visits to once weekly for RN and twice for NA services. The social services provider was scheduled to visit 1-2 times a month and as needed. RN-B identified a blue binder, located at the nursing station contained a calendar with scheduled hospice staff visit dates. Review of the calendars for December 2023 and January 2024 with RN-B confirmed they were blank and had not been competed as per policy. RN-B confirmed the care plan for R27 had not been updated as per policy until 12/19/23 and facility and hospice staff should have coordinated services to be provided and documented those services provided by each entity in the facility care plan. Review of the May 5, 2021, Hospice Program policy identified a coordinated plan of care was to	F 684	responsible for compliance. Audits on facility hospice care plan interventions completed with hospice service visits and hospice services along with completion of hospice company visit schedule completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 684	Continued From page 20 be developed between the facility, hospice agency and the resident/family. The plan of care was to include hospice staff schedules, pain and/or comfort management plans, and be revised or updated as indicated.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff sanitized a gastronomy tube (G-tube) port prior to initializing enteral feeding (nutrition provided thru a tube directly into the stomach) for 1 of 1 resident (R14) during 2 of 2 observations.	F 693	F 693 R 14 MD was contacted and notified that the proper technique for gastric tube procedure was completed incorrectly. The MD response will be recorded in the resident electronic medical record. R 14	1/26/24

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F 693	Continued From page 21 Findings include: R14's undated, current Medical Diagnosis identified diverticulitis (small bulging pouches in the digestive tract that become inflamed or infected) of intestine, disease of digestive system, neutropenia (abnormally low count of a type of white blood cell), malignant neoplasm (cancerous tumor) of lip, oral cavity and pharynx and mild cognitive impairment. R14's undated care plan, identified R9 had potential for alteration in nutrition and dehydration due to malignant neoplasm. Staff were to monitor the G-tube site for signs of infection and would provide enteral feeding and water flushes as ordered. R14's 10/1023, quarterly Minimum Data Set (MDS) identified R14 had a feeding tube. R14 would receive 51% or more of total calories and 501 milliliters (ml) a day or more of fluid intake through tube feeding. R14 had no cognitive impairment or behaviors. R14 was dependent for eating, toileting and cares. R14's 12/20/23, physician Order Summary Report identified R14 had a regular diet, with regular texture and regular (thin) consistency and would eat only at noon meals. R14 had enteral tube feeding via gravity (natural flow infusion) ordered for twice a day with 30 milliliters (ml) of water to be used for a flush and additional fluid before and after feeding twice daily, and 250 ml of a free water flush 1 x day for additional hydration. Observation and interview on 12/19/23 at 9:07 a.m., licensed practical nurse (LPN)-A washed	F 693	experienced no ill effects from this deficient practice. There are no other residents with gastrostomy tube feedings. Future residents will have their gastric feeding prepared, and tubing prepped per manufacturer instructions. Licensed nurses will be in-serviced on the Enteral Gravity Bag manufacturer instructions with emphasis on after priming the tube, replacing the cap until ready to use. Licensed nurses will also be in-serviced on the Enteral Feed Gravity policy with emphasis on pouring the liquid into the feeding bag, prime the tubing, then clamp. Director of Nursing and/or designee will be responsible for compliance. Audits on priming the gastric tubing, clamping and replacing the end cap to maintain sanitary during the feeding procedure will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 693	Continued From page 22 her hands, donned PPE (personal protection equipment) (gown and gloves, gathered R14's medications and feeding supplies before entering R14's room. R14 had enhanced barriers precautions, requiring staff to wear PPE when accessing her gtube. R14 was sitting her recliner watching television. LPN-A entered R14's room and placed clamped feeding bag and tubing up on the IV pole next to R14's recliner and her supplies on the R14's bedside table. R14's tubing had no cover on the port and was exposed. LPN-A washed her hands and donned gloves, grabbed a stethoscope, placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-A grabbed a syringe, attached it to R14's G-tube port without first sanitizing the uncovered port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of residual gastric fluid. LPN-A pushed 30 mLs of water through syringe into R14's G-tube. LPN-A asked R14 if she had any discomfort. R14 stated "no". LPN-A removed the syringe and placed the syringe tip to R14's port. LPN-A administered R14's levothyroxine in the piston syringe attached to the port, poured the medication into port closed the gtube port, drew up 30 mLs of water and pushed it through the piston syringe into R14's gtube. LPN-A removed the inner portion of the syringe and connected the feeding bag to R14's G-tube port. LPN-A unclamped the feeding bag releasing the enteral feed by gravity. LPN-A removed her gloves and her PPE, left the room and sanitized her hands. LPN-A was asked if she sanitized the feeding tube port before connecting it to R14's gtube. LPN-A stated she was not trained to sanitize it before connecting it and would implement the practice.	F 693		

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F 693	Continued From page 23 Observation and interview on 12/19/23 at 4:28 p.m., with LPN-F washed her hands, donned PPE and gloves, grabbed R14's piston syringe and water to the bedside table. R14 was sitting in recliner with television on. LPN-F grabbed the stethoscope and placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-F grabbed R14's syringe, attached it to R14's G-tube port without sanitizing the port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of gastric residual. LPN-F pushed 60 mLs of water through the syringe into R14's gtube. LPN-F separated the syringe, and poured Miralax (treat occasional constipation) medication through the syringe, mixed in water into R14's G-tube and closed the port. LPN-F then reconnected both syringe pieces and drew up 60 mLs of water and pushed it through R14's G-tube. R14's feeding bag port had been observed uncovered on the IV pole in the room. LPN-F connected the clamped feeding bag tube to the R14's G-tube. LPN-F then unclamped the feeding bag, releasing the enteral feed by gravity. LPN-F removed her gloves and her PPE, left the room and sanitized her hands. LPN-F was asked if she sanitized the feeding bag port before connecting it to R14's gtube. LPN-F stated she did not wipe the port before connected it to R14's gtube. Interview on 12/20/23 at 9:49 a.m., director of nursing DON-A identified her expectations would be for nurses to use clean technique when preparing or administering enteral feedings by sanitizing the port before connecting a syringe to lessen the chances of potential infection. Review of September 2021, Enteral Tube Feeding via Gravity Bag policy identified aseptic	F 693		

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F 693	Continued From page 24 (clean) technique would be used when preparing and administering enteral tube feedings. There was no mention staff should sanitize the port.	F 693		
F 695 SS=E	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 document review the facility failed to have a method to identify when oxygen tubing needed to be changed for 4 of 4 residents (R18, R25, R27, and R183). The policy also failed to include documentation of the frequency for oxygen equipment changes for residents receiving oxygen. Findings include: R27's 12/6/23, Significant Change Minimum Data Set (MDS) assessment, identified R27 had intact cognition, and had diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), and required oxygen therapy. R27's, required oxygen at 2 liters (L) / minute (Min) continuously via nasal cannula for hypoxemia (a low level of oxygen in the blood).	F 695	F 695 R 18, R 25, R 27, and R 183 oxygen tubing was changed and dated. In addition, R 18, R 25, R 27, and R 183 oxygen orders and care plans were reviewed and updated as needed. There were no ill effects experienced with this deficient practice. Future residents who utilize oxygen will have oxygen orders, oxygen tubing change orders and care plans created per facility policy. Licensed nurses were in-serviced on the Department of Respiratory Policy and Procedure with emphasis on item #7 the oxygen cannula and tubing must be changed every 7 days or as needed. Director of Nursing and/or designee will be responsible for compliance. Audits on oxygen orders, cannula changes and Oxygen care plans will begin weekly x 3 weeks then monthly to ensure	1/26/24

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F 695	Continued From page 25 Observation on 12/18/23 through 12/20/23 identified an oxygen concentrator with a nasal cannula attached to a long tubing going from the concentrator to R27. Neither the tubing or concentrator contained a date of when it had last been changed or replaced. Interview on 12/19/23 at 9:04 a.m. with R27 reported she always needed her oxygen on, and she did not know when staff had last changed the tube. Interview on 12/19/23 at 9:08 a.m. with nursing assistant (NA)-H reported R27 used her oxygen all the time. She reported nursing took care of changing the tubing and she was not aware of when it had last been changed. Interview and document review on 12/19/23 at 10:02 a.m. with licensed practical nurse (LPN)-A confirmed she was not able to find documentation of the frequency for oxygen tubing changes, nor when it had last been changed. LPN-A reported oxygen tubing was supposed to be changed weekly on Sunday, and a tag placed on the tubing with the date and initials. She confirmed there was no documentation in either the MAR or TAR that R27's tubing had been changed. 12/19/23 at 10:14 a.m., interview with DON confirmed her expectation for oxygen orders to be included in the care plan and upon review of R27's care plan confirmed it was not present. The DON confirmed the O2 tubing had not been dated when it was last changed, and it should have been changed weekly and dated with initials on the MAR/TAR.	F 695	sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 695	Continued From page 26 Review of the November 1, 2021, Med-Pass Oxygen Administration policy identified the purpose to provide safe oxygen administration. The facility was to verify there was an order for oxygen administration. The policy failed to identify the need to document the frequency of tubing changes, and application of a date and initial of when the tubing was last changed on either the tubing and/or medical record. R18's 12/20/23, admission MDS identified . R18's 9/26/23, quarterly Minimum Data Set (MDS) assessment identified R18 was dependent on staff for cares. R18 was short of breath when lying flat and had diagnosis of heart failure, chronic respiratory failure with hypoxia (lack of oxygen), and chronic obstructive pulmonary disease. R18's 7/27/23, care plan identified R18 used oxygen at 2 liters via nasal cannula to keep oxygen level above 90%. Observation and interview on 12/18/23 at 5:31 p.m., of R18's oxygen tubing identified oxygen tubing was dated 11/26/23. R18 reported the staff change the oxygen tubing each week.	F 695		

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F 695	Continued From page 27 Observation on 12/18/23, identified R183 had an oxygen concentrator with humidifying bubbler. The oxygen tubing and humidifier identified no date to indicate when it had last been changed. Observation on 12/19/23 at 10:15 a.m., R183's oxygen tubing and bubbler remained undated. R183's 12/12/23, admission Minimum Data Set (MDS) assessment identified she was dependent on staff for assistance with cares. R183 had shortness of breath or trouble breathing with exertion, while at rest and when lying flat. diagnosis of chronic obstructive pulmonary disease with acute exacerbation (COPD) and acute and chronic respiratory failure with hypercapnia (build up of carbon dioxide in your bloodstream). R183's administration orders identified she was receiving 2 liters of oxygen per nasal cannula at rest and 4 liters with activity to maintain oxygen saturations between 90%-92% for COPD. R183's orders lacked any indication staff were to change oxygen tubing or humidifier on a regular basis. Interview on 12/19/23, at 12:33 p.m., with LPN-B identified they normally put a nursing order in the administration record to change oxygen tubing and bubbler water weekly. She identified the tubing should have been dated. LPN-B looked at R183's orders and identified she was not able to find an order to change the tubing but stated "it should have been there".	F 695		

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F 695	Continued From page 28 R25's 9/22/23, quarterly Minimum Data Set (MDS) assessment, identified R25's Brief Interview for Mental Status (BIMS) had mild cognitive impairment and diagnosis of cerebral edema (swelling that occurs in the brain) and chronic obstructive pulmonary disease. The MDS failed to identify R25 used oxygen therapy. R25's November 2023, Medication Administration Record (MAR) identified oxygen (O2) as needed to maintain O2 saturation over 90% every shift titrated as needed. Oxygen tubing was to be changed on Saturdays. The MAR identified O2 tubing had last been replaced on 11/25/23. Observation on 12/18/23 at 3:41 p.m., of R25's tubing identified her tubing was labeled as last changed on 11/28/23.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		1/26/24

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F 725	Continued From page 29 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADLS) and timely response to call lights for 9 of 31 residents (R2, R8, R10, R13, R15, R23, R24, R25 and R28) with concerns for sufficient staffing. Findings include: Interview on 12/19/23 at 3:09 p.m., during a resident council meeting, R2, R10, R13, R23 and R24 expressed concerns for sufficient staffing especially at night and on the weekends when at times there were only two nursing assistants (NA)s on duty. They voiced agreement that call light wait times got really long and they had to wait up to an hour at times for someone to respond. R2, R13, R15 agreed with the above concerns however, never voiced specific incidents. During the meeting R10, R23, and R24 voiced specific examples of their sufficient staffing concerns as follows: 1) R10 reported she did not feel it was related to	F 725	F 725 Call-lights Social services created grievance form and met with R 2, R 8, R10, R 13, R 15 R 23, R 24, R 25, and R 28 regarding call light wait times and the facility resolution to have call lights answered per facility policy. Nursing will review the ADL care plan for toileting for R 2, R 8, R10, R 13, R 15 R 23, R 24, R 25, and R 28 and will update as needed. Facility staff will be in-serviced on the Answering the Call Light Policy with emphasis on the purpose of the policy is to ensure timely responses to the resident s requests and needs. Social Services and/or designee will be responsible for compliance. Audits on timely call light response and review of the call light log will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for	

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F 725	Continued From page 30 specific times of the day or night, but she had experienced accidents due to having to wait for staff to respond to her call light. She stated, "it was embarrassing" for her to have a staff member clean her up. She reported the nursing assistants (NA)s were often busy helping someone else, and other staff persons were not always willing to help when the aides were busy. R10's 11/15/23, annual Minimum Data Set (MDS) assessment identified her cognition was intact, and she required extensive assistance of one staff for ADLs and used a wheelchair for mobility. R10 had diagnosis of cerebral palsy, paraplegia and was occasionally incontinent of bladder and frequently incontinent of bowel. R10's current undated care plan identified she required extensive assistance from staff for all ADLs, needed assistance to transfer, sit up and lie down, required bilateral AFO (ankle-foot Orthoses) braces applied when she got up and off when she went to bed and used a wheelchair for mobility. 2) R24 reported the facility had a lot of new staff that were temporary, and they did not always know what to do, but she voiced she was concerned because she didn't feel she should have to direct them on how to provide care. R24's 10/29/23, Quarterly MDS assessment identified her cognition was intact and she was dependent on staff for ADLs due to physical limitations. R24 had diagnosis of functional quadriplegia, arthritis of multiple sites and was occasionally incontinent of bladder and always continent of bowel.	F 725	review and recommendation. Compliance: 1/26/2024 Staffing patterns The Facility Assessment was reviewed and updated to reflect facility staffing patterns for direct care staff are subject to change based on facility census and acuity. The facility assessment will also be updated to include that the daily staffing sheets will reflect the daily adjustments to direct care staff as the payroll system does not reflect these daily adjustments. The staffing coordinator, DON and HR director will be in-serviced on the Staffing, Sufficient and Competent Nursing policy with emphasis on item #6 that staffing will be determined by the needs of the residents, based on each resident s plan of care, the resident assessment, and the facility assessment. The Executive Director will be responsible for compliance. Audits on daily sufficient staffing will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 725	Continued From page 31 R24's current undated care plan identified she required limited to extensive assistance with ADLs, needed a walker with assistance or a wheelchair for mobility. She was at high risk for falls due to weakness and attempts to self transfer. Staff were to anticipate and meet her needs, ensure her call light was within reach, and respond promptly to all requests for assistance. 3) R23 reported her call light response was usually fifteen minutes to a half hour, but there had been times when it took a lot longer. R23 voiced there was never enough staff right away in the morning, but her care was provided, she just had to wait for staff. She also stated sometimes she waited to get her medication, but she was not able to give any specific instances. 4) Interview on 12/18/23 at 4:29 p.m., with R28 identified his usual wait for his call light to be answered was usually ten to fifteen minutes, but it was sometimes longer on weekends because there were not as many staff working. R28 verbalized he did not know the longest amount of time he had waited for a response to his call light, but he knew staff were busy and he was located at the end of the hall, so it took longer to get to him. Review of R28's October - December 2023, call light log identified wait times averaged 20 - 43 minutes and one incident of 52 minutes was noted at 8:05 a.m. on 12/1/23. R28's 9/18/23, Admission MDS assessment identified he had moderate cognitive impairment but was able to respond appropriately to interview questions. He required extensive assistance from staff for dressing, toileting, and transfers and had	F 725		

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F 725	Continued From page 32 diagnoses of problems with balance and gait disturbances, and bilateral leg and foot wounds which restricted R28's mobility. R28's current, undated care plan identified he required extensive assistance from 2 staff for ambulation of short distances, and extensive assistance of one staff for all ADLS. R28 was at high risk for falls do to balance and gait disturbances. Staff were to anticipate and meet his needs, ensure his call light was within reach, encourage him to use it, and respond promptly to all requests for assistance. 5) R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and other activities of daily living, in addition, R8 had impairment of bilateral lower extremities. R8 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility. Interview on 12/18/23, at 12:06 p.m., with R8 identified she had to wait a long time for her call light to be answered, she stated "30 minutes to an hour". R8 identified that she felt that wait time was too long. Review of R8's call light log identified the following: 12/1/2023, call light engaged at 3:50 p.m., call light was answered at 5:20 p.m.	F 725		

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F 725	Continued From page 33 12/2/2023, call light engaged at 6:43 a.m., call light was answered at 8:15 a.m. 12/2/2023, call light engaged at 8:38 a.m., call light was answered at 9:20 a.m. 12/2/2023, call light engaged at 12:55 p.m., call light was answered at 3:06 p.m. 12/2/2023, call light engaged at 5:50 p.m., call light was answered at 7:26 p.m. Interview on 12/20/23 at 1:51 p.m., with the administrator identified he was not comfortable with his understanding of how the call light log worked but would have expected staff to answer call lights within 10 minutes. He had not used the call light log to audit call light wait times, and to his knowlege the facility had not completed any call light training and was unaware of the long call light times during the above time period. Review of the undated facility policy "Answering the Call Light" identified staff should answer call lights promptly, turn off the call light, and complete the task requested within 5 minutes if possible. If staff were uncertain whether they could complete the task they were to notify the nurse manager. 6) Interview on 12/18/23 at 5:10 p.m., with R25 revealed she had to wait 15 to 30 minutes for staff response to the call light when needing assistance to the bathroom. R25 stated she didn't feel important when having to wait for assistance from staff. R25's 9/22/23, quarterly Minimum Data Set (MDS) identified R25 had mildly impaired	F 725		

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F 725	Continued From page 34 cognition. R25 had diagnosis of hemiplegia (total or complete paralysis on one side of the body). R25 was dependent on staff for toileting and cares. R25 had impairment bilaterally in lower extremities. R25 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel and took scheduled pain medication in the last 5 days. Interview and document review on 12/21/23 at 8:21 a.m., with the director of nursing (DON) identified her expectation for the staffing level in the facility was for it to be in accordance with the listed facility staffing pattern identified in the Facility Assessment noted above. Review of the reported staffing data report (PBJ) identified the DON agreed staffing had not been provided according to the Staffing Plan documented in the current Facility Assessment. Review of the October 2023, Facility Assessment identified the facility was to have the following nurse aides on duty each shift: 1.) Days-AM's 4 nursing assistants (NA)s 2.) PMS-4 NAs 3.) Nights-2-3 NAs Staffing was to be evaluated and adjusted by the DON, dietary manager, activity manager, housekeeping manager, and the administrator, along with the charge nurse's oversight for direct care (nurse aides). After classification and staffing requirements were completed, targets were to be established and variances managed by moving staff, or calling in potential relief staff (agency staff) or extra facility staff. Review of the documented staffing on weekends for the months of October and November 2023,	F 725		

