DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 3, 2024

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

RE: CCN: 245394
Cycle Start Date: February 7, 2024

Dear Administrator:

On March 29, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 21, 2024

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

RE: CCN: 245394
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 7, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 May 7, 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 August 7, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 02/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/4/24 through 2/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/4/24 through 2/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53949462C (MN00099626), H53949261C (MN00098379), H53949463C (MN00098322), H53949465C (MN00097245), H53949467C (MN00095619), H53949466C (MN00095622), and H53949464C (MN00095621). 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	F 000		

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

Electronically Signed | 02/29/2024

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:	F 553		3/15/24

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F 553	Continued From page 2 Based on interview and document review, the facility failed to allow active residents and resident representatives participation in the development and review of care plan for 2 of 2 residents (R19 and R113) reviewed for care conferences. Findings include: R19's annual Minimum Data Set (MDS) dated 11/30/23, indicated intact cognition and diagnoses of schizoaffective disorder, adult failure to thrive, and chronic pain. R19's care plan dated 10/21/22, indicated R19 plans to remain in the facility for long term care. The resident and family will be invited to care conferences quarterly or as needed and discharge planning options will be discussed as needed. R19's care conference form indicated her last quarterly care conference was on 3/29/23. R19's progress note dated 11/14/23, indicated a care conference was scheduled for 11/27 at 2:00 p.m., however lacked documentation a care conference actually took place. During interview on 2/04/24 at 7:15 p.m., R19 stated she'd been living at the facility for a year and had never had a care conference. During record review of R19's electronic health record her last care conference was on 3/29/23. During an interview on 2/7/24 at 9:24 a.m., the director of social services (SS)-B stated the social workers were responsible for the care conferences on their floor and care conferences should be done with quarterly and significant	F 553	R19's care conference was held on 2/28/2024. R113 discharged from facility on 2/27/2024. Residents will receive admission and quarterly care conferences along with ensuring the resident and/or resident representative is invited to participate. Facility completed full house audit of admission and quarterly care conferences. Any resident(s) identified outside of the timeframe, will receive a care conference. Facilities policy Care Planning was reviewed and remains current. Facility Social Services department and applicable IDT members educated on care planning/care conferences including frequency and completion of the MHM IDT Care Conference Form to be completed in its entirety. The facility will audit 3 resident care conferences to ensure frequency of care conference and completion of the MHM IDT Care Conference Form weekly for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Social Services Director and/or Designee will be responsible party.	

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F 553	Continued From page 3 change MDS assessments. SS-B verified R19's last care conference was on 3/29/23 and she wasn't due for another one yet stating R19 often refuses care conferences and "she doesn't like to talk to us." During a follow up interview at approximately 10:00 a.m., SS-B verified R19 should have had a care conference since her last one on 3/29/23 and if R19 had refused, it should've been documented in a progress note. SS-B looked back in her notes stating a care conference was scheduled for 11/27/23 and then on 11/29/23 SS-B had spoken with her. SS-B never stated a care conference had actually taken place. R113's hospital discharge orders dated 1/16/24, identified orders for physical therapy and occupational therapy for evaluation and treatment. R113's census form identified he was admitted on 1/16/24. R113's admisson Minimum Data Set (MDS) dated 1/23/24, identified intact cognition and a diagnosis of infection and inflammatory reaction due to internal right knee prosthesis. R113's care plan dated 2/4/24, identified a plan to	F 553		

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F 553	Continued From page 4 discharge home back to his independent apartment. The resident and family will be invited to care conferences quarterly or as needed. R113's physical therapy notes identify he was evaluated on 1/16/24 and seen on 1/17/24, 1/20/24, and 2/2/24. R113's forms history dated 1/16/24 through 2/6/24, lacked documentation of a care conference being completed. R113's care conference form dated 1/22/24, had an "error" status and was blank except for the dietary section. The section where the resdient was offered the ability to view and sign their care plan was also left blank. R113's progress notes dated 1/16/24 through 2/6/24, lacked documentation of a care conference. R113 had been in the facility for 23 days without a care conference. During an interview on 2/4/24 at 12:11 p.m., R113 stated he was not sure what was going on with his plan of care. R113 stated he only had therapy once at the facility, and the hospital said that would be the reason he was admitted. R113 stated he was told he could have therapy up to three times per week but that was not happening here and no one has told him why. R113 wanted to get aggressive treatment so he could go home. R113 stated he had not had a care conference yet and had not received a copy of his care plan. R113 stated he wanted that because not knowing the plan was "stressing me out". During a follow up interview on 2/6/24 at 8:56 a.m., R113 stated he wondered what the process	F 553		

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F 553	Continued From page 5 was to discharge and get outpatient therapy. R113 stated his admission here was pointless if he could not get more therapy. During an interview on 2/6/24 at 3:00 p.m., the director of nursing (DON) stated the first initial care conference would be held the day after or during the week of admission, but before day 21. The DON stated the purpose of the care conference was to meet as an interdisciplinary team to get to know the patient and set up the plan of care. The DON stated the documentation was done in the electronic medical record (EMR). During an interview on 2/7/24 at 8:29 a.m. social services (SS)-A stated new admissions would have a care conference within the first couple days, depending on family and resident wishes, but within 21 days, and it would be documented in the EMR. SS-A reviewed R113's care conference form and progress notes and agreed there was no documentation a care conference was held or a copy had been provided to the resident. The facility policy titled Care Planning dated 1/6/22, identified each resident would have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident ' s individual medical, physical, psychosocial, and functional needs. A written summary of the comprehensive care plan or baseline care plan must be provided to the resident and/or resident representative, and if newly admitted, this would be carried out before day 21. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to	F 553		

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F 553	Continued From page 6 participate in the development of his or her care plan. The care plan was to be modified and updated as the condition and care needs of the resident changes.	F 553		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 1 of 1 resident (R7) observed with medications at bedside. Findings included: R7's significant change Minimum Data Set (MDS) dated 1/10/24, indicated intact cognition with behaviors of inattention, disorganized thinking, delusions, and hallucinations. It further indicated diagnoses of schizoaffective disorder, dementia, and psychosis. R7 was dependent on staff for activities of daily living (ADL) and mobility. R7's physicians orders dated 12/11/23, indicated Ipratropium-Albuterol Inhalation Solution 0.5-2.5 3 milligrams (mg) per milliliters (ml) (Ipratropium-Albuterol), 3 ml inhale orally three times a day for shortness of breath. R7's physician's orders lacked an order to SAM.	F 554	R7 was assessed and found to not be safe to self-administer nebulizer. Full house audit was completed to identify all residents that utilize nebulizers to determine if they can self-administer. Full house audit of all residents to determine any other self-administration that may be needed was completed. Completed SAMS with residents that were identified wanting to self-administer any medications to determine if safe to self-administer. If shown to be safe, received orders and care planned this. Education began will staff in regard to what they should do if they see medication in a resident room including supplements, ointments that have pharmacy label etc. Education began with licensed nurses in regards to verifying if resident is able to self-administer and what to do if a resident does want to self-administer who does not have an	3/15/24

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F 554	Continued From page 7 R7's medical record lacked an assessment to SAM. R7's progress note dated 2/4/2024, indicated the resident was found with nebulizer on the floor. Resident refused nebulizer altogether when new set was obtained. During observation on 2/04/24 at 12:31 p.m., surveyor went to interview R7. His door was shut and upon entering the room he was laying in bed with the nebulizer machine sitting on the nightstand next to him running and the mask was laying on the floor. There were no staff in the room and R7 stated "Can you turn that thing off, it's been on forever!" The surveyor went to get the nurse. Licensed practical nurse (LPN)-B picked up the mask off the floor (which was attached to the medication cup) and there was medication in the cup and it started to flow through the mask. LPN-B stated "It looks like you didn't get any (medication)." During an interview on 2/4/24 at 1:56 p.m., trained medication assistant (TMA)-B stated R7 had received his nebulizer treatment this morning after breakfast at approximately 9:45 a.m. The surveyor stated when she walked into his room at 12:31 p.m., the nebulizer machine was running and the mask was on the floor. TMA-B stated R7 must have taken it off. TMA-B also reported standing outside the door while R7 received his nebulizer. During interview on 2/5/24, at 12:30 p.m., TMA-A stated staff are required to stay in the room with the residents until they have taken their medications which also included nebulizer treatments.	F 554	order. Audits to be completed for 5 residents weekly x4 weeks to ensure SAMS policy is followed, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 554	Continued From page 8 During interview on 2/5/24 at 12:39 p.m., LPN-B stated residents were required to have a doctor's order to self adminster their medications and if they didn't the nurse was expected to stay in the room with the resident until they had taken them. LPN-B verified R7 did not have a doctor's order or an assessment to self administer medications and no staff were in the room when he was receiving his nebulizer treatment. During interview on 2/6/24 at 8:07 a.m., RN-B stated if a resident had a nebulizer treatment it usually would last for 15 minutes and if the resident had a mask it was okay for the nurse to put the mask on the resident, start the treatment, and then leave the room. After 15 minutes the nurse was able to come back to the room and remove the nebulizer. RN-B further stated residents do not need a doctor's order or an assessment to do so. During interview on 2/7/24 at 9:39 a.m., RN-C stated residents need a doctor's order to self administer medications and if they don't have one, staff need to stay in the residents room until they've taken them or until the nebulizer treatment was completed. During interview on 2/7/24 at 12:27 p.m., the director of nursing (DON) verified no residents on the 2nd floor dementia care unit (where R7's room was located) were able to self administer their own medications. In order to do so, the facility would need to assess them, update the doctor, and get an order. The DON stated the nurses/TMA were expected to stay with the resident until the medications were administered and/or the nebulizer treatment was completed.	F 554		

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F 554	Continued From page 9 The facility's policy on self administration of medications revised 2/2024, indicated if it was deemed safe and appropriate for a resident to self-administer medications, this would be documented in the residents medical record and care plan.	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 2 residents (R15) reviewed for activities of daily living (ADL). Findings include: R15's quarterly Minimum Data Set (MDS) dated 12/12/23, indicated intact cognition with diagnoses of paranoid schizophrenia, neuroleptic induced parkinsonism, and type II diabetes. It further indicated R15 was independent with activities of daily living (ADL). R15's care plan dated 9/9/23, indicated R15 had the potential for self-care deficit related to dementia and cognitive impairment. R15 was able to complete his own cares however, refused to do so. The care plan further indicated an intervention to provide nail care as needed (PRN).	F 677	R15 was offered nail care and declined. Care plan reflects residents frequent refusals of nail care. Full house audit of nail care completed. Offered to trim nails. Care plans updated to reflect preferences. Began education with clinical staff in regards to process for offering nail care on bath day and prn. Audit 5 residents weekly x 4 weeks to ensure nails are trimmed or that there was documentation of refusal, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits."	3/15/24

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F 677	Continued From page 10 During observation and interview on 2/4/24 at 12:16 p.m., R15 was laying in bed, his fingernails were approximately a half an inch long on both hands and the thumb nail on his left hand was broken and jagged. R15 stated he would like his nails to be cut and showed the surveyor his left thumb. During observation on 2/5/24 at 8:36 a.m., R15 was laying in bed and his fingernails were approximately a half inch long on both hands and the thumb nail on his left hand was broken and jagged. During observation on 2/6/24 at 7:30 a.m., R15 was laying in bed and his fingernails were approximately a half inch long on both hands and thumb nail on his left hand was broken and jagged. During interview on 2/5/24 at 1:10 p.m. nursing assistant (NA)-A stated nurses were responsible for cutting residents nails if they were diabetic and they should be cut once a week on bath day. During interview on 2/6/24 at 2:08 p.m. registered nurse (RN)-B verified R15's nails were long and needed to be cut. RN-B stated it was the nurses responsibility to cut his nails because he was diabetic and they should be cut weekly on bath day along with the skin assessments. RN-B asked R15 if he would like his nails cut and he replied yes. RN-B went to get the nail clippers, came back to R15's room, and proceeded to cut his nails. During interview on 2/7/24 at 9:39 a.m., RN-C stated nurses were responsible for cutting residents nails if they were diabetic and it should	F 677	Director of Nursing and/or Designee will be responsible party.	

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F 677	Continued From page 11 be offered once a week on bath day when they are completing the skin checks. R7's weekly skin inspection form dated 2/6/24 at 6:34 a.m. indicated RN-B had completed the report at 6:34 a.m. and under the section regarding bath and nail care indicated not necessary for his fingernails to be trimmed. During interview on 2/5/24 at 1:10 p.m., NA-A stated nurses were responsible for cutting residents nails if they are diabetic and they should be cut once a week on bath day. During interview on 2/7/24 at 9:39 a.m. RN-C stated nurses were responsible for cutting residents nails who are diabetic and it should be done once a week on bath day. During interview on 2/7/24 at 12:27 p.m., the director of nursing (DON) stated nurses were responsible for clipping residents nails who were diabetic and they should be clipped once a week on bath day when they are completing the skin checks. The facility's policy on ADL's dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. .	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		3/15/24