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F 725	Continued From page 35 and 12/1/23 through 12/20/23 identified: 1.) 10/7/23 and 10/20/23 through 10/22/23, 1 NA was scheduled for night shifts. On 10/7/23 and 10/28/23, 3 NAs for PM shift. 2.) 11/11/23, staffing showed only 1 NA night shift. On 11/4/23, 11/5/23, and 11/26/23, there were only 3 NAs on PM shifts. 3.) 12/1/23, there were 3 NAs on PM shift Interview on 12/20/23 at 5:26 p.m., with the administrator identified he had not had time to review all the documents since he was new to the facility but he would expect the staffing plan noted in the Facility Assessment was to be followed. He reported he would be working to identify problems and develop processes for monitoring in upcoming Quality Assurance Process Improvement (QAPI) meetings.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		1/26/24

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F 758	Continued From page 36 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and identify target behaviors and non-pharmacological interventions for scheduled antidepressant and antipsychotic medication for 1 of 5 residents (R23) reviewed for unnecessary medication usage.	F 758	F 758 R 23 has since discharged from the facility. All current and future residents receiving antidepressants and/or antipsychotics their orders will be reviewed, the behavior module activated, a target behavior included in the order and the care plan with non-pharmacological	

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F 758	Continued From page 37 Findings include: R23's 11/30/23, significant change Minimum Data Set (MDS) assessment identified R23 had moderately impaired cognition. R23 had no behaviors identified. R23 had diagnosis of thyroid disorder, fracture, seizure disorder, depression, and manic depression bipolar type. R23 took a daily antidepressant and antipsychotic. R23's 9/11/23, care plan identified R23 used an antidepressant for depression. R23 would be free from discomfort or adverse reactions to antidepressant medication through the review date. Staff were to administer antidepressant medication as ordered by physician. Staff were to monitor and document side effects and effectiveness of medication every shift. The care plan identified side effects for antidepressant medication but lacked identification of target symptoms that were to be monitored for effectiveness. R23 used an antipsychotic medication for bipolar management. R23 would remain free of psychotropic medication complication, including movement disorder, discomfort, hypotension, gait disturbance, constipation, or cognitive impairment through the review date. Staff were to administer the psychotropic medication as ordered by the physician and monitor for side effects and effectiveness every shift. The care plan identified side effects for psychotropic medication however, had no mention of target behaviors to monitor for effectiveness. R23's 12/20/23, physician Order Summary identified the following medication orders: 1) Bupropion HCl ER (antidepressant) 150 milligrams (mg) every day (QD) in morning for	F 758	interventions initiated as needed. Licensed nursing and Social Services will be in-serviced on the Antipsychotic Medication Use policy with emphasis on item 9a that non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation. Social Services and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 758	Continued From page 38 depression. 2) Fluoxetine HCl (antidepressant) 20 mg QD in morning for major depressive disorder, severe with psychotic symptoms. 3) Fluoxetine HCl (antidepressant) 40 mg QD in morning for major depressive disorder, severe with psychotic symptoms. 4) Olanzapine (antipsychotic) 20 mg QD at bedtime for Bipolar. The order summary had no indication that the antidepressant nor the antipsychotic medication were being monitored for effectiveness or what the target symptoms were that the medications were ordered to treat. Interview on 12/20/23 at 3:49 p.m., with director of nursing (DON) identified her expectation was residents receiving psychoactive medication would have target behaviors identified for what the medication was being prescribed to treat. She also reported residents receiving psychoactive medication had non-pharmacological intervention in place. She agreed if there were no target behaviors identified it would be hard to assess if the medication was effective or not. She expected the facility policy for psychoactive medication use to be followed. Review of the 7/13/23, Antipsychotic Medication Use policy identified residents would only be prescribe antipsychotic medication to treat specific condition indicated. The provider would identify and document symptoms that may warrant the use of an antipsychotic medication. If a resident was admitted and was already receiving an antipsychotic medication the resident would be assessed for appropriateness and indications for use. Antipsychotic medications are ordered to treat specific condition and will be	F 758		

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F 758	Continued From page 39 used within the dosage guidelines. Medication monitoring for side effects and effectiveness including any intervention effectiveness, with any adverse consequences reported to the provider.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure expired foods were disposed of, ensure staff followed their process to log cooked food temperatures to ensure appropriate oversight of cooked foods, and monitor refrigerator and freezer temperatures as indicated per policy. The facility also failed to log the results of their chemical test strips and dishwasher per policy to ensure dishes were sanitized correctly. In addition, the facility failed to	F 812	F 812 All expired food items were removed from the kitchen. The freezer was cleared, cleaned, and restocked. The chemical test strips were obtained, and testing of the dishwasher has been initiated. Dry storage area tiles were replaced on 12/20/2023. A thorough cleaning of the dietary kitchen, refrigerators, freezers, and storage area was conducted on	1/26/24

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F 812	Continued From page 40 ensure the dry storage area was maintained in a clean, sanitary manner and in was in good repair. This had the potential to affect all 31 residents. Findings include: Observation on 12/18/23 at 11:20 during the initial kitchen tour with the dietary manager (DM) identified the following: 1. The walk in refrigerator had a container of potato salad with a use by date of November 2023 and a bag with sliced ham leftovers that was undated. 2. The 3 compartment sink was visibly dirty, with a black unknown substance and food particles scattered throughout the bottom of the sink. A tin can containing grease was sitting in the sink, and a bucket with dirty water and a scoop and serving spoon were observed lying in the bucket inside the sink. 3. A clip board was observed hanging in the dishwashing room with 1 logged entry for the 4th day of the month (December). No other logs were observed in the kitchen area. 4. The dry storage area had broken tiles on the floor around the storage rack. There were missing tiles along the wall beneath a rack, and an area of missing tile was observed with the underside surface exposed. The floor was visibly dirty with pieces of cardboard, a hairnet, a package of Graham crackers, a black and gray dirt-like substance, cobwebs hanging from the bottom rack extending to the floor, and a dirty dish rag was observed lying on the rack. Interview on 12/18/23 at 11:20, with the DM agreed during the initial kitchen tour identified she agreed with the above concerns and identified staff were to check for expired foods on	F 812	1/23/2024. From date of survey posting until present, the refrigerator and freezer temperatures were recorded, and the dish machine was tested utilizing approved dish machine chemical test strips. Resident documentation from survey exit until 12/26/2023 was reviewed and there were no ill effects experienced from this deficient practice. The Dietary Manager and dietary aides were in-serviced on the Food Storage Policy and will be assigned the Relias dietary course on Food Safety Fundamentals to ensure that the facility dietary department remains clean and to avoid residents from experiencing food borne illness. Facility administrator and Maintenance Director will complete monthly kitchen environmental rounds to ensure preventative maintenance. Dietary Manager and/or designee will be responsible for compliance. Audits on chemical test strip documentation, refrigerator/freezer temps, cleaning schedule creation and compliance will begin 2x week x 3 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

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F 812	Continued From page 41 Tuesdays. She noted there were no dishwasher logged temperatures to review to ensure dishes washed in the facility had been appropriately sanitized. Staff were also expected to log temperatures for refrigerator and freezers to ensure temperatures were within appropriate ranges, and log cooked food temperatures when removed from the oven. Staff were to log the results of the chemical test strips for the 3 compartment sink and dishwasher but revealed she had no logs for anything available for review for the current month or 4 months prior. The sinks were to be cleaned after each meal and the dry storage was to be swept daily and mopped weekly. Interview on 12/19/23 at 9:28 a.m., with Cook-(B) identified staff checked for expired food on Tuesdays. He had not worked the last Tuesday. He noted staff had no logs for refrigerator or freezer temperature checks or if staff had signed off they performed their weekly checks for expired foods, so he had no way to know if those tasks had been performed or were within acceptable ranges. He started employment about 6 months prior to survey at the facility. At that time, staff had lists of tasks to be performed and were to sign off they were completed and logs to monitor temperatures. He was unaware how long it had been since the logs and sign off sheets were no longer available for staff use. Interview on 12/19/23 at 1:00 p.m., with the maintenance director identified he was aware of the missing and broken tiles in the dry storage area. They were old asbestos tiles. It would be expensive to have them removed and new tiles installed and had been this way for a "long time". He stated he "may" be able to put new tiles over	F 812		

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F 812	Continued From page 42 the old tiles to ensure a smooth, cleanable surface vs replace the existing tiles that had been missing. Review of undated, facility provided policies for food handling, dish machine sanitization, and kitchen cleaning identified all areas were to be kept clean and sanitary. Foods were to be dated, left over foods were be used within 7 days or discarded, refrigerator and freezer temperatures were to be monitored 2 times each day and logged on a monthly tracking sheet, and the DM was to post a log near the dish machine for the staff to document temperatures and test strip results at each meal.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/26/24

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F 842	Continued From page 43 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 44 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure privacy of resident medical information for 1 of 2 facility medication carts which involved 10 of 31 residents (R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19). This had the potential to be viewed by any resident and visitor passing by on the C wing unit. Findings include: Observation on 12/18/23 at 4:54 p.m., of 1 of 2 facility medication cart located on the C wing unit, displayed personal and medical information of the following residents: R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19. The facility medication cart was left unattended with no staff personnel on the unit. Observation and interview on 12/18/23 at 4:59 p.m., with director of nursing (DON)-A stated her expectations would be for all residents information to be secured at all times. DON-A then closed the computer screen of the C wing medication cart. Interview on 12/20/23 at 10:01 a.m., with administrator (ADM-A) stated his expectations would be for the employees to keep residents' electronic medical records confidential and private when not in use. Review of December 2021, Confidentiality of	F 842	F 842 R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19 resident/resident representative was made aware of potential resident information breech during the annual survey. The resident/resident representative response will be recorded in the resident medical record. Licensed nurses and trained medication aides will be in-serviced on the Confidentiality of Information and Personal Privacy policy with emphasis on safeguarding the resident personal information and the EMR Hidden Screen Feature for both EMAR and POC. Director of Nursing and/or designee will be responsible for compliance. Audits on closed screens when users walk away from the electronic medical record system will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 842	Continued From page 45 Information and Personal Privacy policy indicated personal and medical records of residents would be protected and kept confidential.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 849		1/26/24

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F 849	Continued From page 46 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal	F 849		

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F 849	Continued From page 47 illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in	F 849		

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F 849	Continued From page 48 the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both	F 849		

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F 849	Continued From page 49 the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure coordinated hospice services were documented as scheduled for 1 of 1 resident (R27), have a clear communication process for hospice to notify the facility of their updates, for the facility to notify the hospice of changes to R27's health status, need of potential transfers for care, or delineation of hospice services to be provided. Findings include: R27's 12/6/23, Significant Change, Minimum Data Set (MDS) identified R27's diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), and received oxygen. R27's cognition was intact, and she required limited to extensive assistance for most cares and would attempt to self-transfer at times and required a gait belt, walker, and assistance of one for ambulation. R27's progress notes identified R27 was hospitalized on 11/28/23 through 12/1/23 following a fall when she attempted to self-transfer. She returned to the facility on 12/1/23 and was admitted to hospice. Interview on 12/18/23 at 2:02 p.m., with R27 reported she had started hospice after she came back from the hospital because she had lung cancer, and it was spreading. R27 was not	F 849	F 849 R 27 external facility list was updated to include hospice phone number and address. R 27 hospice order was also updated to include hospice company name. R 27 s hospice visit schedule will be faxed to the DON weekly and hospice visit schedule will be added to the resident electronic calendar and/or will be posted at the facility nurse s station. Facility Social Service Designee will contact hospice nurse to coordinate resident care conference schedule. The hospice aide and nurse schedule will be relayed to the R 27 weekly. All existing and future residents who receive hospice services will have their hospice orders created, external facility information updated to reflect the hospice organization name and number, the hospice care plan and interventions will be fully implemented, and the hospice plan of care and visit schedule will be shared with the resident/resident representative and facility nursing staff. The IDT team and nursing staff will be in-serviced on the Hospice Program with emphasis on providing a coordinated plan of care that is developed between the hospice organization and facility and will include resident/resident representative list of	

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F 849	Continued From page 50 certain when the hospice nurse or aide were supposed to come, but she thought it was weekly. R27 denied receiving a schedule or having knowledge of when hospice staff would be visiting or what services they would provide. Observation of R27 on 12/19/23 at 9:04 a.m., as she was lying in bed, was offered and refused breakfast and stated she wanted to sleep longer. R27 denied pain and shortness of breath and had her oxygen on via nasal cannula. Interview on 12/19/23 at 9:08 a.m., with nursing assistant (NA)-H reported she was aware R27 was on hospice, but she was not certain when hospice staff would visit. She reported she was not aware of a schedule of visits but thought there may be a book at the nurses desk that contained the information. Interview and document review on 12/19/23 at 9:29 a.m., with licensed practical nurse (LPN)-B reported there was a hospice book at the nurse's station that contained contact and schedule information. She reported she thought hospice staff documented their visits, but she was not certain where to find their documentation. LPN-B reported hospice staff did not have access to Point Click Care (PCC), and she thought a report was sent to the facility after each weekly visit. LPN-B retrieved the hospice book which contained a copy of a blank calendar for the months of December 2023 and January 2024 and reported she thought they were supposed to have written down the dates for visits. The calendar in the book was where she would expect to find the schedule of visits and since it had not been filled out, she was not certain when they would be visiting.	F 849	Director of Nursing and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 849	Continued From page 51 Interview on 12/19/23 at 10:02 a.m., with LPN-A reported Hospice had a book kept at the nursing station with the contact information and schedules for visits, but confirmed the current schedule for December 2023 and January 2024 were blank and she was not certain when they would be coming to the facility. Interview and review of R27's medical record on 12/19/23 at 10:14 a.m., with the director of nursing (DON) identified visits were to be marked on the calendars so staff would be aware of when hospice would come. There was no mention on R27's care plan of any hospice services to provide to delineate their provision of services. Interview on 12/19/23 at 2:25 p.m., with registered nurse (RN)-B (hospice) reported she was previously coming twice weekly but following discussion with R27 on 12/18/23, the decision was made to decrease visits to once weekly for the RN and twice weekly for the hospice aide. Hospice social services came to see residents 1-2 times a month or as needed, and all hospice visits should have been documented on the calendar. RN-B confirmed the calendar had not been completed as per policy to include dates of hospice staff visits. RN-B reported hospice documentation by both the nurse and aide was completed on a remote chart since hospice staff did not have access to the facility PCC. A verbal update was given to facility staff following a hospice visit and documentation was sent to the facility weekly after hospice documented care and findings in their records. RN-B confirmed there would normally be a physician order for use of a Foley catheter with direction for use. She agreed R27's care plan had not been updated to include	F 849		

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F 849	Continued From page 52 hospice information prior to notification on 12/19/23. Review of the May 5, 2021 Hospice Program policy identified a coordinated plan of care was to be developed between the facility, hospice agency and the resident/family.	F 849		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		1/26/24

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F 867	Continued From page 53 development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity	F 867		

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F 867	Continued From page 54 of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including	F 867		

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F 867	Continued From page 55 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement action plans for improvement, or ensure the committee participated in the development and oversight of implementation of systems, to ensure quality of life and quality of care were maintained for 31 of 31 residents residing in the facility. Findings include: Review of the QAPI meeting minutes from January 2023, February 2023, March 2023, April 2023, May 2023, June 2023, and November 2023. No QAPI meetings documented as taking place for July 2023, August 2023, September 2023, and October 2023. The minutes failed to identify facility specific concerns, action plans for improvement, and/or analysis of any actions taken previously. Interview on 12/20/23 at 5:26 p.m., with the administrator reported he was not certain how frequently QAPI meetings were held prior to his starting at the facility, but he did not find evidence of meetings for July through October 2023. He identified the facility needed to identify problems, develop plans for areas to monitor and develop a system for tracking and/or monitoring of processes put into place. He reported he was not aware of any Process Improvement Projects (PIP's) in place at the present time and the facility needed to develop systems for monitoring and	F 867	F 867 QAPI meeting will be held on January 23, 2024, to include a review of the November 2023 QAPI report and to record December 2023 QM, to establish facility current status, goals, quality measure percentages with discussion and action plan documented. From the action plan, these items will be discussed monthly per the facility QAPI policy. The IDT team will be in-serviced on the QAPI Policy with emphasis on conducting monthly meetings, attendance, identification of areas of improvement and to identify Performance Improvement Projects to enhance the resident experience and quality of life. Executive Director and/or designee will be responsible for compliance. Audits on monthly meeting attendance, QM action items and improvement percentages will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 867	Continued From page 56 identifying areas for improvement and include them in future meetings. Review of the December 5, 2019, QAPI policy identified the committee was to monitor and sustain performance in both clinical and non-clinical system by identifying and improving areas identified. Elements to demonstrate compliance with the guidelines included: 1.) Monthly meetings with documentation 2.) designated member attendance 3.) Pips developed and implemented for identified areas of improvement. 4.) Additional QAPI meetings as needed to address and improve critical areas in need of improvement between the monthly meetings. The QAPI Committee was to use a template to guide data collection and committee discussion. The template was to include review of systems related to care, management practices, clinical care, quality of life, resident choice, and any unique care, services or changes as identified.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/26/24

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F 880	Continued From page 57 §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 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 58 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, that facility failed to use appropriate infection control technique during 1 of 1 dressing change for resident (R28). In addition, the facility failed to ensure appropriate Infection control (IC) signage was posted outside 2 of 6 resident (R8, and R 103 x 2) rooms that had been placed on transmission-based precautions (TBP). Findings include: DRESSING CHANGE Observation and interview on 12/19/23 at 12:19 p.m., with licensed practical nurse (LPN)-A as she performed a dressing change on R28's right shin, and right and left foot wounds identified R28 was seated in his recliner with both feet wrapped and resting on the floor. LPN-A obtained a plastic carrier with dressing supplies, placed it on the uncovered floor, placed a chux on the floor and picked up the plastic carrier and set it on the chux. She then applied gloves and sat on the floor to begin removing the stockinet from R28's right shin. A quarter sized area of dried red drainage was noted on the stockinet which was	F 880	F 880 Dressing Change R 28 MD was notified that the resident dressing change during the facility survey was not completed properly. The MD response will be recorded in the resident electronic medical record. R 28 wounds were assessed and there were no ill effects experienced for this deficient practice. R 28 wound supplies were discarded and replaced. All current residents with wounds, their documentation was reviewed from survey exit until present and there were no ill effects experienced. Future residents with wounds will have their products placed on a clean surface and the appropriate glove and hand hygiene will be performed per facility policy. Facility nurses will be in-serviced on the Wound Care Policy with emphasis on establishing a clean surface, gloves are discarded, and hand-hygiene performed appropriately. All reusable supplies must be disinfected before storage.	