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F 686	Continued From page 12 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning for 1 of 1 resident (R4) who was at risk for skin breakdown. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/13/23, identified R4 was rarely/never understood, rejected cares one to three days during look-back period, and had impairments to all extremities. R4 was dependent on staff for dressing, mobility, and toileting and personal hygiene. R7 had diagnoses of anxiety, depression, schizophrenia, post traumatic stress disorder, and diabetes mellitus. R4's significant change Care Area Assessment (CAA) dated 9/20/23, triggered pressure ulcer/injury related to R4 requiring extensive assistance with bed mobility and indicated R4 was always incontinent of bladder and bowel and at risk for developing pressure ulcers. R4's care plan for pressure ulcer/injury directed staff to turn and reposition R4 every two to three hours and as needed with start date of 5/1/23.	F 686	R4 has no skin concerns related to missing turning and repositioning at that time and has been repositioned per plan of care. Full house audit of recent Braden scores to identify others at risk. Reviewed their skin interventions including turning and repositioning program, ensured interventions on care plan and care sheets. Began education with clinical staff in regard to following care plan for turning and repositioning, why this is important, what to do if they are unable to follow the plan, reviewing the care sheet to see turn and repositioning plans. Audit 5 residents weekly x 4 weeks to ensure they are being turned and repositioned per plan of care, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or	

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F 686	Continued From page 13 During observation on 2/4/24 at 12:03 p.m., R4 was laying in bed on their back. During observation on 2/5/24 at 12:30 p.m., R4 was laying in bed on their back. During observation on 2/5/24 at 2:11 p.m., R4 was laying in bed on their back. During observation on 2/6/24 at 7:10 a.m., R4's room door was closed and continuous observation began. At 8:11 a.m., nursing assistant (NA)-A entered the room and R4 was laying on their back in bed. NA-A stated R4 was in bed all the time and ate in bed. NA-A pulled R4's covers down and gown up to unfasten R4's incontinent product with gloved hands, and R4 started to cry out. R4 was dry and NA-A secured R4's incontinent product and covered R4 again with their gown and covers. NA-A did not reposition R4 when checking their incontinent product. NA-A removed gloves and washed hands with soap and water. NA-A wiped R4's face with a washcloth and gloved hands, and R4 stopped crying out. NA-A removed their gloves, used hand sanitizer, and exited room with R4's water pitcher. NA-A returned with ice water in pitcher and applied clean gloves. NA-A swabbed R4's mouth with toothette and then removed gloves and performed hand hygiene. Upon exiting room, NA-A stated R4 required two staff to reposition them and did not use their call light. NA-A reviewed the care sheet undated, which indicated R4 required assistance of two staff for bed mobility, the need to toilet and reposition every two to three hours and as needed, and R4 was incontinent of bladder and	F 686	discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 686	Continued From page 14 bowel. NA-stated R4 did not refuse cares, cried when repositioned, and sometimes responded when asked questions. At 8:41 a.m., NA-A brought R4 their breakfast tray, placed on R4's bedside table and left the room. At 8:48 a.m., trained medication asssistant (TMA)-A entered R4's room and assisted R4 with medication and eating breakfast. At 8:58 a.m., NA-D entered R4's room and relieved TMA-A of assisting R4 with breakfast. At 9:13 a.m., NA-D completed assisting R4 with breakfast. TMA-A and NA-D adjusted R4's head of bed up and down and raised knee area of bed throughout medication and eating assistance. No repositioning or offloading occurred. At 9:38 a.m., registered nurse (RN)-B entered and exited the room without completing repositioning. At 10:11 a.m., R4 continued to lay on their back in bed. At 10:43 a.m., R4 continued to lay on their back in bed. During interview on 2/6/24 at 10:47 a.m., NA-D stated staff used the assignment sheets to determine how much assistance was needed for each resident. NA-D stated R4 did not like to get out of bed and sometimes screamed when touched. NA-D thought NA-A had repositioned R4 and stated R4 required assistance of two for repositioning.	F 686		

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F 686	Continued From page 15 During observation and interview on 2/6/24 at 10:50 a.m., NA-A entered R4's room then left. At 10:53 a.m., NA-A returned and RN-C entered the room and closed the door. NA-A and RN-C completed R4's pericares, and R4 stated "yes" when asked if they wanted to go on their side. RN-C and NA-A verified there were no pillows in the room besides the pillow under R4's head and the pillow brought in during cares, and RN-C asked NA-A to get more pillows and pillowcases. RN-C stated R4 usually had more pillows for repositioning. RN-C stated R4 required repositioning every two to three hours and as needed and used a mechanical lift for transfers with assistance of two staff. RN-C and NA-A repositioned R4 on their side with pillows after pillows brought to room and covered with pillowcases. R4 did not refuse cares nor exhibit behaviors during cares. During interview on 2/6/24 at 11:25 a.m., NA-A stated R4 was last repositioned around 6:30 a.m. by the morning staff. NA-A stated NA-D assisted R4 with breakfast and did not know if NA-D repositioned R4 during breakfast. NA-A agreed R4's repositioning care plan was not followed if NA-D had not repositioned R4 during assistance with breakfast. During interview on 2/7/24 at 2:07 p.m., the director of nursing (DON) stated residents were repositioned based on their care plan. Residents were at risk for skin breakdown if care plans for repositioning were not followed. The facility was asked for a policy regarding repositioning and stated they did not have one.	F 686		

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F 688	Continued From page 16	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a residents knee brace was applied per doctor's orders for 1 of 1 resident (R6) reviewed for mobility and range of motion. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/16/23, indicated R6 had severe cognitive impairment and diagnoses of cerbrovascular disease, dementia, and hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side. It further indicated R6 was dependent on staff for mobility.	F 688	R6 had orders changed to reflect his preferences regarding when he wishes his knee brace to be applied. Knee brace has been applied per new order. Full house audit to identify any resident that utilizes braces/splints. Reviewed orders and care plan to ensure appropriate and being followed. Education began with all licensed nurses in regards to splint/brace care and following orders including documenting accurately. Audit 5 residents that utilize braces/splints	3/15/24