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F 880	Continued From page 59 removed and placed on the chux on the floor. LPN-A removed the dressing covering the wounds on R28's right shin, posterior calf, and covering 2nd toe of right foot and placed the used dressings on the chux. LPN-A retrieved bottle of VASHE solution (wound cleanser), and bottle of saline from the tray, and when asked stated it had been sent back with R28 from the wound clinic last week. LPN-A used the bottle of saline to pour onto the old dressing to loosen it and handled the bottle of saline and old dressing with her gloved hands. A moderate amount of serosanguinous drainage was noted on the dressing and once removed was placed on the chux on the floor beside the clean dressing supplies. LPN-A then returned the bottle of saline to the carrier and placed it inside without disinfecting the outside of the bottle in order to co-mingle supplies appropriately without contamination. LPN-A then removed her gloves and performed hand hygiene, applied new gloves, obtained the VASHE solution and applied it onto a sterile gauze pad. After applying the solution, LPN-A returned the contaminated bottle back into the carrier to be co-mingled with other supplies without first disinfecting the bottle to prevent potential contamination. LPN-A then retrieved betadine solution and placed that onto a sterile gauze pad and applied to the scabbed areas on R28's right toe and posterior shin areas. LPN-A removed her contaminated gloves and placed them on the clean barrier chux she had placed on the floor, performed hand hygiene and applied new gloves. LPN-A then retrieved moisturizing lotion, applied it, and returned it to the bin with the contaminated items. Further observation on 12/19/23 at 12:42 p.m. with LPN-A as she changed the dressing on	F 880	Director of Nursing and/or designee will be responsible for compliance. Audits on wound care establishing a clean area, disposal of soiled items, proper glove use and hand hygiene 2x a week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024 Signage R 183 has since been removed from Droplet Precautions. There were no ill effects experienced for this incorrect door signage. As of this writing, there are no residents currently in transmission-based precautions. Future residents requiring transmission-based precautions will have the proper signage displayed per the facility policy. Nursing staff was in-serviced on the Transmission-Based Precautions policy with emphasis on the 3-types of precautions and when these precautions must be implemented. Director of Nursing and/or designee will be responsible for compliance. Audits on proper use of transmission-based precaution signage will begin MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for	

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F 880	Continued From page 60 R28's left foot identified the previously mentioned contaminated and soiled dressings and gloves remained on the chux barrier on the floor as she began the dressing change on the left foot. A trash can with a plastic liner was noted beside R28's nightstand and would have been within LPN-A's arms reach but was not used. LPN-A then removed R28's contaminated soiled dressings on his left foot. Without changing gloves or performing hand hygiene, LPN-A picked up the bottle of contaminated VASHE solution from the bin and applied the solution to a sterile gauze pad, contaminating the pad. She then applied the solution to the wound and dabbed the wound dry with the contaminated gauze pad. She then removed her gloves and performed hand hygiene and applied new gloves. LPN-A then cut a new abdominal (ABD) pad, placed it over the wound and taped it secure. She then replaced the stockinet to cover the wound area on the left foot. LPN-A removed her contaminated glove from her right hand and used that hand to open R28's nightstand drawer to obtain a pair of clean gripper socks without removing both gloves and performing hand hygiene. She reached into the drawer and handled the socks and other miscellaneous items with both her ungloved and soiled gloved hand contaminating the socks and any items within that drawer. She then applied the gripper socks with her ungloved and contaminated gloved hand. LPN-A then removed the contaminated glove, placed it on the chux, and rolled up the chux barrier pad to cover the soiled dressings without performing hand hygiene. LPN-A then picked up the dressing supply bin and returned it to the top of the nightstand in R28's room. She then went to the bathroom to wash her hands. After washing her hands, LPN-A had not donned new gloves.	F 880	review and recommendation. Compliance: 1/26/2024	

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F 880	Continued From page 61 She then collected the contaminated chux barrier pad with her clean hands that contained the soiled, contaminated dressings, without donning gloves or a gown or placing those items in a plastic bag, and left R28's room. She disposed of the items in the soiled utility room and then performed hand hygiene. Interview on 12/19/23 at 12:50 p.m. with LPN-A reported she had used a barrier pad as not to placed the contaminated dressings or previously used items on the floor and was unaware she had contaminated her clean area. When asked about using the trash can, replied she "had not thought of that". When asked about the contamination of using her same gloved hand that had changed the dressing on R28's left foot to retrieve his clean socks, she stated she was unaware she had done that. LPN-A agreed she had not followed IC procedures for wound care, contaminated clean items, failed to disinfect containers of multi-use wound treatments, and sterile gauze etc. She was unaware she had cross contaminated R28's wounds with germs from not using proper IC technique. Interview on 12/20/23 at 4:30 p.m. with the director of nursing/infection preventionist (IP) reported her expectation for staff to follow IC protocols when completing dressing changes and voiced agreement with the above noted concerns. Review of the September 29, 2021, Wound Care Policy identified staff were to use a disposable item such as a chux to establish a clean surface for putting clean supplies on that were to be used during the procedure. Gloves were to be discarded and hand hygiene performed appropriately. Staff were to disinfect reusable	F 880		

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F 880	Continued From page 62 supplies and surfaces of bottles or containers with a disinfectant as needed. TBP Observation on 12/20/23 at 3:59 p.m., of R183's room door had a new sign posted that read "Enhanced barrier. Wear gloves and gown for high contact activities". R183's 12/20/23 progress note identified at 11:31 a.m., R183 had tested positive for COVID-19. R183's room door had been shut and the DON and staff on duty had been notified. Additional note at 2:30 p.m., identified R183 had all services provided in R183's room until they would be off isolation. R183's physician and family had been notified of the positive test result. Interview and observation on 12/20/23 at 4:02 p.m., with director of nursing (DON) identified R183 had new diagnosis of COVID-19 and had been placed on precautions. The DON was unsure who was responsible to set up the personnel protective equipment (PPE) and post the signage. The DON confirmed the wrong sign had been placed on R183's door that identified "Enhanced barrier precautions" The DON then placed a sign on the door that identified "Contact precautions. Everyone must wash hands before and after, and use a glove, gown, mask, and face shield". Additionally, a sign that identified how to don and doff PPE, and a stop sign was placed on the door to "See nurse before visiting resident". Next to the door was a cart with PPE supplies which also included N95 masks and face shields. Interview and observation on 12/21/23 at 8:56 a.m., with licensed practical nurse (LPN)-C who	F 880		

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F 880	Continued From page 63 reported the facility had multiple precaution signs that they used depending on what type of precaution a resident was on. She confirmed and displayed a stack of precaution signs located at the nurse's station on the 300 wing. The signs observed included enhanced precautions, contact precaution, droplet precautions, and airborne precautions. LPN-C confirmed that residents who have tested positive with COVID-19 were to have droplet precautions put into place. Interview and observation on 12/21/23 at 9:03 a.m., with DON identified she had signage for droplet precautions and airborne precautions. She was unaware she had posted the incorrect "Contact precaution" sign on R183's room door. The DON confirmed a resident positive with COVID-19 should be placed on "Droplet" or "Airborne" precautions. The DON then obtained both a sign for "Droplet precautions" and "Airborne precautions" and posted both signs on R183's room door. Review of October 2021, Isolation Categories of Transmission-Based and Enhanced Precautions policy identified standard precaution are used during times of resident cares, transmission-based precautions include 3 types: 1) Contact, 2) Droplet, 3) Airborne. Use was to be determined by the specific pathogen and how it was spread. Staff were to place the appropriate notification on the room door when a resident was placed on TBP. Contact precautions were implemented when a resident was suspected or was known to be infected with an microorganism that was transmittable via direct contact. Droplet	F 880		

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F 880	Continued From page 64 precautions were to be implemented when a resident has been suspected or confirmed to be infected with an microorganism that can be transmitted by droplets such as sneezing, coughing, or suctioning. Airborne precautions are implemented when a resident has been infected with an pathogen that can be transmitted long distance through the air. Enhanced precautions would only be implemented to protect from exposures to anticipated blood or body fluids.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		1/26/24

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F 883	Continued From page 65 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 2 of 5 residents (R8, R9) reviewed for immunizations. Furthermore, the facility failed to have a method or system to ensure the facility offer or provided any initial or updated vaccine to residents per Centers for Disease Control (CDC) vaccination	F 883	F 883 R 8 and R 9 will be offered the pneumonia vaccine on 1/17/2024. Upon consent, these vaccines will be ordered and administered per physician order. All existing residents will have their pneumonia vaccine information reviewed, the vaccine offered and administered as needed. Future residents will have a vaccine consent completed during the	

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F 883	Continued From page 66 recommendations. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at any age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine.	F 883	admission agreement, indicated on the nurse admission assessment and the infection preventionist will review documentation to determine residents acceptance or refusal of vaccines and this information will be recorded in the resident electronic medical record. Facility nurses and admission coordinator will be in-serviced on the Pneumococcal Vaccine Policy with emphasis of offering the vaccine, assess the resident for eligibility and administer vaccine per MD order. Director of Nursing and/or designee will be responsible for compliance. Audits on resident consent, administration and recording results in the resident electronic medical record will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 883	Continued From page 67 R8's 10/21/23, annual Minimum Data Set (MDS) assessment identified R8 was 87 years old and had diagnoses of Heart failure and hypertension, anxiety, and depression. R8's immunization record identified R8 had received the pneumococcal polysaccharide vaccine (PPSV-23) on 5/16/95 and had received the pneumococcal conjugated vaccine (PCV-13) on 6/28/18. R8's medical record did not include evidence R8 or R8's representative received education regarding pneumococcal vaccine booster, the physician notified, or indication R8 was offered the PCV-20 at least 5 years after prior pneumococcal vaccine per CDC guidance. R9's 11/9/23, quarterly Minimum Data Set (MDS) assessment identified R9 was 67 years old and had diagnoses of hypertension, stroke, and peripheral vascular disease. R9's immunization record identified R9 had received pneumococcal polysaccharide vaccine (PPSV-23) on 8/14/17 (approximately at 60 years of age). R9's medical record did not include evidence R9 or R9's representative received education regarding pneumococcal vaccine booster and there was no indication R9 was offered PCV-20 at least 1 year after prior PPSV-23 or a PCV-15 at least 1 year after prior PPSV-23 per CDC guidance. Interview on 12/20/23 at 3:49 p.m., with the director of nursing (DON) identified that neither resident had been offered updated vaccination and should have been. The DON revealed the facility had no method after admission to ensure vaccines were offered to residents when eligible.	F 883		

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F 883	Continued From page 68 Review of undated, Pneumococcal Vaccine policy identified residents would be offered pneumococcal vaccines to prevent pneumonia. Upon admission residents would be assessed for eligibility to receive the pneumococcal vaccine series and when indicated would be offered unless medically contraindicated. Pneumococcal vaccines would be made in accordance with current CDC recommendations.	F 883		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 1 agency staff (nursing assistant (NA)-G) was oriented to the facility policies and procedures including Abuse, Neglect, Exploitation or Misappropriation, Reporting, and Investigating. Findings include: Interview on 12/19/23 at 10:31 a.m., with NA-G revealed he had worked with R8 on 12/18/23 and confirmed R8 had accused him of being rough when he turned her on her side. NA-G revealed	F 940	F 940 Agency employee NA-G received training on the facility policy and procedures on abuse, neglect, misappropriation, reporting and investigating policy on 1/19/2024. Future agency staff will be in-serviced on the facility policy location, abuse policy and will be provided a checklist of items and materials that have been reviewed. This incident noted during the survey was reported to the state agency per facility policy. The facility Staffing coordinator will be	1/26/24

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F 940	Continued From page 69 the nurse had come and talked to him about R8 accusing him of being rough. NA-G reported R8 was in a "bad mood" and was cursing at him while he assisted her to turn on her side. NA-G revealed he had not told anyone that R8 had accused him of being rough during cares as R8 was fine after he had changed her incontinent product and even had him assist her to call her husband. Review of NA-G training records obtained from the agency NA-G was employed by included a copy of an employee handbook and policies that covered the NA job description, resident abuse, neglect, and reporting. NA-G had a signature that was time stamped at 3:26 p.m. on 12/19/23, after this surveyor requested NA-G training records. Interview on 12/20/23 at 9:24 a.m., with trained medication assistant (TMA)-A who was also the staffing coordinator, identified NA-G was an agency staff. When agency staff start at the facility, they usually come an hour or two before their shift starts to get orientated to the floor. As the staffing coordinator, she was unaware of any other type of orientation that was required such as being oriented to facility policies. TMA-A reported there was no documentation that NA-G had been orientated to the facility specific policies prior to working his first scheduled shift. TMA-A was unsure if NA-G was aware of who he should report concerns to especially if a resident accused staff of potential abuse or rough care, but would assume that the agency staff "would know" to report to the charge nurse. Interview on 12/20/23 at 11:38 a.m., with director of nursing (DON) revealed the facility had no orientation on policies and procedures for	F 940	in-serviced on the General Orientation Process for agency staff that includes a review of facility policy on abuse, reporting and investigation along with acknowledgement. Director of Nursing and/or designee will be responsible for compliance. Audits on general orientation for agency staff with acknowledgement sheet completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 940	Continued From page 70 contractual staff including NA-G. She reported the only training she could provide for NA-G regarding abuse and reporting was the training that NA-G received through his agency. Review of October 2023, Facility Assessment identified all new staff are required to have onboarding videos in Healthcare Academy and in Relias. All new hires will also have competencies related to their job description and for any sort of special care needs for facility residents. There was no mention of training or orientation for contractual staff providing services being oriented to facility specific policies. Review of 11/23/22, Orientation Program for Newly Hired Employees, Transfers, Volunteers identified those staff providing services under contractual arrangements shall be orientated to the facility policies. The orientation program included tour of facility, description of the resident population, instructions in an emergency, resident care procedures, and introduction to administrative structure. The policy identified contractual staff would receive general orientation and an in-depth review of the facility's policies and protocols that would be documented on a check list form identifying what materials had been reviewed.	F 940		
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		1/26/24

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F 944	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide mandatory training on the facility's Quality Assurance Program Improvement (QAPI) Program that included facility specific goals, elements of the program, how the facility intended to implement the program, in addition to the staff's role in the facility QAPI program. The facility also failed to provide education on how staff could communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. In addition, the current December 5, 2019, facility policy failed to identify the mandatory component of providing staff education on the facility specific QAPI program. Findings include: Interview on 12/20/23 at 9:38 a.m., with trained medication aide (TMA)-B reported she had been employed at the facility for 4 years and reported she had not received any QAPI training or recalled any facility specific programs, such as a performance improvement project (PIP). Interview on 12/20/23 at 9:42 a.m., with licensed practical nurse (LPN)-A reported she was aware the facility had a QAPI program but was not aware of any current PIP that might be in place. LPN-A identified she had not received any education on a facility specific program and reported she was not aware of any education being provided on the facility's QAPI program to either the facility employed staff or the temporary staff. Interview on 12/20/23 at 9:56 a.m., with the social services designee (SSD) reported she was aware	F 944	F 944 TMA-B will receive in-service education on the facility QAPI program, policy, and PIP process. All current and future staff will receive in-service education on the QAPI program and PIP process upon hire per facility policy. Facility employees were educated on the QAPI process with emphasis on the staff role and how to participate in performance improvement projects. In addition, the facility will post QAPI meeting date/times for all facility staff to view and participate. Director of Nursing and/or designee will be responsible for compliance. Audits on employee QAPI mandatory education in-service training compliance will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 944	Continued From page 72 of the QAPI program and was not aware of any education provided to staff on the facility specific program. She reported she was not aware of any current PIP or designated methods for staff to communicate ideas or suggestions. Interview on 12/20/23 at 5:26 p.m., with the administrator identified the facility needed to identify problems, develop plans for areas to monitor and develop a system for tracking and/or monitoring of processes put into place. He was not aware of any PIP in place at the present time. He agreed the facility needed to develop systems for monitoring and identifying areas for improvement and include them in future meetings. The administrator identified he was not aware of education provided to staff on the QAPI program, or methods to communicate suggestions. Interview on 12/21/23 at 8:28 a.m., with the director of nursing reported the facility had one QAPI meeting since she started in September 2023. The DON reported the facility had department meetings in the morning 5 days/week and concerns were identified and discussed at that time. She was not aware of a formalized process for staff input concerns, ideas, or commentary to the QAPI team. There was no facility specific QAPI education provided to staff that she was aware of. Review of the December 5, 2019, QAPI policy identified the committee was to monitor and sustain performance in both clinical and non-clinical system by identifying and improving areas identified. Elements to demonstrate compliance with the guidelines included: 1.) Monthly meetings with documentation	F 944		

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F 944	Continued From page 73 2.) Designated member attendance 3.) Pips developed and implemented for identified areas of improvement. 4.) Additional QAPI meetings as needed to address and improve critical areas in need of improvement between the monthly meetings. The QAPI Committee was to use a template to guide data collection and committee discussion. The template was to include review of systems related to care, management practices, clinical care, quality of life, resident choice, and any unique care, services or changes as identified. The policy failed to identify the facility needed to provide mandatory training on the facilities QAPI program, have a PIP, or educate staff on those specifics.	F 944		

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E 000	Initial Comments On 12/18/23 through 12/21/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		2/1/24

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

Electronically Signed | 01/20/2024

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

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community based excercise, a facility based excercise or a facility drill to test their emergency preparedness (EP) program at least twice per year. This had the potential to affect all 31 residents who currently resided in the facility, along with staff who work in the facility. Findings include: Interview and review of the EP plan and policy on 12/21/23 at 4:00 p.m., with the administrator identified they had not completed or planned a full-scale exercise or table top exercise to test their emergency plan. The administrator agreed the facility had not followed the EP plan or policy.	E 039	E 039 The facility will have a table-top exercise on 2/1/2024. The live drill will take place in tentatively scheduled for May 1, 2024. There were no ill effects experienced by this deficient practice. Future drills and tabletop exercises will be conducted per facility policy. The Maintenance Director will be in-serviced on the Disaster Training Policy with emphasis on item #4 that training exercises are conducted bi-annually to test the emergency plan. Executive Director and/or designee will be responsible for compliance. Audits on completion of the required table-top exercise, employee attendance and mock drill scheduling will begin monthly x3 months then yearly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 10 On 12/18/23 through 12/21/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55965530C (MN92569), H55967817C(MN97909), H55967820C (MN94418), H55967958C (MN96983), and H55967821C (MN97725). The following complaints were reviewed H55968190C (MN99372) with a deficiency cited at F609 and F940. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		1/26/24

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F 609	Continued From page 11 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of potential abuse timely to the facility management staff and the State Agency for 1 of 1 resident (R8) reviewed. Findings include: R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and cares. R8 had impairment bilaterally in her lower extremities. R8 had inattention and disorganized thinking that fluctuated. R8 had verbal behaviors directed towards others 1-3 days and other behaviors not directed towards others such as screaming, 1-3 days. R8 had no toileting program	F 609	F 609 R 8 will have a risk management incident created, a root cause identified, and care plan was updated to include resident preferences and bed mobility assistance. All other residents who require 2 persons assistance with bed mobility, their care plans were reviewed and updated as needed. Future residents who require extensive assistance with bed mobility, will be reviewed for 1- or 2-person assistance upon admission and as needed. Facility staff will be in-serviced on the Abuse, Neglect, and Investigation policy with emphasis on reporting abuse immediately to the administrator and/or	

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F 609	Continued From page 12 and was frequently incontinent of bladder and always incontinent of bowel. R8 took a daily anti-psychotic, anti-anxiety, and anti-depressant. R8's 11/30/23, Significant Change MDS assessment identified R8 had severe cognitive deficit. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility and was able to assist with turning by using the grab bars on the bed. Behavioral focused area last revised 9/7/22, identified R8 was found to be verbally aggressive. She yelled out to staff to come to her room. She was to ask staff to come back to her room right after they stepped out even after they asked if there was anything else she needed. R8 was socially inappropriate and was known to undress, bang on the walls, threaten staff, call the facility, and making false accusations against staff. There was no mention what staff were to do if R8 made accusations against them. Interview on 12/18/23 at 12:06 p.m., with R8 identified a "guy" had helped her earlier today and shook her when he rolled her on her side. R8 reported she told the "guy" she was going to report him, and he responded he did not care. R8 stated she told the nurse about him. Interview on 12/18/23 at 5:21 p.m., with licensed practical nurse (LPN)-D identified R8 reported to her a "guy" was rough when rolling her. LPN-D reported she was unaware of who the male staff was and then reported that R8 was sometimes confused. LPN-D said R8's anxiety was high today. LPN-D reported that R8 will report staff so someone goes into talk to her. LPN-D said there	F 609	director of nursing on all allegation of abuse immediately within 2 hours of an allegation. Social Services and/or designee will be responsible for compliance. Audits on reporting abuse timely will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 609	Continued From page 13 were 2 male staff on duty, and she checked to see who had assisted R8 however, everyone on duty had been in to assist R8 during the shift. LPN-D said if there were concerns, she would report them to the director of nursing (DON), but it depended on the circumstance, as sometimes R8 got upset with staff if they did not come fast enough when she wanted help. Today R8 was upset because the "guy" (nurse aide (NA-G), a contracted staff) left the room after R8 was placed on the bedpan and R8 wanted him to stay there. LPN-D revealed R8 liked to report staff for things when things did not "go exactly" as she wanted. LPN-D confirmed she had checked with NA-G and he said he left her room to give her privacy and had visited with R8. LPN-D revealed that R8 had reported her concerns to her around noon-ish that day. LPN-D would not answer if she had reported the allegation of abuse to the DON at that time. Additional interview on 12/18/23 at 5:43 p.m., with LPN-D identified she had followed up again with R8 who advised her she had not wanted to make a "complaint" against NA-G. She then reported the allegation to the DON and thought the DON had went in to talk with R8. She also revealed the social service designee (SSD) had been in to talk to R8 during the day due to R8's anxiety. She was unaware if the SSD had knowledge of the incident. Interview on 12/19/23 at 8:35 a.m., with LPN-B who identified if R8 made a report about a staff member, licensed staff were to make sure R8 was ok and interview the resident to determine as much information about the incident as possible, then interview the staff in question and call the DON for direction before letting the staff proceed	F 609		

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F 609	Continued From page 14	F 609		

with work. LPN-B reported that R8 was known to threaten to "report staff" sometimes but not frequently. She reported R8 yelled out for help a lot.