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F 688	Continued From page 17 R6's physician's orders dated 3/1/23 indicated R6 was to wear a left knee brace continuously for 8-10 hours daily and to monitor the skin under the brace before and after removal, twice a day for contracture. On at 1400 (2:00 p.m.) and off 2200 (10:00 p.m.). R6's care plan dated 10/26/22 indicated R6 had an alteration in mobility related to diagnoses of cerebral infarction, cerebral vascular accident (CVA), hemiplegia, chronic pain syndrome, and headaches. R6 needs extensive assist with bed mobility and transfers, uses wheelchair for mobility, able to propel short distances. R6 to wear left knee brace continuously for 8-10 hours daily. Monitor skin under brace before and after removal. During observation on 2/4/24 at 12:38 p.m., R6 was laying in bed and was not wearing his knee brace on his left knee. During observation on 2/5/24 at 8:43 a.m., R6 was sitting in his wheelchair in the dining area watching TV with other residents. He was not wearing his knee brace on his left knee. During observation on 2/5/24 at 12:14 p.m. R6 was sitting in his wheelchair in the dining area. He was not wearing his knee brace. During observation on 2/6/24 1:57 p.m., R6 was laying in bed resting. His left knee was bent over to the side and he was not wearing his knee brace. During interview on 2/6/24 at 2:08 p.m. RN-B verified R6 did not have his knee brace on. The surveyor asked where the knee brace was and	F 688	weekly x 4 weeks to ensure they are being applied per orders and documented accurately, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 688	Continued From page 18 RN-B found it in R6's closet in his room (top shelf), stating he was supposed to have it on in the morning and off at night, whether he was laying in bed or up in his wheelchair. RN-B also stated it was the NA's responsiblity to put the brace on. During interview on 2/7/24 at 8:57 a.m. nursing assistant (NA)-A stated R6 had a knee brace and the nursing assistants were responsible for putting it on at 2:00 p.m. and removing it at 10:00 p.m. During interview on 2/7/24 at 9:14 a.m. NA-D stated R6 had knee brace and that anyone (NA, nurses, therapy, etc.) can put it on. NA-D also stated R6 was supposed to wear it in the morning but he was always complaining about it and didn't want to wear it. "Sometimes" NA-D would let the nurse know when he refused to wear it. During interview on 2/7/24 at 9:39 a.m., RN-C stated the nurses were responsible for putting on/taking off the knee brace so they can asses the skin underneath. RN-C further stated the brace should be applied in the morning and taken off at night. R6 had a history of refusing to wear it but refusals should be documented in his chart. During interview on 2/7/24 at 12:27 p.m., the director of nursing (DON) stated it was the responsibility of the nurses, NA's, or anyone who had been trained by therapy to apply R6's knee brace. She further stated R6 was supposed to have the knee brace on at 2:00 p.m. and then taken off at bed time but he often refused to wear it so she changed the time to overnight (revised care plan on 2/7/24 after entrance). All refusals should be documented and staff should be	F 688		

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F 688	Continued From page 19 documenting in the residents medical record. The facility's policy on adaptive equipment/braces was asked for but not received.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		3/15/24

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F 690	Continued From page 20 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter drainage bags were maintained in accordance with professional standards of practice for 1 of 1 resident (R25) reviewed for catheters. The Center for Disease Control (CDC) Catheter-Associated Urinary Tract Infections (CAUTI) guideline dated 11/5/2015, identified after aseptic insertion of the urinary catheter, a closed drainage system should be maintained. If the aseptic technique was broken, disconnected, or if leakage occurred, the catheter and collecting system should be replaced with aseptic technique and sterile equipment used R25's significant change Minimum Data Set (MDS) dated 11/6/23, identified intact cognition and diagnoses of obstructive uropathy. R38 had an indwelling catheter and required supervision with one person assist for toileting. R25's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/6/23, identified an indwelling catheter was in place for diagnosis of urinary retention, bladder neck obstruction, and obstructive and reflux uropathy. R25 was at risk for urinary tract infection (UTI) related to catheter use. R25's care plan dated 9/24/20, identified he had an indwelling catheter related to bladder neck obstruction inserted on 9/24/20. Goals included remain free from signs of UTI. Interventions	F 690	R25 leg bag was disinfected and stored per policy. Vinegar and basin for leg bag was placed in appropriate location in resident room. Full house audit of all residents that utilize leg bags. No other residents identified. Vinegar is being provided along with basin and location for storage for any resident going forward that requires a leg bag. Education began with clinical staff to the disinfection of urinary catheter bag policy including where to find items and proper storage of. Will audit 5 times weekly x 4 weeks to ensure policy is being followed for cleansing of catheter bag, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 690	Continued From page 21 included wear leg bag during day and noc bag at night and foley cath care per policy. The care plan lacked interventions related to breaking the closed system with a catheter leg bag for drainage. R25's catheter care orders dated 2/4/24, identified R25 wears leg bag during day and noc (nighttime) bag during noc. Staff were directed to ensure the bag was changed according to the order. Additionally, dated 4/1/22, change Foley catheter every four weeks and as needed 16F (French, diameter measurement) and 10 cc (cubic centimeters, volume measurement). During an observation and interview on 2/4/24 at 3:58 p.m., R25 was sitting on his bed, had a McKesson brand leg bag on. R25 stated he was not sure how staff clean or store his catheter bags, but staff switch him over to a drainage bag at night. During an observation and interview on 2/5/24 at 12:57 p.m., nursing assistant (NA)-B emptied out R25's catheter leg bag of 250 cc of yellow urine. NA-B stated staff switched R25's leg bag to an overnight drainage bag. NA-B stated the bag would be disconnected, brought into the bathroom, rinsed out with water, placed in a plastic garbage bag and stored in a closed drawer. NA-B stated he was not taught to use soap or vinegar or other cleaning solutions to rinse out the catheter leg bag. NA-B opened up a wooden clothing drawer that contained the overnight drainage bag. The drainage bag was inside a clear plastic garbage bag and there was moisture noted in the bag. The catheter tubing did not have a cap on it and touched the inside of the clear plastic garbage bag.	F 690		

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F 690	Continued From page 22 During an observation on 2/6/24 at 7:01 a.m., R25 had his leg bag on. During an interview on 2/6/24 at 8:12 a.m., NA-B stated R25's overnight bag had already been switched to the leg bag using the process he described yesterday. During an interview on 2/6/24 at 8:48 a.m., NA-C stated stated staff switched R25's leg bag to an overnight drainage bag and vice versa. NA-C stated the bag would be disconnected, brought into the bathroom, rinsed out with water, placed in a plastic garbage bag and stored in a closed drawer. NA-B stated he was not taught to use soap or vinegar or other cleaning solutions to rinse out the catheter leg bag. During an interview on 2/6/24 at 8:50 a.m., licensed practical nurse (LPN)-A stated she was unsure what the NA's used to clean the catheter bags, not sure if rinsed with anything other than water. Catheter drainage bags were changed according to the provider orders. During an interview on 2/6/24 at 9:24 a.m., NA-D stated there was one resident that had a catheter that was switched from leg bag to an overnight drainage bag and vice versa. NA-D stated the bag would be disconnected, brought into the bathroom, rinsed out with water, placed in a plastic garbage bag and stored in a closed drawer. NA-D stated she was not taught to use soap or vinegar or other cleaning solutions to rinse out the catheter leg bag. During an interview on 2/6/24 at 9:27 a.m., registered nurse (RN)-B stated catheters were	F 690		