Interview on 12/19/23 at 10:10 a.m., with R8 identified a guy had rolled her onto her side and shook her. R8 said she told the nurse and the nurse visited with her and then the head nurse came in and visited with her. She later said there was also a girl in with the guy that shook her and stated she will lie for him. R8 then reported she only spoke to the nurse that was helping her and that no one else talked to her yesterday. She confirmed the guy had not been back to assist her as she had told him he could not come back. She reported when he shook her it made her feel like a "pig" and when she was asked if she was afraid of this person she stated, "yes wouldn't you be".

Interview on 12/19/23 at 10:31 a.m., with nursing assistant (NA)-G identified that R8's mood depended on the day and some days R8 was angry and cursed at staff and complained and other days she was fine. NA-G confirmed he was the staff that had assisted R8 yesterday and R8 accused him of being rough when he turned her on her side. NA-G reported he was the only staff member in the room at the time. He reported R8 was mad and cursing saying "this is bullshit" as he assisted her to change her brief. He reported after assisting her with her brief she was fine and asked him to help her call her husband. NA-G reported R8 will call her husband if she feels staff are not helping her fast enough or doing a good enough job. NA-G said yesterday was the first time R8 had complained about how he assisted her, and he had assisted her many times. NA-G

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F 609	Continued From page 15 confirmed that the nurse did speak to him yesterday and asked what had happened and he reported all he had done was turn her on her side to change her brief. Interview on 12/19/23 at 10:45 a.m., with the DON identified she was unaware of any accusation of staff being rough with R8 yesterday. She reported she was in the building into the evening and had no knowledge of an accusation of staff being rough. She revealed the nurse on duty should have interviewed R8 and informed her immediately so she could interview the staff and other residents. The DON noted R8's care plan identified she had previously made false accusations against staff however, that had not meant staff would not report allegations of potential abuse and facility management would investigate all allegations. Interview of 12/20/23 at 11:30 a.m. with the SSD identified she was unaware of the allegation of potential abuse with rough care. R8 never mentioned that when she spoke with R8 on 12/18/23. Review of 10/21/22, Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy identified all reports of abuse would be reported to the state agency and thoroughly investigated by facility management. All reports of abuse must be reported immediately to the administrator and to other officials according to state laws. The administrator will make report to state official immediately within 2 hours of an allegation involving abuse or result in serious bodily injury. Upon receiving an allegation of abuse the administrator was responsible for determining what actions (if any) are needed for	F 609		

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F 609	Continued From page 16 the protection of the residents. All reports would be thoroughly investigated. Employees who have been accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. A follow up 5-day report of the investigation with sufficient information to describe the results of the investigation and any corrective action taken if allegation was verified.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status and needs for 1 of 1 resident (R9) for depression. Findings include: R9's undated, current care plan identified R9 would be free from discomfort or adverse reactions to antidepressant medication through the review date. Staff were to administer antidepressant medication as ordered by physician. Staff were to monitor and document side effects and effectiveness of medication every shift and report adverse reactions of medications and consult Southwest Mental Health for services. The care plan identified side effects for antidepressant medication but lacked identification of target symptoms that were to be monitored for effectiveness.	F 641	F 641 R 9 antidepressant and antipsychotic medication orders was updated to include resident target behavior, the behavior module activated, the care plan updated to reflect resident target behavior for use of antidepressant or antipsychotic medication, the diagnosis listed updated and appropriate interventions initiated. R 9 s MDS diagnosis list will include major depression for the next quarterly assessment. All existing and future residents will have their medications, diagnosis and care plan include the target behavior and interventions initiated. The MDS coordinator will be in-serviced on the RAI Manual Section I pages 7-11 which the IDT team will review the resident diagnosis list and physician documented diagnosis in the last 60 days that have a direct relationship with the	1/26/24

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F 641	Continued From page 17 R9's 10/02/23 Southwestern Mental Health Center Standard Diagnostic Assessment identified R9 had a depression disorder. R9's 11/09/23, quarterly Minimum Data Set (MDS) assessment identified R9 had no cognitive impairment. R9 had little interest in doing things, feeling down, depressed, or hopeless, trouble concentrating on things, and feeling tired or having little energy for 12 to 14 days. R9 took a daily antidepressant and antipsychotic. R9 had a diagnosis of anxiety but did not indicate a diagnosis of depression. R9 had cerebral infarct of right middle cerebral artery (stroke occurs when blood flow from the main carotid artery of the brain suddenly stops), peripheral vascular disease, nicotine dependence, and anxiety. R9's 12/21/23, physician Order Summary Report identified the following medication orders: 1) mirtazapine 15 milligrams (mg) at night for depression 2) risperidone (used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder) 1 mg at night for depression disorder 3) clonidine 0.1 mg three times a day for anxiety and depression The physician Order summary had no indication of target symptoms ordered to treat with use of the antidepressants. Interview on 12/20/23 at 5:13 p.m., with registered nurse (RN)-A stated R9's depression diagnosis was not listed on his current medical record or in the MDS. Interview on 12/21/23 at 9:02 a.m., with DON-A	F 641	resident s functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look-back period. Social Services and/or designee will be responsible for compliance. Audits on physician diagnosis list matching the resident electronic diagnosis list and this information correctly submitted into the MDS will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 641	Continued From page 18 stated R9's depression diagnosis wasn't identified and had no behavior monitoring in place for R9's depression. A policy was requested but none provided by the end of the survey.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have an integrated hospice care plan for 1 of 1 resident (R27). Findings include: R27's 12/6/23, Significant Change Minimum Data Set (MDS) assessment, identified diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), required oxygen therapy and was admitted to hospice care. R27's current, undated care plan identified there was no mention R27 was on hospice services, what services the facility was to provide, nor services the hospice agency was to provide.	F 684	F 684 R 27 will have a thorough care plan review, the hospice care plan updated with all hospice interventions initiated including hospice staff visits and services that will be provided. R 27 hospice company plan of care will also be uploaded into the resident electronic medical record. All existing and future hospice residents will have an integrated care plan initiated with a listing of hospice services being provided per facility policy. Social services along with the DON and ADON will be in-serviced on the Hospice Program policy with emphasis on item #13 that a coordinated care plan will be initiated. Social Services and/or designee will be	1/26/24

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F 684	Continued From page 19 Interview and document review on 12/19/23 at 10:02 a.m., with LPN-A identified R27's care plan failed to contain documentation of any hospice services, R27's oxygen use, or use of a Foley catheter which should have been documented and included ont he facility care plan. LPN-A agreed it was not documented on what services hospice was to provide. Interview on 12/19/23, at 10:14 a.m., with the director of nursing (DON) confirmed her expectation for coordination of services between hospice providers and the facility. She confirmed the information on hospice and facility provided services had not been included in R27's current care plan. Interview and document review on 12/19/23 at 2:25 p.m., with the hospice registered nurse (RN)-B reported she had previously visited R27 weekly, but following a discussion on the evening of 12/18/23 the decision was made to decrease visits to once weekly for RN and twice for NA services. The social services provider was scheduled to visit 1-2 times a month and as needed. RN-B identified a blue binder, located at the nursing station contained a calendar with scheduled hospice staff visit dates. Review of the calendars for December 2023 and January 2024 with RN-B confirmed they were blank and had not been competed as per policy. RN-B confirmed the care plan for R27 had not been updated as per policy until 12/19/23 and facility and hospice staff should have coordinated services to be provided and documented those services provided by each entity in the facility care plan. Review of the May 5, 2021, Hospice Program policy identified a coordinated plan of care was to	F 684	responsible for compliance. Audits on facility hospice care plan interventions completed with hospice service visits and hospice services along with completion of hospice company visit schedule completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 684	Continued From page 20 be developed between the facility, hospice agency and the resident/family. The plan of care was to include hospice staff schedules, pain and/or comfort management plans, and be revised or updated as indicated.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff sanitized a gastronomy tube (G-tube) port prior to initializing enteral feeding (nutrition provided thru a tube directly into the stomach) for 1 of 1 resident (R14) during 2 of 2 observations.	F 693	F 693 R 14 MD was contacted and notified that the proper technique for gastric tube procedure was completed incorrectly. The MD response will be recorded in the resident electronic medical record. R 14	1/26/24

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F 693	Continued From page 21 Findings include: R14's undated, current Medical Diagnosis identified diverticulitis (small bulging pouches in the digestive tract that become inflamed or infected) of intestine, disease of digestive system, neutropenia (abnormally low count of a type of white blood cell), malignant neoplasm (cancerous tumor) of lip, oral cavity and pharynx and mild cognitive impairment. R14's undated care plan, identified R9 had potential for alteration in nutrition and dehydration due to malignant neoplasm. Staff were to monitor the G-tube site for signs of infection and would provide enteral feeding and water flushes as ordered. R14's 10/1023, quarterly Minimum Data Set (MDS) identified R14 had a feeding tube. R14 would receive 51% or more of total calories and 501 milliliters (ml) a day or more of fluid intake through tube feeding. R14 had no cognitive impairment or behaviors. R14 was dependent for eating, toileting and cares. R14's 12/20/23, physician Order Summary Report identified R14 had a regular diet, with regular texture and regular (thin) consistency and would eat only at noon meals. R14 had enteral tube feeding via gravity (natural flow infusion) ordered for twice a day with 30 milliliters (ml) of water to be used for a flush and additional fluid before and after feeding twice daily, and 250 ml of a free water flush 1 x day for additional hydration. Observation and interview on 12/19/23 at 9:07 a.m., licensed practical nurse (LPN)-A washed	F 693	experienced no ill effects from this deficient practice. There are no other residents with gastrostomy tube feedings. Future residents will have their gastric feeding prepared, and tubing prepped per manufacturer instructions. Licensed nurses will be in-serviced on the Enteral Gravity Bag manufacturer instructions with emphasis on after priming the tube, replacing the cap until ready to use. Licensed nurses will also be in-serviced on the Enteral Feed Gravity policy with emphasis on pouring the liquid into the feeding bag, prime the tubing, then clamp. Director of Nursing and/or designee will be responsible for compliance. Audits on priming the gastric tubing, clamping and replacing the end cap to maintain sanitary during the feeding procedure will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 693	Continued From page 22 her hands, donned PPE (personal protection equipment) (gown and gloves, gathered R14's medications and feeding supplies before entering R14's room. R14 had enhanced barriers precautions, requiring staff to wear PPE when accessing her gtube. R14 was sitting her recliner watching television. LPN-A entered R14's room and placed clamped feeding bag and tubing up on the IV pole next to R14's recliner and her supplies on the R14's bedside table. R14's tubing had no cover on the port and was exposed. LPN-A washed her hands and donned gloves, grabbed a stethoscope, placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-A grabbed a syringe, attached it to R14's G-tube port without first sanitizing the uncovered port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of residual gastric fluid. LPN-A pushed 30 mLs of water through syringe into R14's G-tube. LPN-A asked R14 if she had any discomfort. R14 stated "no". LPN-A removed the syringe and placed the syringe tip to R14's port. LPN-A administered R14's levothyroxine in the piston syringe attached to the port, poured the medication into port closed the gtube port, drew up 30 mLs of water and pushed it through the piston syringe into R14's gtube. LPN-A removed the inner portion of the syringe and connected the feeding bag to R14's G-tube port. LPN-A unclamped the feeding bag releasing the enteral feed by gravity. LPN-A removed her gloves and her PPE, left the room and sanitized her hands. LPN-A was asked if she sanitized the feeding tube port before connecting it to R14's gtube. LPN-A stated she was not trained to sanitize it before connecting it and would implement the practice.	F 693		

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F 693	Continued From page 23 Observation and interview on 12/19/23 at 4:28 p.m., with LPN-F washed her hands, donned PPE and gloves, grabbed R14's piston syringe and water to the bedside table. R14 was sitting in recliner with television on. LPN-F grabbed the stethoscope and placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-F grabbed R14's syringe, attached it to R14's G-tube port without sanitizing the port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of gastric residual. LPN-F pushed 60 mLs of water through the syringe into R14's gtube. LPN-F separated the syringe, and poured Miralax (treat occasional constipation) medication through the syringe, mixed in water into R14's G-tube and closed the port. LPN-F then reconnected both syringe pieces and drew up 60 mLs of water and pushed it through R14's G-tube. R14's feeding bag port had been observed uncovered on the IV pole in the room. LPN-F connected the clamped feeding bag tube to the R14's G-tube. LPN-F then unclamped the feeding bag, releasing the enteral feed by gravity. LPN-F removed her gloves and her PPE, left the room and sanitized her hands. LPN-F was asked if she sanitized the feeding bag port before connecting it to R14's gtube. LPN-F stated she did not wipe the port before connected it to R14's gtube. Interview on 12/20/23 at 9:49 a.m., director of nursing DON-A identified her expectations would be for nurses to use clean technique when preparing or administering enteral feedings by sanitizing the port before connecting a syringe to lessen the chances of potential infection. Review of September 2021, Enteral Tube Feeding via Gravity Bag policy identified aseptic	F 693		

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F 693	Continued From page 24 (clean) technique would be used when preparing and administering enteral tube feedings. There was no mention staff should sanitize the port.	F 693		
F 695 SS=E	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 document review the facility failed to have a method to identify when oxygen tubing needed to be changed for 4 of 4 residents (R18, R25, R27, and R183). The policy also failed to include documentation of the frequency for oxygen equipment changes for residents receiving oxygen. Findings include: R27's 12/6/23, Significant Change Minimum Data Set (MDS) assessment, identified R27 had intact cognition, and had diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), and required oxygen therapy. R27's, required oxygen at 2 liters (L) / minute (Min) continuously via nasal cannula for hypoxemia (a low level of oxygen in the blood).	F 695	F 695 R 18, R 25, R 27, and R 183 oxygen tubing was changed and dated. In addition, R 18, R 25, R 27, and R 183 oxygen orders and care plans were reviewed and updated as needed. There were no ill effects experienced with this deficient practice. Future residents who utilize oxygen will have oxygen orders, oxygen tubing change orders and care plans created per facility policy. Licensed nurses were in-serviced on the Department of Respiratory Policy and Procedure with emphasis on item #7 the oxygen cannula and tubing must be changed every 7 days or as needed. Director of Nursing and/or designee will be responsible for compliance. Audits on oxygen orders, cannula changes and Oxygen care plans will begin weekly x 3 weeks then monthly to ensure	1/26/24

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F 695	Continued From page 25 Observation on 12/18/23 through 12/20/23 identified an oxygen concentrator with a nasal cannula attached to a long tubing going from the concentrator to R27. Neither the tubing or concentrator contained a date of when it had last been changed or replaced. Interview on 12/19/23 at 9:04 a.m. with R27 reported she always needed her oxygen on, and she did not know when staff had last changed the tube. Interview on 12/19/23 at 9:08 a.m. with nursing assistant (NA)-H reported R27 used her oxygen all the time. She reported nursing took care of changing the tubing and she was not aware of when it had last been changed. Interview and document review on 12/19/23 at 10:02 a.m. with licensed practical nurse (LPN)-A confirmed she was not able to find documentation of the frequency for oxygen tubing changes, nor when it had last been changed. LPN-A reported oxygen tubing was supposed to be changed weekly on Sunday, and a tag placed on the tubing with the date and initials. She confirmed there was no documentation in either the MAR or TAR that R27's tubing had been changed. 12/19/23 at 10:14 a.m., interview with DON confirmed her expectation for oxygen orders to be included in the care plan and upon review of R27's care plan confirmed it was not present. The DON confirmed the O2 tubing had not been dated when it was last changed, and it should have been changed weekly and dated with initials on the MAR/TAR.	F 695	sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 695	Continued From page 26 Review of the November 1, 2021, Med-Pass Oxygen Administration policy identified the purpose to provide safe oxygen administration. The facility was to verify there was an order for oxygen administration. The policy failed to identify the need to document the frequency of tubing changes, and application of a date and initial of when the tubing was last changed on either the tubing and/or medical record. R18's 12/20/23, admission MDS identified . R18's 9/26/23, quarterly Minimum Data Set (MDS) assessment identified R18 was dependent on staff for cares. R18 was short of breath when lying flat and had diagnosis of heart failure, chronic respiratory failure with hypoxia (lack of oxygen), and chronic obstructive pulmonary disease. R18's 7/27/23, care plan identified R18 used oxygen at 2 liters via nasal cannula to keep oxygen level above 90%. Observation and interview on 12/18/23 at 5:31 p.m., of R18's oxygen tubing identified oxygen tubing was dated 11/26/23. R18 reported the staff change the oxygen tubing each week.	F 695		

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F 695	Continued From page 27 Observation on 12/18/23, identified R183 had an oxygen concentrator with humidifying bubbler. The oxygen tubing and humidifier identified no date to indicate when it had last been changed. Observation on 12/19/23 at 10:15 a.m., R183's oxygen tubing and bubbler remained undated. R183's 12/12/23, admission Minimum Data Set (MDS) assessment identified she was dependent on staff for assistance with cares. R183 had shortness of breath or trouble breathing with exertion, while at rest and when lying flat. diagnosis of chronic obstructive pulmonary disease with acute exacerbation (COPD) and acute and chronic respiratory failure with hypercapnia (build up of carbon dioxide in your bloodstream). R183's administration orders identified she was receiving 2 liters of oxygen per nasal cannula at rest and 4 liters with activity to maintain oxygen saturations between 90%-92% for COPD. R183's orders lacked any indication staff were to change oxygen tubing or humidifier on a regular basis. Interview on 12/19/23, at 12:33 p.m., with LPN-B identified they normally put a nursing order in the administration record to change oxygen tubing and bubbler water weekly. She identified the tubing should have been dated. LPN-B looked at R183's orders and identified she was not able to find an order to change the tubing but stated "it should have been there".	F 695		