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F 690	Continued From page 23 changed usually monthly, in accordance with the provider orders. RN-B stated one bag would be disconnected, brought into the bathroom, rinsed out with water, placed in a plastic garbage bag and stored in a closed drawer. RN-B stated she was not taught to use soap or vinegar or other cleaning solutions to rinse out the catheter leg bag. During an interview on 2/6/24 10:12 a.m. the McKesson catheter systems support representative (SR) stated there were no instructions on the catheter package for cleaning or reuse because, in accordance with the CDC, catheters should not be broken apart from their closed system. The SR stated he heard places use vinegar to clean between uses but could not offer recommendations due to liability. During an interview on 2/6/24 at 3:00 p.m., the director of nursing (DON) stated catheter drainage bags were to be cleaned with soap and water after disconnecting for a switch to leg bag from overnight bag and vice versa. The DON stated the catheter bags should be hung up to dry and not stored wet inside another bag or stored in a drawer due to risk of germ build up and infection control concerns. Facility policy titled Disinfection of Urinary Drainage Bag dated 12/2023, identified the following process to prohibit the growth of bacteria when a urinary drainage bag was removed from a resident: 1. Before disconnecting, cleanse both connecting ends of catheter and tubing with alcohol swab. (This prevents bacteria from entering the catheter end when the bag is disconnected.) 2. Disconnect the bag from the catheter, being	F 690		

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F 690	Continued From page 24 careful not to contaminate the connecting ends by touching other surfaces. 3. Connect the drainage bag to the catheter. 4. Remove gloves and dispose of them in waste container. 5. Make resident comfortable with signal light within reach. 6. Record amount of urine in bag. 7. Remove top cap. Partially fill the bag with 55-65cc of vinegar. 8. Shake the bag gently so the entire inside of bag is rinsed well. 9. Drain vinegar from bag, replace the cap and store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. 10. Wash your hands. 11. Change out bag for a new appliance on bath day. 12. Supplies will be stored in resident room, vinegar, gallon container with plastic disposable cups, alcohol swabs, gloves and paper towels are available in private resident bathrooms. If the resident shares a bathroom, these supplies will be stored in the resident room.	F 690		
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	F 758		3/15/24

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F 758	Continued From page 25 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 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 ensure a rationale was	F 758	R25 prn psychotropic was DC	

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F 758	Continued From page 26 documented for the extended order of an as needed (PRN) psychotropic medication beyond 14 days for 1 of 2 residents (R25) reviewed who had PRN psychotropic medications ordered. Findings include: R25's significant change Minimum Data Set (MDS) dated 11/6/23, identified intact cognition, no behaviors or rejection of care and diagnoses which included anxiety and bipolar disorder. R25 took antianxiety medications, antidepressant and antipsychotic. R25's Care Area Assessment (CAA) dated 11/6/23, identified a trigger for psychotropic drug use related to use of psychotropic medications. Side effect monitoring was in place for these medications. R25's care plan dated 9/24/20, identified a potential for psychotropic drug adverse drug reactions (ADRs) related to daily use of psychotropic medication. Administer medication as ordered monitoring for ADRs. R25's orders dated 11/26/23 with no end date, identified lorazepam (psychotropic antianxiety medication) oral tablet 0.5 milligrams (mg) give 0.5 mg by mouth every 2 hours PRN agitation. R25's Medication Administration Record (MAR) reviewed 11/1/23 through 2/5/24, identified no PRN lorazepam was given, however the order remained active. R25's Consultant Pharmacist Recommendation to Physician dated 12/7/23, identified the current order of lorazepam PRN for agitation needed to	F 758	Full house audit to identify all prn psychotropics. Ensured end dates were in place for all prn psychotropics. Some were DC due to not being utilized. Add psych med section to morning meeting to pull info from dashboard daily to ensure all follow up completed including end dates. Clinical leadership was educated to regulations regarding 14-day prn psychotropics. Audit 5 residents weekly x 4 weeks to check for prn psychotropic orders and ensure have end dates, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 758	Continued From page 27 be addressed. Per nursing home regulations, psychotropics PRN orders are to be limited to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner. During an interview on 2/6/24 at 3:00 p.m., the director of nursing (DON) stated for psychotropic medications the pharmacist would write a report of recommendations and email it to the DON and administrator. The DON would then bring the reports to the nurse managers and they would address with the providers. The DON stated for PRN psychotropics an order was required with an end date, if used for longer than 14 days. The DON stated R25's PRN lorazepam order was in place for longer than 14 days and should not have been. The DON stated they called the doctor yesterday to discontinue the order. During an interview on 2/6/24 at 2:20 p.m. the consultant pharmacist (CP) stated for PRN psychotropics, per regulations, there should be a stop date, no more than 14 days, and reevaluated. The CP reviewed the pharmacy recommendation dated 12/7/23 and stated during her review in January 2024, the 12/7/23 form had not been addressed. The CP stated R25's lorazepam was continued for longer than 14 days and should have not been without provider review. The CP stated the 14 day limit with reevaluation was to help minimize ADRs. The facility's undated policy titled Psychotropic Medication Use, identified residents would not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders	F 758		

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F 758	Continued From page 28 for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order should be indicated in the order. PRN orders for psychotropic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 8% with 2 errors out of 25 opportunities involving 2 of 7 residents (R115 and R12) who were observed during medication administration. Findings include: R115's order summary report printed 2/7/24, included diagnoses of hypokalemia (low potassium) and iron deficiency anemia (too few healthy red blood cells due to low iron in the blood). R115's medication administration summary (MAR) for February 2024, identified the following orders: -start date 1/23/24, potassium chloride oral tablet	F 759	R115 has discharged. R12 had no adverse effects from error. Times of medication has been changed to decrease risk of error. All residents that receive medications have the potential to be affected. Full house audit was completed to determine if any residents require orders to crush medications. Began education with licensed nurses in regards to process of crushing medications. Also began education in regard to administering medications per orders, including not administering medications together that are ordered spread out from each other. Audit 5 residents weekly x 4 weeks to	3/15/24

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F 759	Continued From page 29 extended release give 20 milliequivalent (mEq) by mouth two time a day related to hypokalemia. - start date 1/24/24, ferrous sulfate (iron supplement) 325 milligram (mg) tablet give one tablet by mouth in the afternoon with a meal related to iron deficiency anemia. During an observation and interview on 2/5/24, at 12:10 p.m. registered nurse (RN)-A was preparing R115's medications. RN-A put all medications into a plastic envelope and placed the envelope into the pill crusher proceeding to crush the medications. RN-A placed R115's medications in applesauce and administered. During an interview on 2/5/24, at 2:46 p.m. RN-A indicated that all R115's medications can be crushed. They stated that they had verified this with the nurse practitioner last week. They indicated they had not put a progress note regarding it. RN-A indicated typically there is an order for crushing medications and is not sure if R115 has an order. RN-A verified there is no order to crush medications after reviewing the medical record. RN-A indicated they thought all the medications were safe to crush. R115's order summary report lacked an order for crushing medications. R115's care plan, printed 2/7/24, lacked evidence of R115's preference for medications crushed, or difficulty swallowing. R12's quarterly Minimum Data Set (MDS), dated 12/5/23, identified intact cognition. R12 diagnoses included schizoaffective disorder, dementia related to other diseases. R12's MAR report identified an order with a start date of 2/9/22, for Sinemet Tablet 25-100 mg	F 759	ensure medications are being administered per orders (including not crushing if they do not have orders to do so, and not administering medications from one med pass timeframe with medications from another med pass timeframe), then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 759	Continued From page 30 (carbidopa-levodopa) give two tablets by mouth three times a day related to Parkinson's disease. The identified times of administration were 0700 [7:00 a.m.], 1100 [11:00 a.m.], and 1500 [3:00 p.m.]. During an observation and interview on 2/5/24, at 1:01 p.m. (RN)-A prepared and administered R12's morning medications. RN-A stated R12 takes his medications around or after lunch per his preference as he sleeps in. RN-A stated the MD is aware and has approved this. During an interview and observation with RN-A on 2/5/24 at 1:10 p.m., RN-A indicated they forgot to include the 7:00 a.m. dose of Sinemet with the medication and RN-A administered it. RN-A stated the MD is aware all four tablets are given at that time every day as R12 is never up early in the morning. RN-A stated R12 does not have any side effects from taking four tablets of Sinemet together as that is how "they" all administer his medications. During an interview with RN-A on 2/5/24 at 2:51 p.m., indicated they followed up with the director of nursing (DON) and should have marked the 7:00 a.m. dose as refused and not administered it. RN-A verified it was a medication error. R12's care plan printed on 2/7/24, indicated to administer medications as ordered. The electronic medical record (EMR) lacked evidence of notification of provider of medication error. During interview on 2/6/24 11:04 a.m., DON indicated an order is needed to crush any medication. DON indicated it is important to obtain an order as the doctor and the pharmacist	F 759		

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F 759	Continued From page 31 would review which medications can and cannot be crushed. DON indicated if medications were crushed that shouldn't be it can have an impact on a resident such as it can affect absorption of the medication. DON also indicated if a resident goes from whole medications to needing crushed medications, they need to be assessed as to what has changed. DON verified there was no order to crush R115's medications. DON verified medications need to be given at the scheduled times. She stated if a resident prefers to sleep in and take medications later, the MD should be updated, and medications adjusted. DON indicated medications should not be "doubled up". DON indicated was not aware of a medication error occurring on 2/5/24, involving Sinemet. DON indicated she would follow up on the this. DON verified crushing medications without an order and administering two doses of medications at the same time are both medication errors. During an interview on 2/6/24 at 2:27 p.m., consulting pharmacist (CP) verified potassium chloride oral tablet extended release cannot be crushed. CP verified it would affect the absorption of the medication and it would affect the efficacy. CP verified ferrous sulfate should not be crushed as the liquid form is better for someone who needs their medication crushed. CP indicated it was best to switch a ferrous sulfate tablet to a liquid form to ensure the absorption and efficacy of the medication. They indicated sometimes it can be difficult due to the cost. CP indicated Sinemet should be given at the same time every day when it being given multiple times a day as it was important to minimize the fluctuations of drug concentrations in the blood stream. CP stated the more gap between the doses the more increase and risk of side effects. CP indicated taking two	F 759		

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F 759	Continued From page 32 doses of Sinemet was not recommended and causes increased risks of increased side effects such as confusion, anxiety, and hallucinations. A facility policy regarding medication administration - general guidelines dated 4/18, was provided. It indicates "an order to crush medication may be required or preferred .... orders to crush medications should not be applied to medications which if crushed present a risk to the resident .... the pharmacist should be contacted to review all medication being considered for crushing".	F 759		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F 851		3/15/24

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F 851	Continued From page 33 §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to submit complete and accurate	F 851	The facility has completed an analysis of Q4 PBJ to ensure accuracy based on the	

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F 851	Continued From page 34 direct care staffing information, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Q4), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D dated 7/1/23 through 9/30/23 (Q4), identified excessively low weekend staffing triggered. Review of the facility's PBJ Q4 information identified staffing hours for contracted and facility staff was submitted. Review of staffing schedules from Q4 identified the facility had no obvious gaps in staffing. Review of staff's time cards from Q4 identified no obvious gaps in staffing. During an interview on 2/7/24 at 10:41 a.m., administrator-A stated she was not sure why Q4 triggered, however, it was being reviewed now, and it might have to do with the invoices for contracted staff not being submitted with facility staff timecard hours with PBJ staffing information. During a follow up interview on 2/7/23 at 1:15 p.m., administrator-A stated they reviewed the Q4 census which had remained stable and started a review of Minimum Data Sets (MDS's), staff schedules and time cards to identify they triggers. Administrator-A stated she was previously unaware of the PBJ reports for staffing and would now pull them when available so they can be reviewed for triggers.	F 851	"PBJ Staffing Data Report" specific to the trigger of "excessively low weekend staffing." The facility has submitted Q1 PBJ and will complete analysis based on the "PBJ Staffing Data Report." The facilities Payroll Based Journal Policy has been reviewed and remains current. Staff education initiated on PBJ policy specific to ensuring accuracy. The facility will audit PBJ submissions specific to the "PBJ Staffing Data Report" for accuracy quarterly for 2 quarters, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Administrator and/or Designee will be responsible party.	