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F 695	Continued From page 28 R25's 9/22/23, quarterly Minimum Data Set (MDS) assessment, identified R25's Brief Interview for Mental Status (BIMS) had mild cognitive impairment and diagnosis of cerebral edema (swelling that occurs in the brain) and chronic obstructive pulmonary disease. The MDS failed to identify R25 used oxygen therapy. R25's November 2023, Medication Administration Record (MAR) identified oxygen (O2) as needed to maintain O2 saturation over 90% every shift titrated as needed. Oxygen tubing was to be changed on Saturdays. The MAR identified O2 tubing had last been replaced on 11/25/23. Observation on 12/18/23 at 3:41 p.m., of R25's tubing identified her tubing was labeled as last changed on 11/28/23.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		1/26/24

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F 725	Continued From page 29 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADLS) and timely response to call lights for 9 of 31 residents (R2, R8, R10, R13, R15, R23, R24, R25 and R28) with concerns for sufficient staffing. Findings include: Interview on 12/19/23 at 3:09 p.m., during a resident council meeting, R2, R10, R13, R23 and R24 expressed concerns for sufficient staffing especially at night and on the weekends when at times there were only two nursing assistants (NA)s on duty. They voiced agreement that call light wait times got really long and they had to wait up to an hour at times for someone to respond. R2, R13, R15 agreed with the above concerns however, never voiced specific incidents. During the meeting R10, R23, and R24 voiced specific examples of their sufficient staffing concerns as follows: 1) R10 reported she did not feel it was related to	F 725	F 725 Call-lights Social services created grievance form and met with R 2, R 8, R10, R 13, R 15 R 23, R 24, R 25, and R 28 regarding call light wait times and the facility resolution to have call lights answered per facility policy. Nursing will review the ADL care plan for toileting for R 2, R 8, R10, R 13, R 15 R 23, R 24, R 25, and R 28 and will update as needed. Facility staff will be in-serviced on the Answering the Call Light Policy with emphasis on the purpose of the policy is to ensure timely responses to the resident s requests and needs. Social Services and/or designee will be responsible for compliance. Audits on timely call light response and review of the call light log will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for	

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F 725	Continued From page 30 specific times of the day or night, but she had experienced accidents due to having to wait for staff to respond to her call light. She stated, "it was embarrassing" for her to have a staff member clean her up. She reported the nursing assistants (NA)s were often busy helping someone else, and other staff persons were not always willing to help when the aides were busy. R10's 11/15/23, annual Minimum Data Set (MDS) assessment identified her cognition was intact, and she required extensive assistance of one staff for ADLs and used a wheelchair for mobility. R10 had diagnosis of cerebral palsy, paraplegia and was occasionally incontinent of bladder and frequently incontinent of bowel. R10's current undated care plan identified she required extensive assistance from staff for all ADLs, needed assistance to transfer, sit up and lie down, required bilateral AFO (ankle-foot Orthoses) braces applied when she got up and off when she went to bed and used a wheelchair for mobility. 2) R24 reported the facility had a lot of new staff that were temporary, and they did not always know what to do, but she voiced she was concerned because she didn't feel she should have to direct them on how to provide care. R24's 10/29/23, Quarterly MDS assessment identified her cognition was intact and she was dependent on staff for ADLs due to physical limitations. R24 had diagnosis of functional quadriplegia, arthritis of multiple sites and was occasionally incontinent of bladder and always continent of bowel.	F 725	review and recommendation. Compliance: 1/26/2024 Staffing patterns The Facility Assessment was reviewed and updated to reflect facility staffing patterns for direct care staff are subject to change based on facility census and acuity. The facility assessment will also be updated to include that the daily staffing sheets will reflect the daily adjustments to direct care staff as the payroll system does not reflect these daily adjustments. The staffing coordinator, DON and HR director will be in-serviced on the Staffing, Sufficient and Competent Nursing policy with emphasis on item #6 that staffing will be determined by the needs of the residents, based on each resident s plan of care, the resident assessment, and the facility assessment. The Executive Director will be responsible for compliance. Audits on daily sufficient staffing will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 725	Continued From page 31 R24's current undated care plan identified she required limited to extensive assistance with ADLs, needed a walker with assistance or a wheelchair for mobility. She was at high risk for falls due to weakness and attempts to self transfer. Staff were to anticipate and meet her needs, ensure her call light was within reach, and respond promptly to all requests for assistance. 3) R23 reported her call light response was usually fifteen minutes to a half hour, but there had been times when it took a lot longer. R23 voiced there was never enough staff right away in the morning, but her care was provided, she just had to wait for staff. She also stated sometimes she waited to get her medication, but she was not able to give any specific instances. 4) Interview on 12/18/23 at 4:29 p.m., with R28 identified his usual wait for his call light to be answered was usually ten to fifteen minutes, but it was sometimes longer on weekends because there were not as many staff working. R28 verbalized he did not know the longest amount of time he had waited for a response to his call light, but he knew staff were busy and he was located at the end of the hall, so it took longer to get to him. Review of R28's October - December 2023, call light log identified wait times averaged 20 - 43 minutes and one incident of 52 minutes was noted at 8:05 a.m. on 12/1/23. R28's 9/18/23, Admission MDS assessment identified he had moderate cognitive impairment but was able to respond appropriately to interview questions. He required extensive assistance from staff for dressing, toileting, and transfers and had	F 725		

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F 725	Continued From page 32 diagnoses of problems with balance and gait disturbances, and bilateral leg and foot wounds which restricted R28's mobility. R28's current, undated care plan identified he required extensive assistance from 2 staff for ambulation of short distances, and extensive assistance of one staff for all ADLS. R28 was at high risk for falls do to balance and gait disturbances. Staff were to anticipate and meet his needs, ensure his call light was within reach, encourage him to use it, and respond promptly to all requests for assistance. 5) R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and other activities of daily living, in addition, R8 had impairment of bilateral lower extremities. R8 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility. Interview on 12/18/23, at 12:06 p.m., with R8 identified she had to wait a long time for her call light to be answered, she stated "30 minutes to an hour". R8 identified that she felt that wait time was too long. Review of R8's call light log identified the following: 12/1/2023, call light engaged at 3:50 p.m., call light was answered at 5:20 p.m.	F 725		

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F 725	Continued From page 33 12/2/2023, call light engaged at 6:43 a.m., call light was answered at 8:15 a.m. 12/2/2023, call light engaged at 8:38 a.m., call light was answered at 9:20 a.m. 12/2/2023, call light engaged at 12:55 p.m., call light was answered at 3:06 p.m. 12/2/2023, call light engaged at 5:50 p.m., call light was answered at 7:26 p.m. Interview on 12/20/23 at 1:51 p.m., with the administrator identified he was not comfortable with his understanding of how the call light log worked but would have expected staff to answer call lights within 10 minutes. He had not used the call light log to audit call light wait times, and to his knowlege the facility had not completed any call light training and was unaware of the long call light times during the above time period. Review of the undated facility policy "Answering the Call Light" identified staff should answer call lights promptly, turn off the call light, and complete the task requested within 5 minutes if possible. If staff were uncertain whether they could complete the task they were to notify the nurse manager. 6) Interview on 12/18/23 at 5:10 p.m., with R25 revealed she had to wait 15 to 30 minutes for staff response to the call light when needing assistance to the bathroom. R25 stated she didn't feel important when having to wait for assistance from staff. R25's 9/22/23, quarterly Minimum Data Set (MDS) identified R25 had mildly impaired	F 725		

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F 725	Continued From page 34 cognition. R25 had diagnosis of hemiplegia (total or complete paralysis on one side of the body). R25 was dependent on staff for toileting and cares. R25 had impairment bilaterally in lower extremities. R25 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel and took scheduled pain medication in the last 5 days. Interview and document review on 12/21/23 at 8:21 a.m., with the director of nursing (DON) identified her expectation for the staffing level in the facility was for it to be in accordance with the listed facility staffing pattern identified in the Facility Assessment noted above. Review of the reported staffing data report (PBJ) identified the DON agreed staffing had not been provided according to the Staffing Plan documented in the current Facility Assessment. Review of the October 2023, Facility Assessment identified the facility was to have the following nurse aides on duty each shift: 1.) Days-AM's 4 nursing assistants (NA)s 2.) PMS-4 NAs 3.) Nights-2-3 NAs Staffing was to be evaluated and adjusted by the DON, dietary manager, activity manager, housekeeping manager, and the administrator, along with the charge nurse's oversight for direct care (nurse aides). After classification and staffing requirements were completed, targets were to be established and variances managed by moving staff, or calling in potential relief staff (agency staff) or extra facility staff. Review of the documented staffing on weekends for the months of October and November 2023,	F 725		

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F 725	Continued From page 35 and 12/1/23 through 12/20/23 identified: 1.) 10/7/23 and 10/20/23 through 10/22/23, 1 NA was scheduled for night shifts. On 10/7/23 and 10/28/23, 3 NAs for PM shift. 2.) 11/11/23, staffing showed only 1 NA night shift. On 11/4/23, 11/5/23, and 11/26/23, there were only 3 NAs on PM shifts. 3.) 12/1/23, there were 3 NAs on PM shift Interview on 12/20/23 at 5:26 p.m., with the administrator identified he had not had time to review all the documents since he was new to the facility but he would expect the staffing plan noted in the Facility Assessment was to be followed. He reported he would be working to identify problems and develop processes for monitoring in upcoming Quality Assurance Process Improvement (QAPI) meetings.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		1/26/24

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F 758	Continued From page 36 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and identify target behaviors and non-pharmacological interventions for scheduled antidepressant and antipsychotic medication for 1 of 5 residents (R23) reviewed for unnecessary medication usage.	F 758	F 758 R 23 has since discharged from the facility. All current and future residents receiving antidepressants and/or antipsychotics their orders will be reviewed, the behavior module activated, a target behavior included in the order and the care plan with non-pharmacological	

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F 758	Continued From page 37 Findings include: R23's 11/30/23, significant change Minimum Data Set (MDS) assessment identified R23 had moderately impaired cognition. R23 had no behaviors identified. R23 had diagnosis of thyroid disorder, fracture, seizure disorder, depression, and manic depression bipolar type. R23 took a daily antidepressant and antipsychotic. R23's 9/11/23, care plan identified R23 used an antidepressant for depression. R23 would be free from discomfort or adverse reactions to antidepressant medication through the review date. Staff were to administer antidepressant medication as ordered by physician. Staff were to monitor and document side effects and effectiveness of medication every shift. The care plan identified side effects for antidepressant medication but lacked identification of target symptoms that were to be monitored for effectiveness. R23 used an antipsychotic medication for bipolar management. R23 would remain free of psychotropic medication complication, including movement disorder, discomfort, hypotension, gait disturbance, constipation, or cognitive impairment through the review date. Staff were to administer the psychotropic medication as ordered by the physician and monitor for side effects and effectiveness every shift. The care plan identified side effects for psychotropic medication however, had no mention of target behaviors to monitor for effectiveness. R23's 12/20/23, physician Order Summary identified the following medication orders: 1) Bupropion HCl ER (antidepressant) 150 milligrams (mg) every day (QD) in morning for	F 758	interventions initiated as needed. Licensed nursing and Social Services will be in-serviced on the Antipsychotic Medication Use policy with emphasis on item 9a that non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation. Social Services and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 758	Continued From page 38 depression. 2) Fluoxetine HCl (antidepressant) 20 mg QD in morning for major depressive disorder, severe with psychotic symptoms. 3) Fluoxetine HCl (antidepressant) 40 mg QD in morning for major depressive disorder, severe with psychotic symptoms. 4) Olanzapine (antipsychotic) 20 mg QD at bedtime for Bipolar. The order summary had no indication that the antidepressant nor the antipsychotic medication were being monitored for effectiveness or what the target symptoms were that the medications were ordered to treat. Interview on 12/20/23 at 3:49 p.m., with director of nursing (DON) identified her expectation was residents receiving psychoactive medication would have target behaviors identified for what the medication was being prescribed to treat. She also reported residents receiving psychoactive medication had non-pharmacological intervention in place. She agreed if there were no target behaviors identified it would be hard to assess if the medication was effective or not. She expected the facility policy for psychoactive medication use to be followed. Review of the 7/13/23, Antipsychotic Medication Use policy identified residents would only be prescribe antipsychotic medication to treat specific condition indicated. The provider would identify and document symptoms that may warrant the use of an antipsychotic medication. If a resident was admitted and was already receiving an antipsychotic medication the resident would be assessed for appropriateness and indications for use. Antipsychotic medications are ordered to treat specific condition and will be	F 758		

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F 758	Continued From page 39 used within the dosage guidelines. Medication monitoring for side effects and effectiveness including any intervention effectiveness, with any adverse consequences reported to the provider.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure expired foods were disposed of, ensure staff followed their process to log cooked food temperatures to ensure appropriate oversight of cooked foods, and monitor refrigerator and freezer temperatures as indicated per policy. The facility also failed to log the results of their chemical test strips and dishwasher per policy to ensure dishes were sanitized correctly. In addition, the facility failed to	F 812	F 812 All expired food items were removed from the kitchen. The freezer was cleared, cleaned, and restocked. The chemical test strips were obtained, and testing of the dishwasher has been initiated. Dry storage area tiles were replaced on 12/20/2023. A thorough cleaning of the dietary kitchen, refrigerators, freezers, and storage area was conducted on	1/26/24

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	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

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F 812	Continued From page 40 ensure the dry storage area was maintained in a clean, sanitary manner and in was in good repair. This had the potential to affect all 31 residents. Findings include: Observation on 12/18/23 at 11:20 during the initial kitchen tour with the dietary manager (DM) identified the following: 1. The walk in refrigerator had a container of potato salad with a use by date of November 2023 and a bag with sliced ham leftovers that was undated. 2. The 3 compartment sink was visibly dirty, with a black unknown substance and food particles scattered throughout the bottom of the sink. A tin can containing grease was sitting in the sink, and a bucket with dirty water and a scoop and serving spoon were observed lying in the bucket inside the sink. 3. A clip board was observed hanging in the dishwashing room with 1 logged entry for the 4th day of the month (December). No other logs were observed in the kitchen area. 4. The dry storage area had broken tiles on the floor around the storage rack. There were missing tiles along the wall beneath a rack, and an area of missing tile was observed with the underside surface exposed. The floor was visibly dirty with pieces of cardboard, a hairnet, a package of Graham crackers, a black and gray dirt-like substance, cobwebs hanging from the bottom rack extending to the floor, and a dirty dish rag was observed lying on the rack. Interview on 12/18/23 at 11:20, with the DM agreed during the initial kitchen tour identified she agreed with the above concerns and identified staff were to check for expired foods on	F 812	1/23/2024. From date of survey posting until present, the refrigerator and freezer temperatures were recorded, and the dish machine was tested utilizing approved dish machine chemical test strips. Resident documentation from survey exit until 12/26/2023 was reviewed and there were no ill effects experienced from this deficient practice. The Dietary Manager and dietary aides were in-serviced on the Food Storage Policy and will be assigned the Relias dietary course on Food Safety Fundamentals to ensure that the facility dietary department remains clean and to avoid residents from experiencing food borne illness. Facility administrator and Maintenance Director will complete monthly kitchen environmental rounds to ensure preventative maintenance. Dietary Manager and/or designee will be responsible for compliance. Audits on chemical test strip documentation, refrigerator/freezer temps, cleaning schedule creation and compliance will begin 2x week x 3 weeks, weekly x 4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 812	Continued From page 41 Tuesdays. She noted there were no dishwasher logged temperatures to review to ensure dishes washed in the facility had been appropriately sanitized. Staff were also expected to log temperatures for refrigerator and freezers to ensure temperatures were within appropriate ranges, and log cooked food temperatures when removed from the oven. Staff were to log the results of the chemical test strips for the 3 compartment sink and dishwasher but revealed she had no logs for anything available for review for the current month or 4 months prior. The sinks were to be cleaned after each meal and the dry storage was to be swept daily and mopped weekly. Interview on 12/19/23 at 9:28 a.m., with Cook-(B) identified staff checked for expired food on Tuesdays. He had not worked the last Tuesday. He noted staff had no logs for refrigerator or freezer temperature checks or if staff had signed off they performed their weekly checks for expired foods, so he had no way to know if those tasks had been performed or were within acceptable ranges. He started employment about 6 months prior to survey at the facility. At that time, staff had lists of tasks to be performed and were to sign off they were completed and logs to monitor temperatures. He was unaware how long it had been since the logs and sign off sheets were no longer available for staff use. Interview on 12/19/23 at 1:00 p.m., with the maintenance director identified he was aware of the missing and broken tiles in the dry storage area. They were old asbestos tiles. It would be expensive to have them removed and new tiles installed and had been this way for a "long time". He stated he "may" be able to put new tiles over	F 812		

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F 812	Continued From page 42 the old tiles to ensure a smooth, cleanable surface vs replace the existing tiles that had been missing. Review of undated, facility provided policies for food handling, dish machine sanitization, and kitchen cleaning identified all areas were to be kept clean and sanitary. Foods were to be dated, left over foods were be used within 7 days or discarded, refrigerator and freezer temperatures were to be monitored 2 times each day and logged on a monthly tracking sheet, and the DM was to post a log near the dish machine for the staff to document temperatures and test strip results at each meal.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/26/24

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F 842	Continued From page 43 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 44 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure privacy of resident medical information for 1 of 2 facility medication carts which involved 10 of 31 residents (R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19). This had the potential to be viewed by any resident and visitor passing by on the C wing unit. Findings include: Observation on 12/18/23 at 4:54 p.m., of 1 of 2 facility medication cart located on the C wing unit, displayed personal and medical information of the following residents: R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19. The facility medication cart was left unattended with no staff personnel on the unit. Observation and interview on 12/18/23 at 4:59 p.m., with director of nursing (DON)-A stated her expectations would be for all residents information to be secured at all times. DON-A then closed the computer screen of the C wing medication cart. Interview on 12/20/23 at 10:01 a.m., with administrator (ADM-A) stated his expectations would be for the employees to keep residents' electronic medical records confidential and private when not in use. Review of December 2021, Confidentiality of	F 842	F 842 R2, R24, R22, R11, R28, R15, R1, R26, R183, and R19 resident/resident representative was made aware of potential resident information breech during the annual survey. The resident/resident representative response will be recorded in the resident medical record. Licensed nurses and trained medication aides will be in-serviced on the Confidentiality of Information and Personal Privacy policy with emphasis on safeguarding the resident personal information and the EMR Hidden Screen Feature for both EMAR and POC. Director of Nursing and/or designee will be responsible for compliance. Audits on closed screens when users walk away from the electronic medical record system will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 842	Continued From page 45 Information and Personal Privacy policy indicated personal and medical records of residents would be protected and kept confidential.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 849		1/26/24

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F 849	Continued From page 46 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal	F 849		

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F 849	Continued From page 47 illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in	F 849		

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F 849	Continued From page 48 the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both	F 849		