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F 851	Continued From page 35 The facility undated policy titled Payroll Based Journal, identified PBJ staffing data submissions are to be completed. Following the federal policy manual created by CMS. Staffing Data was generated and exported from our timekeeping system (UKG) and then imported into CMS according to the submission guidelines provided by CMS.	F 851		
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,	F 867		3/15/24

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F 867	Continued From page 36 and evaluation of performance indicators, including the methodology and frequency for such 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	F 867		

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F 867	Continued From page 37 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity 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	F 867		

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F 867	Continued From page 38 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including 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 failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to environmental concerns and medication errors which resulted in deficiencies identified during this survey. This deficient practice had the potential to affect all 65 residents residing in the facility. Findings include: During an interview on 2/7/23 at 1:02 p.m., administrator-A and administrator-B reviewed findings from previous survey and compared them to findings from current survey, which included ongoing citations for medication errors and environmental concerns: 1. 2/7/24, medication errors and environmental concerns cited 2. 5/11/23, medication errors and environmental concerns cited 3. 10/14/21, environmental concerns cited 4. 8/29/19, medication errors and environmental concerns cited 5. 7/12/18, medication errors and environmental concerns cited. Administrator-B stated the facility had conducted several QAPI meetings since the previous survey with exit date of 5/11/23. Minutes from each meeting were reviewed with the	F 867	Facility completed a Quality Assessment and Assurance (QAA)/Quality Assurance Process Improvement (QAPI) committee on 3/14/2024 and have implemented appropriate action plans specific to medication errors and environmental concerns. The facility completes QAPI monthly and will continue to utilize QAPI Agenda along with working through identified action plans. The facilities QAPI Agenda was reviewed and remains current. The facilities IDT has had education initiated regarding the QAPI Agenda and action plans. The facility will audit monthly QAPI meetings for 3 months, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Administrator and/or Designee will be responsible party.	

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F 867	Continued From page 39 administrator, specifically minutes that were relevant to repeat citations. Since the last survey exited on 5/11/23, Administrator-B stated staff retention was a focus along with implementing a maintenance notification system (TELS). Administrator-B stated 1:1's were completed with two trained medication aide's (TMA's) medication passing skills and environmental rounds were being completed. Administrator-B acknowledged continued and sustained corrective action had not occurred related to medication errors and environmental concerns, and no PIP was conducted to ensure corrective action from previous survey had been sustained. The facility QAPI Plan dated 1/2/24, indicated the QAPI plan provided guidance for the quality improvement program; that QAPI principles would drive the decision-making. Decisions would be made to promote excellence in quality of care, quality of life, resident choice, and resident transitions. Focus areas would include systems that affect resident and family satisfaction, quality of care and services provided, and areas that affect the quality of life for residents. The facility would conduct PIP's that were designed to take a systemic approach to revise and improve care or services in areas identified. The facility would conduct PIP's that lead to changes and guide corrective actions in systems that had an impact on the quality of life and quality of care for residents. An important aspect of PIP's was a plan to determine the effectiveness of performance improvement activities and whether the improvement was sustained.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		3/15/24

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F 883	Continued From page 40 §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 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	F 883		

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F 883	Continued From page 41 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 implement the current standards of vaccinations regarding pneumonia for 4 of 5 residents (R7, R19, R45, and R144) whose vaccinations histories were reviewed. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. One graph identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. An additional graph labeled, "Adults 19-64 years	F 883	R7 and R114 discharged from facility. R19 and R45 were offered the pneumococcal vaccine. Full house audit was completed to determine others that are not up to date with pneumococcal vaccine. The vaccine was offered Will utilize the CDC pneumococcal app to determine who requires the pneumococcal vaccine for all new admissions and will review quarterly during care conferences. Clinical leadership was educated regarding utilizing the CDC app upon admission and to completing the review of vaccines during care conferences. 5 residents will be audited weekly x 4 weeks to ensure they are up to date with vaccines or refusal was documented, then	

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F 883	Continued From page 42 old with chronic health conditions ...," listed multiple columns to reference with which vaccine(s) had already been given and, from that, which were now recommended. The graph contained various conditions which were considered chronic health conditions including, "alcoholism," and "diabetes mellitus," and the graph identified two options for administration of the pneumococcal vaccines. Option A would be administration of PCV20 and option B would be administration of Pneumococcal 15-valent Conjugate Vaccine (PCV15) and more than 1 year later administration of PPSV23. R7's face sheet, dated 2/6/24, indicated he was 64 years old. The record indicated diagnoses included alcohol dependence and type 2 diabetes mellitus. R7's facility immunization record, dated 2/6/24, lacked evidence that R7 was offered or received a pneumococcal vaccine. A care conference note, dated 12/6/23, indicated that R7 was current and up to date on pneumococcal immunization. R7's electronic medical record (EMR) lacked evidence R7 was provided education or offered a pneumococcal vaccine. R19's face sheet, dated 2/6/24, indicated she was 76 years old. R19's facility immunization record, dated 2/6/24, indicated she received the PCV13 on 9/15/15 followed by the PPSV23 on 5/23/17. R19 had signed a consent to receive a pneumococcal vaccine on 12/22/23. The record lacked evidence R19 had received the PCV20 despite her signing a consent to receive it and lacked evidence of shared clinical decision making with the physician. The EMR lacked evidence of any further conversations regarding the pneumococcal vaccine.	F 883	PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible party.	

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F 883	Continued From page 43 R45's face sheet, dated 2/6/24, indicated she was 57 years old. The record indicated diagnoses included alcoholic cirrhosis of liver with ascites (advanced liver disease) and alcohol dependence. R45's immunization record, dated 2/6/24, lacked evidence that R45 was offered or received a pneumococcal vaccine. A consent for administration of pneumococcal vaccine (PCV15, PCV20, PCV13, Prevnar13), dated 12/12/23, was given by her power of attorney. The record lacked evidence that R45 had received administration of any pneumococcal vaccine. The EMR further lacked evidence of any follow-up conversations regarding the pneumococcal vaccination. R144's face sheet, dated 2/6/24, indicated he was 76 years old. R144's immunization record, dated 2/6/24, indicated he received the PCV13 on 7/13/17 followed by the PPSV23 on 9/16/18. The record indicated consent was signed on 10/2/23 to receive all immunizations needed. The EMR lacked evidence of shared clinical decision making with the physician for PCV20. The EMR lacked evidence R144 was offered or received PCV20. During an interview with director of nursing (DON), on 2/7/24 at 11:11 a.m., she indicated she was the infection preventionist. DON verified she ensured residents are up to date on all immunizations. She verified immunization upon admission through MIIC (Minnesota Immunization Information Connection). DON indicated she used the current Centers for Disease Control and Prevention (CDC) recommendations for immunization guidelines, more specifically the PneumoRec VaxAdvisor for pneumococcal recommendations. DON verified R7, R19, R45, and R144's pneumococcal immunizations as	F 883		