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F 849	Continued From page 49 the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure coordinated hospice services were documented as scheduled for 1 of 1 resident (R27), have a clear communication process for hospice to notify the facility of their updates, for the facility to notify the hospice of changes to R27's health status, need of potential transfers for care, or delineation of hospice services to be provided. Findings include: R27's 12/6/23, Significant Change, Minimum Data Set (MDS) identified R27's diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), and received oxygen. R27's cognition was intact, and she required limited to extensive assistance for most cares and would attempt to self-transfer at times and required a gait belt, walker, and assistance of one for ambulation. R27's progress notes identified R27 was hospitalized on 11/28/23 through 12/1/23 following a fall when she attempted to self-transfer. She returned to the facility on 12/1/23 and was admitted to hospice. Interview on 12/18/23 at 2:02 p.m., with R27 reported she had started hospice after she came back from the hospital because she had lung cancer, and it was spreading. R27 was not	F 849	F 849 R 27 external facility list was updated to include hospice phone number and address. R 27 hospice order was also updated to include hospice company name. R 27 s hospice visit schedule will be faxed to the DON weekly and hospice visit schedule will be added to the resident electronic calendar and/or will be posted at the facility nurse s station. Facility Social Service Designee will contact hospice nurse to coordinate resident care conference schedule. The hospice aide and nurse schedule will be relayed to the R 27 weekly. All existing and future residents who receive hospice services will have their hospice orders created, external facility information updated to reflect the hospice organization name and number, the hospice care plan and interventions will be fully implemented, and the hospice plan of care and visit schedule will be shared with the resident/resident representative and facility nursing staff. The IDT team and nursing staff will be in-serviced on the Hospice Program with emphasis on providing a coordinated plan of care that is developed between the hospice organization and facility and will include resident/resident representative list of	

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F 849	Continued From page 50 certain when the hospice nurse or aide were supposed to come, but she thought it was weekly. R27 denied receiving a schedule or having knowledge of when hospice staff would be visiting or what services they would provide. Observation of R27 on 12/19/23 at 9:04 a.m., as she was lying in bed, was offered and refused breakfast and stated she wanted to sleep longer. R27 denied pain and shortness of breath and had her oxygen on via nasal cannula. Interview on 12/19/23 at 9:08 a.m., with nursing assistant (NA)-H reported she was aware R27 was on hospice, but she was not certain when hospice staff would visit. She reported she was not aware of a schedule of visits but thought there may be a book at the nurses desk that contained the information. Interview and document review on 12/19/23 at 9:29 a.m., with licensed practical nurse (LPN)-B reported there was a hospice book at the nurse's station that contained contact and schedule information. She reported she thought hospice staff documented their visits, but she was not certain where to find their documentation. LPN-B reported hospice staff did not have access to Point Click Care (PCC), and she thought a report was sent to the facility after each weekly visit. LPN-B retrieved the hospice book which contained a copy of a blank calendar for the months of December 2023 and January 2024 and reported she thought they were supposed to have written down the dates for visits. The calendar in the book was where she would expect to find the schedule of visits and since it had not been filled out, she was not certain when they would be visiting.	F 849	Director of Nursing and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 849	Continued From page 51 Interview on 12/19/23 at 10:02 a.m., with LPN-A reported Hospice had a book kept at the nursing station with the contact information and schedules for visits, but confirmed the current schedule for December 2023 and January 2024 were blank and she was not certain when they would be coming to the facility. Interview and review of R27's medical record on 12/19/23 at 10:14 a.m., with the director of nursing (DON) identified visits were to be marked on the calendars so staff would be aware of when hospice would come. There was no mention on R27's care plan of any hospice services to provide to delineate their provision of services. Interview on 12/19/23 at 2:25 p.m., with registered nurse (RN)-B (hospice) reported she was previously coming twice weekly but following discussion with R27 on 12/18/23, the decision was made to decrease visits to once weekly for the RN and twice weekly for the hospice aide. Hospice social services came to see residents 1-2 times a month or as needed, and all hospice visits should have been documented on the calendar. RN-B confirmed the calendar had not been completed as per policy to include dates of hospice staff visits. RN-B reported hospice documentation by both the nurse and aide was completed on a remote chart since hospice staff did not have access to the facility PCC. A verbal update was given to facility staff following a hospice visit and documentation was sent to the facility weekly after hospice documented care and findings in their records. RN-B confirmed there would normally be a physician order for use of a Foley catheter with direction for use. She agreed R27's care plan had not been updated to include	F 849		

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F 849	Continued From page 52 hospice information prior to notification on 12/19/23. Review of the May 5, 2021 Hospice Program policy identified a coordinated plan of care was to be developed between the facility, hospice agency and the resident/family.	F 849		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		1/26/24

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F 867	Continued From page 53 development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity	F 867		

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F 867	Continued From page 54 of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including	F 867		

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F 867	Continued From page 55 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement action plans for improvement, or ensure the committee participated in the development and oversight of implementation of systems, to ensure quality of life and quality of care were maintained for 31 of 31 residents residing in the facility. Findings include: Review of the QAPI meeting minutes from January 2023, February 2023, March 2023, April 2023, May 2023, June 2023, and November 2023. No QAPI meetings documented as taking place for July 2023, August 2023, September 2023, and October 2023. The minutes failed to identify facility specific concerns, action plans for improvement, and/or analysis of any actions taken previously. Interview on 12/20/23 at 5:26 p.m., with the administrator reported he was not certain how frequently QAPI meetings were held prior to his starting at the facility, but he did not find evidence of meetings for July through October 2023. He identified the facility needed to identify problems, develop plans for areas to monitor and develop a system for tracking and/or monitoring of processes put into place. He reported he was not aware of any Process Improvement Projects (PIP's) in place at the present time and the facility needed to develop systems for monitoring and	F 867	F 867 QAPI meeting will be held on January 23, 2024, to include a review of the November 2023 QAPI report and to record December 2023 QM, to establish facility current status, goals, quality measure percentages with discussion and action plan documented. From the action plan, these items will be discussed monthly per the facility QAPI policy. The IDT team will be in-serviced on the QAPI Policy with emphasis on conducting monthly meetings, attendance, identification of areas of improvement and to identify Performance Improvement Projects to enhance the resident experience and quality of life. Executive Director and/or designee will be responsible for compliance. Audits on monthly meeting attendance, QM action items and improvement percentages will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 867	Continued From page 56 identifying areas for improvement and include them in future meetings. Review of the December 5, 2019, QAPI policy identified the committee was to monitor and sustain performance in both clinical and non-clinical system by identifying and improving areas identified. Elements to demonstrate compliance with the guidelines included: 1.) Monthly meetings with documentation 2.) designated member attendance 3.) Pips developed and implemented for identified areas of improvement. 4.) Additional QAPI meetings as needed to address and improve critical areas in need of improvement between the monthly meetings. The QAPI Committee was to use a template to guide data collection and committee discussion. The template was to include review of systems related to care, management practices, clinical care, quality of life, resident choice, and any unique care, services or changes as identified.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/26/24

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F 880	Continued From page 57 §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 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 58 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, that facility failed to use appropriate infection control technique during 1 of 1 dressing change for resident (R28). In addition, the facility failed to ensure appropriate Infection control (IC) signage was posted outside 2 of 6 resident (R8, and R 103 x 2) rooms that had been placed on transmission-based precautions (TBP). Findings include: DRESSING CHANGE Observation and interview on 12/19/23 at 12:19 p.m., with licensed practical nurse (LPN)-A as she performed a dressing change on R28's right shin, and right and left foot wounds identified R28 was seated in his recliner with both feet wrapped and resting on the floor. LPN-A obtained a plastic carrier with dressing supplies, placed it on the uncovered floor, placed a chux on the floor and picked up the plastic carrier and set it on the chux. She then applied gloves and sat on the floor to begin removing the stockinet from R28's right shin. A quarter sized area of dried red drainage was noted on the stockinet which was	F 880	F 880 Dressing Change R 28 MD was notified that the resident dressing change during the facility survey was not completed properly. The MD response will be recorded in the resident electronic medical record. R 28 wounds were assessed and there were no ill effects experienced for this deficient practice. R 28 wound supplies were discarded and replaced. All current residents with wounds, their documentation was reviewed from survey exit until present and there were no ill effects experienced. Future residents with wounds will have their products placed on a clean surface and the appropriate glove and hand hygiene will be performed per facility policy. Facility nurses will be in-serviced on the Wound Care Policy with emphasis on establishing a clean surface, gloves are discarded, and hand-hygiene performed appropriately. All reusable supplies must be disinfected before storage.	

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F 880	Continued From page 59 removed and placed on the chux on the floor. LPN-A removed the dressing covering the wounds on R28's right shin, posterior calf, and covering 2nd toe of right foot and placed the used dressings on the chux. LPN-A retrieved bottle of VASHE solution (wound cleanser), and bottle of saline from the tray, and when asked stated it had been sent back with R28 from the wound clinic last week. LPN-A used the bottle of saline to pour onto the old dressing to loosen it and handled the bottle of saline and old dressing with her gloved hands. A moderate amount of serosanguinous drainage was noted on the dressing and once removed was placed on the chux on the floor beside the clean dressing supplies. LPN-A then returned the bottle of saline to the carrier and placed it inside without disinfecting the outside of the bottle in order to co-mingle supplies appropriately without contamination. LPN-A then removed her gloves and performed hand hygiene, applied new gloves, obtained the VASHE solution and applied it onto a sterile gauze pad. After applying the solution, LPN-A returned the contaminated bottle back into the carrier to be co-mingled with other supplies without first disinfecting the bottle to prevent potential contamination. LPN-A then retrieved betadine solution and placed that onto a sterile gauze pad and applied to the scabbed areas on R28's right toe and posterior shin areas. LPN-A removed her contaminated gloves and placed them on the clean barrier chux she had placed on the floor, performed hand hygiene and applied new gloves. LPN-A then retrieved moisturizing lotion, applied it, and returned it to the bin with the contaminated items. Further observation on 12/19/23 at 12:42 p.m. with LPN-A as she changed the dressing on	F 880	Director of Nursing and/or designee will be responsible for compliance. Audits on wound care establishing a clean area, disposal of soiled items, proper glove use and hand hygiene 2x a week for 2 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024 Signage R 183 has since been removed from Droplet Precautions. There were no ill effects experienced for this incorrect door signage. As of this writing, there are no residents currently in transmission-based precautions. Future residents requiring transmission-based precautions will have the proper signage displayed per the facility policy. Nursing staff was in-serviced on the Transmission-Based Precautions policy with emphasis on the 3-types of precautions and when these precautions must be implemented. Director of Nursing and/or designee will be responsible for compliance. Audits on proper use of transmission-based precaution signage will begin MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for	

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F 880	Continued From page 60 R28's left foot identified the previously mentioned contaminated and soiled dressings and gloves remained on the chux barrier on the floor as she began the dressing change on the left foot. A trash can with a plastic liner was noted beside R28's nightstand and would have been within LPN-A's arms reach but was not used. LPN-A then removed R28's contaminated soiled dressings on his left foot. Without changing gloves or performing hand hygiene, LPN-A picked up the bottle of contaminated VASHE solution from the bin and applied the solution to a sterile gauze pad, contaminating the pad. She then applied the solution to the wound and dabbed the wound dry with the contaminated gauze pad. She then removed her gloves and performed hand hygiene and applied new gloves. LPN-A then cut a new abdominal (ABD) pad, placed it over the wound and taped it secure. She then replaced the stockinet to cover the wound area on the left foot. LPN-A removed her contaminated glove from her right hand and used that hand to open R28's nightstand drawer to obtain a pair of clean gripper socks without removing both gloves and performing hand hygiene. She reached into the drawer and handled the socks and other miscellaneous items with both her ungloved and soiled gloved hand contaminating the socks and any items within that drawer. She then applied the gripper socks with her ungloved and contaminated gloved hand. LPN-A then removed the contaminated glove, placed it on the chux, and rolled up the chux barrier pad to cover the soiled dressings without performing hand hygiene. LPN-A then picked up the dressing supply bin and returned it to the top of the nightstand in R28's room. She then went to the bathroom to wash her hands. After washing her hands, LPN-A had not donned new gloves.	F 880	review and recommendation. Compliance: 1/26/2024	

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F 880	Continued From page 61 She then collected the contaminated chux barrier pad with her clean hands that contained the soiled, contaminated dressings, without donning gloves or a gown or placing those items in a plastic bag, and left R28's room. She disposed of the items in the soiled utility room and then performed hand hygiene. Interview on 12/19/23 at 12:50 p.m. with LPN-A reported she had used a barrier pad as not to placed the contaminated dressings or previously used items on the floor and was unaware she had contaminated her clean area. When asked about using the trash can, replied she "had not thought of that". When asked about the contamination of using her same gloved hand that had changed the dressing on R28's left foot to retrieve his clean socks, she stated she was unaware she had done that. LPN-A agreed she had not followed IC procedures for wound care, contaminated clean items, failed to disinfect containers of multi-use wound treatments, and sterile gauze etc. She was unaware she had cross contaminated R28's wounds with germs from not using proper IC technique. Interview on 12/20/23 at 4:30 p.m. with the director of nursing/infection preventionist (IP) reported her expectation for staff to follow IC protocols when completing dressing changes and voiced agreement with the above noted concerns. Review of the September 29, 2021, Wound Care Policy identified staff were to use a disposable item such as a chux to establish a clean surface for putting clean supplies on that were to be used during the procedure. Gloves were to be discarded and hand hygiene performed appropriately. Staff were to disinfect reusable	F 880		

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F 880	Continued From page 62 supplies and surfaces of bottles or containers with a disinfectant as needed. TBP Observation on 12/20/23 at 3:59 p.m., of R183's room door had a new sign posted that read "Enhanced barrier. Wear gloves and gown for high contact activities". R183's 12/20/23 progress note identified at 11:31 a.m., R183 had tested positive for COVID-19. R183's room door had been shut and the DON and staff on duty had been notified. Additional note at 2:30 p.m., identified R183 had all services provided in R183's room until they would be off isolation. R183's physician and family had been notified of the positive test result. Interview and observation on 12/20/23 at 4:02 p.m., with director of nursing (DON) identified R183 had new diagnosis of COVID-19 and had been placed on precautions. The DON was unsure who was responsible to set up the personnel protective equipment (PPE) and post the signage. The DON confirmed the wrong sign had been placed on R183's door that identified "Enhanced barrier precautions" The DON then placed a sign on the door that identified "Contact precautions. Everyone must wash hands before and after, and use a glove, gown, mask, and face shield". Additionally, a sign that identified how to don and doff PPE, and a stop sign was placed on the door to "See nurse before visiting resident". Next to the door was a cart with PPE supplies which also included N95 masks and face shields. Interview and observation on 12/21/23 at 8:56 a.m., with licensed practical nurse (LPN)-C who	F 880		

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F 880	Continued From page 63 reported the facility had multiple precaution signs that they used depending on what type of precaution a resident was on. She confirmed and displayed a stack of precaution signs located at the nurse's station on the 300 wing. The signs observed included enhanced precautions, contact precaution, droplet precautions, and airborne precautions. LPN-C confirmed that residents who have tested positive with COVID-19 were to have droplet precautions put into place. Interview and observation on 12/21/23 at 9:03 a.m., with DON identified she had signage for droplet precautions and airborne precautions. She was unaware she had posted the incorrect "Contact precaution" sign on R183's room door. The DON confirmed a resident positive with COVID-19 should be placed on "Droplet" or "Airborne" precautions. The DON then obtained both a sign for "Droplet precautions" and "Airborne precautions" and posted both signs on R183's room door. Review of October 2021, Isolation Categories of Transmission-Based and Enhanced Precautions policy identified standard precaution are used during times of resident cares, transmission-based precautions include 3 types: 1) Contact, 2) Droplet, 3) Airborne. Use was to be determined by the specific pathogen and how it was spread. Staff were to place the appropriate notification on the room door when a resident was placed on TBP. Contact precautions were implemented when a resident was suspected or was known to be infected with an microorganism that was transmittable via direct contact. Droplet	F 880		

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	245596	A. BUILDING _____ B. WING _____	C 12/21/2023

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F 880	Continued From page 64 precautions were to be implemented when a resident has been suspected or confirmed to be infected with an microorganism that can be transmitted by droplets such as sneezing, coughing, or suctioning. Airborne precautions are implemented when a resident has been infected with an pathogen that can be transmitted long distance through the air. Enhanced precautions would only be implemented to protect from exposures to anticipated blood or body fluids.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		1/26/24

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F 883	Continued From page 65 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 2 of 5 residents (R8, R9) reviewed for immunizations. Furthermore, the facility failed to have a method or system to ensure the facility offer or provided any initial or updated vaccine to residents per Centers for Disease Control (CDC) vaccination	F 883	F 883 R 8 and R 9 will be offered the pneumonia vaccine on 1/17/2024. Upon consent, these vaccines will be ordered and administered per physician order. All existing residents will have their pneumonia vaccine information reviewed, the vaccine offered and administered as needed. Future residents will have a vaccine consent completed during the	

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F 883	Continued From page 66 recommendations. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at any age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine.	F 883	admission agreement, indicated on the nurse admission assessment and the infection preventionist will review documentation to determine residents acceptance or refusal of vaccines and this information will be recorded in the resident electronic medical record. Facility nurses and admission coordinator will be in-serviced on the Pneumococcal Vaccine Policy with emphasis of offering the vaccine, assess the resident for eligibility and administer vaccine per MD order. Director of Nursing and/or designee will be responsible for compliance. Audits on resident consent, administration and recording results in the resident electronic medical record will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 883	Continued From page 67 R8's 10/21/23, annual Minimum Data Set (MDS) assessment identified R8 was 87 years old and had diagnoses of Heart failure and hypertension, anxiety, and depression. R8's immunization record identified R8 had received the pneumococcal polysaccharide vaccine (PPSV-23) on 5/16/95 and had received the pneumococcal conjugated vaccine (PCV-13) on 6/28/18. R8's medical record did not include evidence R8 or R8's representative received education regarding pneumococcal vaccine booster, the physician notified, or indication R8 was offered the PCV-20 at least 5 years after prior pneumococcal vaccine per CDC guidance. R9's 11/9/23, quarterly Minimum Data Set (MDS) assessment identified R9 was 67 years old and had diagnoses of hypertension, stroke, and peripheral vascular disease. R9's immunization record identified R9 had received pneumococcal polysaccharide vaccine (PPSV-23) on 8/14/17 (approximately at 60 years of age). R9's medical record did not include evidence R9 or R9's representative received education regarding pneumococcal vaccine booster and there was no indication R9 was offered PCV-20 at least 1 year after prior PPSV-23 or a PCV-15 at least 1 year after prior PPSV-23 per CDC guidance. Interview on 12/20/23 at 3:49 p.m., with the director of nursing (DON) identified that neither resident had been offered updated vaccination and should have been. The DON revealed the facility had no method after admission to ensure vaccines were offered to residents when eligible.	F 883		

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F 883	Continued From page 68 Review of undated, Pneumococcal Vaccine policy identified residents would be offered pneumococcal vaccines to prevent pneumonia. Upon admission residents would be assessed for eligibility to receive the pneumococcal vaccine series and when indicated would be offered unless medically contraindicated. Pneumococcal vaccines would be made in accordance with current CDC recommendations.	F 883		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 1 agency staff (nursing assistant (NA)-G) was oriented to the facility policies and procedures including Abuse, Neglect, Exploitation or Misappropriation, Reporting, and Investigating. Findings include: Interview on 12/19/23 at 10:31 a.m., with NA-G revealed he had worked with R8 on 12/18/23 and confirmed R8 had accused him of being rough when he turned her on her side. NA-G revealed	F 940	F 940 Agency employee NA-G received training on the facility policy and procedures on abuse, neglect, misappropriation, reporting and investigating policy on 1/19/2024. Future agency staff will be in-serviced on the facility policy location, abuse policy and will be provided a checklist of items and materials that have been reviewed. This incident noted during the survey was reported to the state agency per facility policy. The facility Staffing coordinator will be	1/26/24

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F 940	Continued From page 69 the nurse had come and talked to him about R8 accusing him of being rough. NA-G reported R8 was in a "bad mood" and was cursing at him while he assisted her to turn on her side. NA-G revealed he had not told anyone that R8 had accused him of being rough during cares as R8 was fine after he had changed her incontinent product and even had him assist her to call her husband. Review of NA-G training records obtained from the agency NA-G was employed by included a copy of an employee handbook and policies that covered the NA job description, resident abuse, neglect, and reporting. NA-G had a signature that was time stamped at 3:26 p.m. on 12/19/23, after this surveyor requested NA-G training records. Interview on 12/20/23 at 9:24 a.m., with trained medication assistant (TMA)-A who was also the staffing coordinator, identified NA-G was an agency staff. When agency staff start at the facility, they usually come an hour or two before their shift starts to get orientated to the floor. As the staffing coordinator, she was unaware of any other type of orientation that was required such as being oriented to facility policies. TMA-A reported there was no documentation that NA-G had been orientated to the facility specific policies prior to working his first scheduled shift. TMA-A was unsure if NA-G was aware of who he should report concerns to especially if a resident accused staff of potential abuse or rough care, but would assume that the agency staff "would know" to report to the charge nurse. Interview on 12/20/23 at 11:38 a.m., with director of nursing (DON) revealed the facility had no orientation on policies and procedures for	F 940	in-serviced on the General Orientation Process for agency staff that includes a review of facility policy on abuse, reporting and investigation along with acknowledgement. Director of Nursing and/or designee will be responsible for compliance. Audits on general orientation for agency staff with acknowledgement sheet completion will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 940	Continued From page 70 contractual staff including NA-G. She reported the only training she could provide for NA-G regarding abuse and reporting was the training that NA-G received through his agency. Review of October 2023, Facility Assessment identified all new staff are required to have onboarding videos in Healthcare Academy and in Relias. All new hires will also have competencies related to their job description and for any sort of special care needs for facility residents. There was no mention of training or orientation for contractual staff providing services being oriented to facility specific policies. Review of 11/23/22, Orientation Program for Newly Hired Employees, Transfers, Volunteers identified those staff providing services under contractual arrangements shall be orientated to the facility policies. The orientation program included tour of facility, description of the resident population, instructions in an emergency, resident care procedures, and introduction to administrative structure. The policy identified contractual staff would receive general orientation and an in-depth review of the facility's policies and protocols that would be documented on a check list form identifying what materials had been reviewed.	F 940		
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		1/26/24

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F 944	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide mandatory training on the facility's Quality Assurance Program Improvement (QAPI) Program that included facility specific goals, elements of the program, how the facility intended to implement the program, in addition to the staff's role in the facility QAPI program. The facility also failed to provide education on how staff could communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. In addition, the current December 5, 2019, facility policy failed to identify the mandatory component of providing staff education on the facility specific QAPI program. Findings include: Interview on 12/20/23 at 9:38 a.m., with trained medication aide (TMA)-B reported she had been employed at the facility for 4 years and reported she had not received any QAPI training or recalled any facility specific programs, such as a performance improvement project (PIP). Interview on 12/20/23 at 9:42 a.m., with licensed practical nurse (LPN)-A reported she was aware the facility had a QAPI program but was not aware of any current PIP that might be in place. LPN-A identified she had not received any education on a facility specific program and reported she was not aware of any education being provided on the facility's QAPI program to either the facility employed staff or the temporary staff. Interview on 12/20/23 at 9:56 a.m., with the social services designee (SSD) reported she was aware	F 944	F 944 TMA-B will receive in-service education on the facility QAPI program, policy, and PIP process. All current and future staff will receive in-service education on the QAPI program and PIP process upon hire per facility policy. Facility employees were educated on the QAPI process with emphasis on the staff role and how to participate in performance improvement projects. In addition, the facility will post QAPI meeting date/times for all facility staff to view and participate. Director of Nursing and/or designee will be responsible for compliance. Audits on employee QAPI mandatory education in-service training compliance will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 1/26/2024	

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F 944	Continued From page 72 of the QAPI program and was not aware of any education provided to staff on the facility specific program. She reported she was not aware of any current PIP or designated methods for staff to communicate ideas or suggestions. Interview on 12/20/23 at 5:26 p.m., with the administrator identified the facility needed to identify problems, develop plans for areas to monitor and develop a system for tracking and/or monitoring of processes put into place. He was not aware of any PIP in place at the present time. He agreed the facility needed to develop systems for monitoring and identifying areas for improvement and include them in future meetings. The administrator identified he was not aware of education provided to staff on the QAPI program, or methods to communicate suggestions. Interview on 12/21/23 at 8:28 a.m., with the director of nursing reported the facility had one QAPI meeting since she started in September 2023. The DON reported the facility had department meetings in the morning 5 days/week and concerns were identified and discussed at that time. She was not aware of a formalized process for staff input concerns, ideas, or commentary to the QAPI team. There was no facility specific QAPI education provided to staff that she was aware of. Review of the December 5, 2019, QAPI policy identified the committee was to monitor and sustain performance in both clinical and non-clinical system by identifying and improving areas identified. Elements to demonstrate compliance with the guidelines included: 1.) Monthly meetings with documentation	F 944		

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F 944	Continued From page 73 2.) Designated member attendance 3.) Pips developed and implemented for identified areas of improvement. 4.) Additional QAPI meetings as needed to address and improve critical areas in need of improvement between the monthly meetings. The QAPI Committee was to use a template to guide data collection and committee discussion. The template was to include review of systems related to care, management practices, clinical care, quality of life, resident choice, and any unique care, services or changes as identified. The policy failed to identify the facility needed to provide mandatory training on the facilities QAPI program, have a PIP, or educate staff on those specifics.	F 944		

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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 12/18/23 through 12/21/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/20/24

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO licensing orders issued: H55965530C (MN92569), H55967817C(MN97909), H55967820C (MN94418), H55967958C (MN96983), and H55967821C (MN97725). The following complaints were reviewed: H55968190C (MN99372) with a licensing order issued at 1980. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 255	Corrected	1/26/24

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2 255	Continued From page 3 facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement action plans for improvement, or ensure the committee participated in the development and oversight of implementation of systems, to ensure quality of life and quality of care were maintained for 31 of 31 residents residing in the facility. Findings include: Review of the QAPI meeting minutes from January 2023, February 2023, March 2023, April 2023, May 2023, June 2023, and November 2023. No QAPI meetings documented as taking place for July 2023, August 2023, September 2023, and October 2023. The minutes failed to identify facility specific concerns, action plans for improvement, and/or analysis of any actions taken previously. Interview on 12/20/23 at 5:26 p.m., with the administrator reported he was not certain how frequently QAPI meetings were held prior to his starting at the facility, but he did not find evidence of meetings for July through October 2023. He identified the facility needed to identify problems, develop plans for areas to monitor and develop a system for tracking and/or monitoring of processes put into place. He reported he was not aware of any Process Improvement Projects (PIP's) in place at the present time and the facility needed to develop systems for monitoring and identifying areas for improvement and include them in future meetings. Review of the December 5, 2019, QAPI policy identified the committee was to monitor and sustain performance in both clinical and non-clinical system by identifying and improving	2 255		

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2 255	Continued From page 4 areas identified. Elements to demonstrate compliance with the guidelines included: 1.) Monthly meetings with documentation 2.) designated member attendance 3.) Pips developed and implemented for identified areas of improvement. 4.) Additional QAPI meetings as needed to address and improve critical areas in need of improvement between the monthly meetings. The QAPI Committee was to use a template to guide data collection and committee discussion. The template was to include review of systems related to care, management practices, clinical care, quality of life, resident choice, and any unique care, services or changes as identified. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's	2 302		1/26/24

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2 302	Continued From page 5 disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure that 1 of 8 staff (director of nursing (DON)) received annual Alzheimer's training. Findings include: Review of the DON's employee file identified the DON had no record of receiving annual mandatory Alzheimer's training. Interview on 12/21/23, at 9:00 a.m., with DON identified she had not completed the training and that it had not been added to her training schedule. The DON agreed she needed annual	2 302	Corrected	

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2 302	Continued From page 6 training. A policy was requested but nothing was provided by end of survey. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive	2 540		1/26/24

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2 540	Continued From page 7 resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status and needs for 1 of 1 resident (R9) for depression. Findings include: R9's undated, current care plan identified R9 would be free from discomfort or adverse reactions to antidepressant medication through the review date. Staff were to administer antidepressant medication as ordered by physician. Staff were to monitor and document	2 540	Corrected	

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2 540	Continued From page 8 side effects and effectiveness of medication every shift and report adverse reactions of medications and consult Southwest Mental Health for services. The care plan identified side effects for antidepressant medication but lacked identification of target symptoms that were to be monitored for effectiveness. R9's 10/02/23 Southwestern Mental Health Center Standard Diagnostic Assessment identified R9 had a depression disorder. R9's 11/09/23, quarterly Minimum Data Set (MDS) assessment identified R9 had no cognitive impairment. R9 had little interest in doing things, feeling down, depressed, or hopeless, trouble concentrating on things, and feeling tired or having little energy for 12 to 14 days. R9 took a daily antidepressant and antipsychotic. R9 had a diagnosis of anxiety but did not indicate a diagnosis of depression. R9 had cerebral infarct of right middle cerebral artery (stroke occurs when blood flow from the main carotid artery of the brain suddenly stops), peripheral vascular disease, nicotine dependence, and anxiety. R9's 12/21/23, physician Order Summary Report identified the following medication orders: 1) mirtazapine 15 milligrams (mg) at night for depression 2) risperidone (used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder) 1 mg at night for depression disorder 3) clonidine 0.1 mg three times a day for anxiety and depression The physician Order summary had no indication of target symptoms ordered to treat with use of the antidepressants.	2 540		

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2 540	Continued From page 9 Interview on 12/20/23 at 5:13 p.m., with registered nurse (RN)-A stated R9's depression diagnosis was not listed on his current medical record or in the MDS. Interview on 12/21/23 at 9:02 a.m., with DON-A stated R9's depression diagnosis wasn't identified and had no behavior monitoring in place for R9's depression. A policy was requested but none provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and	2 800		1/26/24

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2 800	Continued From page 10 in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADLS) and timely response to call lights for 9 of 31 residents (R2, R8, R10, R13, R15, R23, R24, R25 and R28) with concerns for sufficient staffing. Findings include: Interview on 12/19/23 at 3:09 p.m., during a resident council meeting, R2, R10, R13, R23 and R24 expressed concerns for sufficient staffing especially at night and on the weekends when at times there were only two nursing assistants (NA)s on duty. They voiced agreement that call light wait times got really long and they had to wait up to an hour at times for someone to respond. R2, R13, R15 agreed with the above concerns however, never voiced specific incidents. During the meeting R10, R23, and R24 voiced specific examples of their sufficient staffing concerns as follows: 1) R10 reported she did not feel it was related to specific times of the day or night, but she had experienced accidents due to having to wait for staff to respond to her call light. She stated, "it was embarrassing" for her to have a staff member clean her up. She reported the nursing assistants (NA)s were often busy helping someone else, and other staff persons were not always willing to help when the aides were busy.	2 800	Corrected	

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2 800	Continued From page 11 R10's 11/15/23, annual Minimum Data Set (MDS) assessment identified her cognition was intact, and she required extensive assistance of one staff for ADLs and used a wheelchair for mobility. R10 had diagnosis of cerebral palsy, paraplegia and was occasionally incontinent of bladder and frequently incontinent of bowel. R10's current undated care plan identified she required extensive assistance from staff for all ADLs, needed assistance to transfer, sit up and lie down, required bilateral AFO (ankle-foot Orthoses) braces applied when she got up and off when she went to bed and used a wheelchair for mobility. 2) R24 reported the facility had a lot of new staff that were temporary, and they did not always know what to do, but she voiced she was concerned because she didn't feel she should have to direct them on how to provide care. R24's 10/29/23, Quarterly MDS assessment identified her cognition was intact and she was dependent on staff for ADLs due to physical limitations. R24 had diagnosis of functional quadriplegia, arthritis of multiple sites and was occasionally incontinent of bladder and always continent of bowel. R24's current undated care plan identified she required limited to extensive assistance with ADLs, needed a walker with assistance or a wheelchair for mobility. She was at high risk for falls due to weakness and attempts to self transfer. Staff were to anticipate and meet her needs, ensure her call light was within reach, and respond promptly to all requests for assistance.	2 800		

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2 800	Continued From page 12 3) R23 reported her call light response was usually fifteen minutes to a half hour, but there had been times when it took a lot longer. R23 voiced there was never enough staff right away in the morning, but her care was provided, she just had to wait for staff. She also stated sometimes she waited to get her medication, but she was not able to give any specific instances. 4) Interview on 12/18/23 at 4:29 p.m., with R28 identified his usual wait for his call light to be answered was usually ten to fifteen minutes, but it was sometimes longer on weekends because there were not as many staff working. R28 verbalized he did not know the longest amount of time he had waited for a response to his call light, but he knew staff were busy and he was located at the end of the hall, so it took longer to get to him. Review of R28's October - December 2023, call light log identified wait times averaged 20 - 43 minutes and one incident of 52 minutes was noted at 8:05 a.m. on 12/1/23. R28's 9/18/23, Admission MDS assessment identified he had moderate cognitive impairment but was able to respond appropriately to interview questions. He required extensive assistance from staff for dressing, toileting, and transfers and had diagnoses of problems with balance and gait disturbances, and bilateral leg and foot wounds which restricted R28's mobility. R28's current, undated care plan identified he required extensive assistance from 2 staff for ambulation of short distances, and extensive assistance of one staff for all ADLS. R28 was at high risk for falls do to balance and gait disturbances. Staff were to anticipate and meet	2 800		

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2 800	Continued From page 13 his needs, ensure his call light was within reach, encourage him to use it, and respond promptly to all requests for assistance. 5) R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and other activities of daily living, in addition, R8 had impairment of bilateral lower extremities. R8 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility. Interview on 12/18/23, at 12:06 p.m., with R8 identified she had to wait a long time for her call light to be answered, she stated "30 minutes to an hour". R8 identified that she felt that wait time was too long. Review of R8's call light log identified the following: 12/1/2023, call light engaged at 3:50 p.m., call light was answered at 5:20 p.m. 12/2/2023, call light engaged at 6:43 a.m., call light was answered at 8:15 a.m. 12/2/2023, call light engaged at 8:38 a.m., call light was answered at 9:20 a.m. 12/2/2023, call light engaged at 12:55 p.m., call light was answered at 3:06 p.m. 12/2/2023, call light engaged at 5:50 p.m., call light was answered at 7:26 p.m. Interview on 12/20/23 at 1:51 p.m., with the administrator identified he was not comfortable with his understanding of how the call light log	2 800		

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2 800	Continued From page 14 worked but would have expected staff to answer call lights within 10 minutes. He had not used the call light log to audit call light wait times, and to his knowlege the facility had not completed any call light training and was unaware of the long call light times during the above time period. Review of the undated facility policy "Answering the Call Light" identified staff should answer call lights promptly, turn off the call light, and complete the task requested within 5 minutes if possible. If staff were uncertain whether they could complete the task they were to notify the nurse manager. 6) Interview on 12/18/23 at 5:10 p.m., with R25 revealed she had to wait 15 to 30 minutes for staff response to the call light when needing assistance to the bathroom. R25 stated she didn't feel important when having to wait for assistance from staff. R25's 9/22/23, quarterly Minimum Data Set (MDS) identified R25 had mildly impaired cognition. R25 had diagnosis of hemiplegia (total or complete paralysis on one side of the body). R25 was dependent on staff for toileting and cares. R25 had impairment bilaterally in lower extremities. R25 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel and took scheduled pain medication in the last 5 days. Interview and document review on 12/21/23 at 8:21 a.m., with the director of nursing (DON) identified her expectation for the staffing level in the facility was for it to be in accordance with the listed facility staffing pattern identified in the Facility Assessment noted above. Review of the reported staffing data report (PBJ) identified the	2 800		

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2 800	Continued From page 15 DON agreed staffing had not been provided according to the Staffing Plan documented in the current Facility Assessment. Review of the October 2023, Facility Assessment identified the facility was to have the following nurse aides on duty each shift: 1.) Days-AM's 4 nursing assistants (NA)s 2.) PMS-4 NAs 3.) Nights-2-3 NAs Staffing was to be evaluated and adjusted by the DON, dietary manager, activity manager, housekeeping manager, and the administrator, along with the charge nurse's oversight for direct care (nurse aides). After classification and staffing requirements were completed, targets were to be established and variances managed by moving staff, or calling in potential relief staff (agency staff) or extra facility staff. Review of the documented staffing on weekends for the months of October and November 2023, and 12/1/23 through 12/20/23 identified: 1.) 10/7/23 and 10/20/23 through 10/22/23, 1 NA was scheduled for night shifts. On 10/7/23 and 10/28/23, 3 NAs for PM shift. 2.) 11/11/23, staffing showed only 1 NA night shift. On 11/4/23, 11/5/23, and 11/26/23, there were only 3 NAs on PM shifts. 3.) 12/1/23, there were 3 NAs on PM shift Interview on 12/20/23 at 5:26 p.m., with the administrator identified he had not had time to review all the documents since he was new to the facility but he would expect the staffing plan noted in the Facility Assessment was to be followed. He reported he would be working to identify problems and develop processes for monitoring in upcoming Quality Assurance Process	2 800		

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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
2 800	Continued From page 16 Improvement (QAPI) meetings. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		1/26/24

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	00885	A. BUILDING: _____ B. WING _____	C 12/21/2023

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2 830	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have an integrated hospice care plan for 1 of 1 resident (R27). Findings include: R27's 12/6/23, Significant Change Minimum Data Set (MDS) assessment, identified diagnoses of malignant neoplasm of the lung (cancer), chronic obstructive lung disease (COPD), required oxygen therapy and was admitted to hospice care. R27's current, undated care plan identified there was no mention R27 was on hospice services, what services the facility was to provide, nor services the hospice agency was to provide. Interview and document review on 12/19/23 at 10:02 a.m., with LPN-A identified R27's care plan failed to contain documentation of any hospice services, R27's oxygen use, or use of a Foley catheter which should have been documented and included ont he facility care plan. LPN-A agreed it was not documented on what services hospice was to provide. Interview on 12/19/23, at 10:14 a.m., with the director of nursing (DON) confirmed her expectation for coordination of services between hospice providers and the facility. She confirmed the information on hospice and facility provided services had not been included in R27's current care plan. Interview and document review on 12/19/23 at 2:25 p.m., with the hospice registered nurse	2 830	Corrected	

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2 830	Continued From page 18 (RN)-B reported she had previously visited R27 weekly, but following a discussion on the evening of 12/18/23 the decision was made to decrease visits to once weekly for RN and twice for NA services. The social services provider was scheduled to visit 1-2 times a month and as needed. RN-B identified a blue binder, located at the nursing station contained a calendar with scheduled hospice staff visit dates. Review of the calendars for December 2023 and January 2024 with RN-B confirmed they were blank and had not been competed as per policy. RN-B confirmed the care plan for R27 had not been updated as per policy until 12/19/23 and facility and hospice staff should have coordinated services to be provided and documented those services provided by each entity in the facility care plan. Review of the May 5, 2021, Hospice Program policy identified a coordinated plan of care was to be developed between the facility, hospice agency and the resident/family. The plan of care was to include hospice staff schedules, pain and/or comfort management plans, and be revised or updated as indicated. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, should develop and update the care plan to ensure integration was developed in coordination with hospice including but not limited to: resident and/or representative choices regarding care, the hospice philosophy of care and all services necessary for the palliation and management of the terminal illness and related conditions, include measurable goals and interventions based on comprehensive and ongoing assessments, identify interventions that address, as appropriate, the identification of timely, pertinent non-pharmacologic and pharmacological	2 830		

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2 830	Continued From page 19 interventions to manage pain and other symptoms of discomfort, identify the hospice portion that governs the actions of the hospice and describes the services that are needed to care for the resident, identify services the nursing home will continue to provide and identify the provider responsible for performing specific services/functions that have been agreed upon. The director of nursing or designee, could re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.	2 930		1/26/24

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2 930	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff sanitized a gastronomy tube (G-tube) port prior to initializing enteral feeding (nutrition provided thru a tube directly into the stomach) for 1 of 1 resident (R14) during 2 of 2 observations. Findings include: R14's undated, current Medical Diagnosis identified diverticulitis (small bulging pouches in the digestive tract that become inflamed or infected) of intestine, disease of digestive system, neutropenia (abnormally low count of a type of white blood cell), malignant neoplasm (cancerous tumor) of lip, oral cavity and pharynx and mild cognitive impairment. R14's undated care plan, identified R9 had potential for alteration in nutrition and dehydration due to malignant neoplasm. Staff were to monitor the G-tube site for signs of infection and would provide enteral feeding and water flushes as ordered. R14's 10/1023, quarterly Minimum Data Set (MDS) identified R14 had a feeding tube. R14 would receive 51% or more of total calories and 501 milliliters (ml) a day or more of fluid intake through tube feeding. R14 had no cognitive impairment or behaviors. R14 was dependent for eating, toileting and cares. R14's 12/20/23, physician Order Summary Report identified R14 had a regular diet, with regular texture and regular (thin) consistency and would eat only at noon meals. R14 had enteral tube feeding via gravity (natural flow infusion) ordered	2 930	Corrected	

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2 930	Continued From page 21 for twice a day with 30 milliliters (ml) of water to be used for a flush and additional fluid before and after feeding twice daily, and 250 ml of a free water flush 1 x day for additional hydration. Observation and interview on 12/19/23 at 9:07 a.m., licensed practical nurse (LPN)-A washed her hands, donned PPE (personal protection equipment) (gown and gloves, gathered R14's medications and feeding supplies before entering R14's room. R14 had enhanced barriers precautions, requiring staff to wear PPE when accessing her gtube. R14 was sitting her recliner watching television. LPN-A entered R14's room and placed clamped feeding bag and tubing up on the IV pole next to R14's recliner and her supplies on the R14's bedside table. R14's tubing had no cover on the port and was exposed. LPN-A washed her hands and donned gloves, grabbed a stethoscope, placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-A grabbed a syringe, attached it to R14's G-tube port without first sanitizing the uncovered port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of residual gastric fluid. LPN-A pushed 30 mLs of water through syringe into R14's G-tube. LPN-A asked R14 if she had any discomfort. R14 stated "no". LPN-A removed the syringe and placed the syringe tip to R14's port. LPN-A administered R14's levothyroxine in the piston syringe attached to the port, poured the medication into port closed the gtube port, drew up 30 mLs of water and pushed it through the piston syringe into R14's gtube. LPN-A removed the inner portion of the syringe and connected the feeding bag to R14's G-tube port. LPN-A unclamped the feeding bag releasing the enteral feed by gravity. LPN-A removed her gloves and her PPE, left the room and sanitized her hands.	2 930		

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2 930	Continued From page 22 LPN-A was asked if she sanitized the feeding tube port before connecting it to R14's gtube. LPN-A stated she was not trained to sanitize it before connecting it and would implement the practice. Observation and interview on 12/19/23 at 4:28 p.m., with LPN-F washed her hands, donned PPE and gloves, grabbed R14's piston syringe and water to the bedside table. R14 was sitting in recliner with television on. LPN-F grabbed the stethoscope and placed them in her ears and put the diaphragm on R14's left side of her abdomen. LPN-F grabbed R14's syringe, attached it to R14's G-tube port without sanitizing the port, then pulled back to check for gastric residual in the port. R14's port had less than 5 mLs of gastric residual. LPN-F pushed 60 mLs of water through the syringe into R14's gtube. LPN-F separated the syringe, and poured Miralax (treat occasional constipation) medication through the syringe, mixed in water into R14's G-tube and closed the port. LPN-F then reconnected both syringe pieces and drew up 60 mLs of water and pushed it through R14's G-tube. R14's feeding bag port had been observed uncovered on the IV pole in the room. LPN-F connected the clamped feeding bag tube to the R14's G-tube. LPN-F then unclamped the feeding bag, releasing the enteral feed by gravity. LPN-F removed her gloves and her PPE, left the room and sanitized her hands. LPN-F was asked if she sanitized the feeding bag port before connecting it to R14's gtube. LPN-F stated she did not wipe the port before connected it to R14's gtube. Interview on 12/20/23 at 9:49 a.m., director of nursing DON-A identified her expectations would be for nurses to use clean technique when preparing or administering enteral feedings by	2 930		

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2 930	Continued From page 23 sanitizing the port before connecting a syringe to lessen the chances of potential infection. Review of September 2021, Enteral Tube Feeding via Gravity Bag policy identified aseptic (clean) technique would be used when preparing and administering enteral tube feedings. There was no mention staff should sanitize the port. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident feeding tube cares to ensure placement is being checked before medication administration, and educate all staff on facility policy and procedures related to feeding tubes. The director of nursing could bring the results of the audits to the quality assurance committee for further follow up and recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure expired foods were disposed of, ensure staff followed their process to log cooked food temperatures to ensure appropriate oversight of cooked foods,	21015	Corrected	1/26/24

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21015	Continued From page 24 and monitor refrigerator and freezer temperatures as indicated per policy. The facility also failed to log the results of their chemical test strips and dishwasher per policy to ensure dishes were sanitized correctly. In addition, the facility failed to ensure the dry storage area was maintained in a clean, sanitary manner and in was in good repair. This had the potential to affect all 31 residents. Findings include: Observation on 12/18/23 at 11:20 during the initial kitchen tour with the dietary manager (DM) identified the following: 1. The walk in refrigerator had a container of potato salad with a use by date of November 2023 and a bag with sliced ham leftovers that was undated. 2. The 3 compartment sink was visibly dirty, with a black unknown substance and food particles scattered throughout the bottom of the sink. A tin can containing grease was sitting in the sink, and a bucket with dirty water and a scoop and serving spoon were observed lying in the bucket inside the sink. 3. A clip board was observed hanging in the dishwashing room with 1 logged entry for the 4th day of the month (December). No other logs were observed in the kitchen area. 4. The dry storage area had broken tiles on the floor around the storage rack. There were missing tiles along the wall beneath a rack, and an area of missing tile was observed with the underside surface exposed. The floor was visibly dirty with pieces of cardboard, a hairnet, a package of Graham crackers, a black and gray dirt-like substance, cobwebs hanging from the bottom rack extending to the floor, and a dirty dish rag was observed lying on the rack.	21015		

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21015	Continued From page 25 Interview on 12/18/23 at 11:20, with the DM agreed during the initial kitchen tour identified she agreed with the above concerns and identified staff were to check for expired foods on Tuesdays. She noted there were no dishwasher logged temperatures to review to ensure dishes washed in the facility had been appropriately sanitized. Staff were also expected to log temperatures for refrigerator and freezers to ensure temperatures were within appropriate ranges, and log cooked food temperatures when removed from the oven. Staff were to log the results of the chemical test strips for the 3 compartment sink and dishwasher but revealed she had no logs for anything available for review for the current month or 4 months prior. The sinks were to be cleaned after each meal and the dry storage was to be swept daily and mopped weekly. Interview on 12/19/23 at 9:28 a.m., with Cook-(B) identified staff checked for expired food on Tuesdays. He had not worked the last Tuesday. He noted staff had no logs for refrigerator or freezer temperature checks or if staff had signed off they performed their weekly checks for expired foods, so he had no way to know if those tasks had been performed or were within acceptable ranges. He started employment about 6 months prior to survey at the facility. At that time, staff had lists of tasks to be performed and were to sign off they were completed and logs to monitor temperatures. He was unaware how long it had been since the logs and sign off sheets were no longer available for staff use. Interview on 12/19/23 at 1:00 p.m., with the maintenance director identified he was aware of the missing and broken tiles in the dry storage area. They were old asbestos tiles. It would be	21015		

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21015	Continued From page 26 expensive to have them removed and new tiles installed and had been this way for a "long time". He stated he "may" be able to put new tiles over the old tiles to ensure a smooth, cleanable surface vs replace the existing tiles that had been missing. Review of undated, facility provided policies for food handling, dish machine sanitization, and kitchen cleaning identified all areas were to be kept clean and sanitary. Foods were to be dated, left over foods were be used within 7 days or discarded, refrigerator and freezer temperatures were to be monitored 2 times each day and logged on a monthly tracking sheet, and the DM was to post a log near the dish machine for the staff to document temperatures and test strip results at each meal. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		1/26/24

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21426	Continued From page 27 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 obtain verification of a chest X-ray for 1 of 1 employee (nursing assistant (NA)-B) who had a previous active tuberculosis infection to ensure no active TB. Furthermore, the facility failed to ensure tuberculosis (TB) second step testing was completed for 2 of 5 employees (NA-A, dietary aide (DA)-A) according to the Centers for Disease Control & Prevention (CDC) guidelines. Findings include: NA-B's undated, Baseline TB Screening Tool for Health Care Workers (HCWs) identified on the screening question if the person had a positive	21426	Corrected	

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21426	Continued From page 28 reaction to a TB test or TB blood test and if yes, give date which NA-B identified as yes in 2015. The question of have you ever been treated for active TB disease was also marked yes. The symptoms of active TB disease that were to be circled if present had been left blank. NA-B's medical record lacked evidence that the facility had obtained verification of a negative chest X-ray to confirm no active TB and documentation of no symptoms. NA-A's 7/6/23, Baseline TB Screening for HCWs, identified no symptoms and no history of positive TB or TB test. The form further identified Tuberculin skin testing (TST) first step had been completed on 7/6/23 with the results recorded on 7/8/23 as negative. The record lacked evidence that the second step TST had been completed. DA-A's 11/14/23, Baseline TB Screening for HCWs, identified no symptoms and no history of positive TB or TB test. The form further identified Tuberculin skin testing (TST) first step had been completed on 11/14/23 with the results recorded on 11/16/23 as negative. The record lacked evidence that the second step TST had been completed. Interview on 12/20/23 at 3:49 p.m., with director of nursing (DON) revealed she oversaw infection prevention and confirmed that NA-A and DA-A did not have a second step skin test and should have had one completed. She further, confirmed the facility did not obtain a copy of a negative chest X-ray for NA-B and the facility should have had that in place prior to NA-B working. Review of 6/20/23, Facility TB Risk Assessment Worksheet for Health Care Settings identified TB screening of health care personnel would be	21426		

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21426	Continued From page 29 completed at time of hire. Review of 10/4/21, Tuberculosis, Employee Screening for policy identified employees would be screened for latent tuberculosis infection (LTBI) and active tuberculosis (TB) disease, using a skin test or interferon gamma release assay (IGRA) and symptoms prior to employment. If a employee had previous TB test that was positive, but the individual was at low risk for TB infection, was asymptomatic, and was at low risk of disease progression, a second test would be conducted. The policy had no mention of what steps needed to be made if an employee had a prior positive TB test and had been treated for TB such as obtaining documented normal chest X-ray and would not require a repeat chest X-ray unless they are symptomatic or starting LTBI treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), infection preventionist could review and revise policies and procedures for proper monitoring of TB screenings for history, risk factors, symptoms, and TB testing according to the CDC guidelines. The DON or designee, along with the infection preventionist, could audit TB screenings for history, risk factors, symptoms, and TB testing on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21426		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless	21942		1/26/24

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	00885	A. BUILDING: _____ B. WING _____	C 12/21/2023

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21942	Continued From page 30 fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council within the past 12 months. This had the potential to affect all 31 residents residing in the facility and their representatives. Findings include; Interview on 12/19/23 at 2:43 p.m., with the social services designee reported the facility sent out notices regarding implementation of a family council electronically, but she was not certain when it had last been completed or if there was any documentation of an attempt She confirmed that as of the date of survey there had been no interest in developing a family council and she was not certain when she had last sent out an electronic inquiry. She did report she was aware of the requirement to attempt to form a family council, but there had been no interest from family members. Interview on 12/20/23 at 3:15 p.m., with family member (FM)-1 identified her family member had been in the facility for several months and she reported she had not received any verbal, email, or paper notice asking about setting up a family	21942	Corrected	

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21942	Continued From page 31 council. Interview on 2/20/23 at 4:13 p.m., with FM-2 reported her family member had been a resident for a long period of time. She denied receiving notice of attempts to develop a family council and denied knowing anything about a family council. No policy on forming or having a family council was provided by completion of survey. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21942		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	21980		1/26/24

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21980	Continued From page 32 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of potential abuse timely to the facility management staff and	21980	Corrected	

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21980	Continued From page 33 the State Agency for 1 of 1 resident (R8) reviewed. Findings include: R8's 10/21/23, annual Minimum Data Set (MDS) identified R8 had moderately impaired cognition. R8 was dependent on staff for toileting and cares. R8 had impairment bilaterally in her lower extremities. R8 had inattention and disorganized thinking that fluctuated. R8 had verbal behaviors directed towards others 1-3 days and other behaviors not directed towards others such as screaming, 1-3 days. R8 had no toileting program and was frequently incontinent of bladder and always incontinent of bowel. R8 took a daily anti-psychotic, anti-anxiety, and anti-depressant. R8's 11/30/23, Significant Change MDS assessment identified R8 had severe cognitive deficit. R8's 5/5/23, care plan identified R8 preferred to use bedpan for toileting and refused to sit on a commode most of the time. R8 required 1 staff assist with bed mobility and was able to assist with turning by using the grab bars on the bed. Behavioral focused area last revised 9/7/22, identified R8 was found to be verbally aggressive. She yelled out to staff to come to her room. She was to ask staff to come back to her room right after they stepped out even after they asked if there was anything else she needed. R8 was socially inappropriate and was known to undress, bang on the walls, threaten staff, call the facility, and making false accusations against staff. There was no mention what staff were to do if R8 made accusations against them. Interview on 12/18/23 at 12:06 p.m., with R8 identified a "guy" had helped her earlier today and	21980		

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21980	Continued From page 34 shook her when he rolled her on her side. R8 reported she told the "guy" she was going to report him, and he responded he did not care. R8 stated she told the nurse about him. Interview on 12/18/23 at 5:21 p.m., with licensed practical nurse (LPN)-D identified R8 reported to her a "guy" was rough when rolling her. LPN-D reported she was unaware of who the male staff was and then reported that R8 was sometimes confused. LPN-D said R8's anxiety was high today. LPN-D reported that R8 will report staff so someone goes into talk to her. LPN-D said there were 2 male staff on duty, and she checked to see who had assisted R8 however, everyone on duty had been in to assist R8 during the shift. LPN-D said if there were concerns, she would report them to the director of nursing (DON), but it depended on the circumstance, as sometimes R8 got upset with staff if they did not come fast enough when she wanted help. Today R8 was upset because the "guy" (nurse aide (NA-G), a contracted staff) left the room after R8 was placed on the bedpan and R8 wanted him to stay there. LPN-D revealed R8 liked to report staff for things when things did not "go exactly" as she wanted. LPN-D confirmed she had checked with NA-G and he said he left her room to give her privacy and had visited with R8. LPN-D revealed that R8 had reported her concerns to her around noon-ish that day. LPN-D would not answer if she had reported the allegation of abuse to the DON at that time. Additional interview on 12/18/23 at 5:43 p.m., with LPN-D identified she had followed up again with R8 who advised her she had not wanted to make a "complaint" against NA-G. She then reported the allegation to the DON and thought the DON had went in to talk with R8. She also revealed the	21980		

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21980	Continued From page 35 social service designee (SSD) had been in to talk to R8 during the day due to R8's anxiety. She was unaware if the SSD had knowledge of the incident. Interview on 12/19/23 at 8:35 a.m., with LPN-B who identified if R8 made a report about a staff member, licensed staff were to make sure R8 was ok and interview the resident to determine as much information about the incident as possible, then interview the staff in question and call the DON for direction before letting the staff proceed with work. LPN-B reported that R8 was known to threaten to "report staff" sometimes but not frequently. She reported R8 yelled out for help a lot. Interview on 12/19/23 at 10:10 a.m., with R8 identified a guy had rolled her onto her side and shook her. R8 said she told the nurse and the nurse visited with her and then the head nurse came in and visited with her. She later said there was also a girl in with the guy that shook her and stated she will lie for him. R8 then reported she only spoke to the nurse that was helping her and that no one else talked to her yesterday. She confirmed the guy had not been back to assist her as she had told him he could not come back. She reported when he shook her it made her feel like a "pig" and when she was asked if she was afraid of this person she stated, "yes wouldn't you be". Interview on 12/19/23 at 10:31 a.m., with nursing assistant (NA)-G identified that R8's mood depended on the day and some days R8 was angry and cursed at staff and complained and other days she was fine. NA-G confirmed he was the staff that had assisted R8 yesterday and R8 accused him of being rough when he turned her	21980		

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21980	Continued From page 36 on her side. NA-G reported he was the only staff member in the room at the time. He reported R8 was mad and cursing saying "this is bullshit" as he assisted her to change her brief. He reported after assisting her with her brief she was fine and asked him to help her call her husband. NA-G reported R8 will call her husband if she feels staff are not helping her fast enough or doing a good enough job. NA-G said yesterday was the first time R8 had complained about how he assisted her, and he had assisted her many times. NA-G confirmed that the nurse did speak to him yesterday and asked what had happened and he reported all he had done was turn her on her side to change her brief. Interview on 12/19/23 at 10:45 a.m., with the DON identified she was unaware of any accusation of staff being rough with R8 yesterday. She reported she was in the building into the evening and had no knowledge of an accusation of staff being rough. She revealed the nurse on duty should have interviewed R8 and informed her immediately so she could interview the staff and other residents. The DON noted R8's care plan identified she had previously made false accusations against staff however, that had not meant staff would not report allegations of potential abuse and facility management would investigate all allegations. Interview of 12/20/23 at 11:30 a.m. with the SSD identified she was unaware of the allegation of potential abuse with rough care. R8 never mentioned that when she spoke with R8 on 12/18/23. Review of 10/21/22, Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy identified all reports of abuse would be	21980		

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21980	Continued From page 37 reported to the state agency and thoroughly investigated by facility management. All reports of abuse must be reported immediately to the administrator and to other officials according to state laws. The administrator will make report to state official immediately within 2 hours of an allegation involving abuse or result in serious bodily injury. Upon receiving an allegation of abuse the administrator was responsible for determining what actions (if any) are needed for the protection of the residents. All reports would be thoroughly investigated. Employees who have been accused of resident abuse would be placed on leave with no resident contact until the investigation was completed. A follow up 5-day report of the investigation with sufficient information to describe the results of the investigation and any corrective action taken if allegation was verified. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		