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F 883	Continued From page 44 listed above. DON verified R7 and R45 are recommended to receive either the PCV20 or PCV15 based on CDC guidelines. She verified R45 has a consent on file to receive the vaccine was signed 12/12/23 and has not received the pneumococcal immunization. DON verified R7 has not been offered PCV20 or PCV15. DON verified R19 and R144 would be eligible for PCV20. DON verified there has been no shared clinical decision making at this time regarding PCV20 for R19 and R144. A facility policy titled "Pneumococcal Policy" with a review date of 4/6/22 was provided. Policy indicated: it is the practice of the Health Care Facility to offer all residents the pneumococcal vaccines to aid in prevention of pneumococcal/pneumonia infections ...follow recommendations of Centers for Disease Control. Further indicated that residents will be assessed for current immunization stated within 5 days of admission and will 30 days will be offered the pneumococcal vaccine if eligible.	F 883		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility	F 919	R15 care plan has been revised to reflect	3/15/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 45 failed to ensure call lights were accessible to residents for 2 of 2 residents (R15, R190) Findings include: R15's quarterly Minimum Data Set (MDS) dated 12/12/23, indicated R15 had intact cognition and diagnoses of paranoid schizophrenia, neuroleptic induced parkinsonism (Parkinsonism caused by antipsychotic medication), and type II diabetes. It further indicated R15 was independent with activities of daily living (ADL) and mobility. R15's care plan dated 9/9/23, indicated R15 had the potential for self-care deficit related to dementia and cognitive impairment with an intervention of putting the call light within reach. R15's care plan further indicated a revision made on 2/4/24 (survey entrance date) indicating R15 prefers to have the call light over light and hanging. During observation on 2/04/24 at 12:16 p.m., R15 was laying in bed and the call light was hanging across the overhead light. R15 was able to access the call light while in bed but would not be able to access the call light if he was out of bed or were to fall on the floor. R19's annual Minimum Data Set (MDS) dated 11/30/23, indicated R19 had intact cognition and diagnoses of schizoaffective disorder, adult failure to thrive, and chronic pain. It further indicated R19 was independent with all ADL's and mobility except toileting which requires staff assistance. R19's care plan dated 10/21/22, indicated R19 had a potential for falls related to unsteady	F 919	that he prefers call light hanging over the overbed light. R190 call light was placed within reach. Full house audit to determine any preferences related to call light placement.Adjusted the care plan to match that preference Began education with all staff in regard to ensuring call light is within reach unless care sheet indicates otherwise Will audit 5 residents weekly x 4 weeks to ensure call light is within reach or in location of preference, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing and/or Designee will be responsible part	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 02/07/2024

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F 919	Continued From page 46 balance moving off/on the toilet and between surfaces with an intervention to keep the call light within reach. During observation on 2/4/24 at 1:01 p.m., R19 was laying in bed and the call light was on the floor at the foot of her bed not within reach. R19 stated "Oh it always ends up down there somewhere on the ground" and pointed at the foot of her bed. During interview on 2/4/24 at 1:45 p.m., licensed practical nurse (LPN)-B verified R19's call light was on the floor at the foot of her bed and stated call lights were supposed to be within the residents reach. During interview on 2/4/24 at 7:26 p.m., nursing assistant (NA)-E verified R15's call light was hanging across the overhead light and should be next to or within reach of the resident. During interview on 2/5/24 at 1:10 p.m., NA-B stated call lights should be within reach of the resident so they can access it if they need assistance. During interview on 2/6/24 at 8:03 a.m., TMA-A stated R15 and R19 were capable of using their call lights and call lights should be on the bed or attached to the resident (within reach). During interview on 2/6/24 at 12:27 p.m., the director of nursing (DON) stated call lights should be within reach of the resident but some residents don't want them within reach so in that case she would expect it to be care planned. The facility's policy on call lights dated 5/16/23,	F 919		

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F 919	Continued From page 47 indicated a nurse call must be provided for each resident's bed or other sleeping accommodations. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A nurse call must be provided for each resident bathroom, facility bathroom (if the resident is able to access it), and in all areas used for resident bathing. If a pull cord is provided it must extend to within six inches above the floor so it is accessible to a resident lying on the floor.	F 919		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: During observation and interview, the facility failed to ensure handrails on the second floor were securely attached to the wall and in good repair. This had the potential to affect resident R40 and all residents, staff, and visitors who had access to the handrails. Findings include: R40's quarterly Minimum Data Set dated 12/27/23, indicated they were moderately cognitively impaired, had a diagnosis of dementia, and walked independently. R40's care plan dated 12/14/21, included they had a potential for falls related to unsteady balance and pacing in the hallways. During observation on 2/6/24 at 8:57 a.m., R40 was repeatedly walking down on one side of the	F 924	Handrails on second floor have been securely attached to the wall and are in good repair. All other handrails throughout the facility are securely attached to the wall. Facility completed full house audit to ensure handrails are secured to the wall and fully operational. Any handrails identified as needing repairs, have been fixed. TELS guideline/procedure was reviewed and remains current. Staff education initiated to utilize TELS for maintenance repairs specific to handrails not being secured or in good repair. Facility will audit 3 handrails throughout the facility to ensure they are securely	3/15/24

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F 924	Continued From page 48 hallway and back on the other while dragging their right hand along the top of each handrail as they walked. During observation on 2/6/24 at 9:15 a.m., the handrail in the hallway between rooms 216 and 217 was affixed to the wall by two brackets, each approximately one foot from each end. The right bracket was loose, allowing the rail to move up and down at least one inch and away from the wall at least one-half inch. The curved end piece of the right end of the rail was broken off which left a sharp pointed piece of plastic approximately 1/8 - 1/4-inches wide sticking out from the end approximately one inch. The handrail between rooms 214 and 216 had four brackets with the last one on the right broken, allowing the rail to be pulled up and down two-plus inches and away from wall one inch. The handrail between rooms 213 and 215 had two brackets, with the one on the right side broken and sharp plastic edges exposed. The short handrail on the right side of the elevator on the second floor was missing the curved piece in the left side which left sharp plastic edges and sharp metal rail structure exposed. The left curved piece of rail outside room 208 was broken which left broken sharp plastic exposed. During observation and interview on 2/7/24 at 9:06 a.m., director of maintenance was fixing the handrail between rooms 214 and 216. They stated it appeared it may have been hit by a power chair, and indicated someone should have	F 924	attached to the wall and in good repair for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Maintenance Director and/or Designee will be responsible party.	

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F 924	Continued From page 49 placed a work order in the electronic system to let them know it needed to be fixed. They stated handrail audits were scheduled to be completed in the facility preventative maintenance program, but they were unsure of the frequency. They identified fixing broken hand rails was "super-important", and a "drop everything and get it fixed thing" since a resident could get a skin tear or have a fall. During interview on 2/7/24 at 9:11 a.m., nursing assistant (NA)-A stated R40 continuously walked up and down the hallways all day every day. The stated R40 kept going until she got tired, would sit for a bit, and then started again once they had more energy until they went to bed. NA-A verified R40 consistently ran their hands over all of the handrails as they walked along the side of the hallway. During interview om 2/7/24 at 9:13 a.m., trained medication aide (TMA)-A stated R40 walked up and down the hallway using the handrails all day every day, and only stopped to eat. During interview on 2/7/24 at 9:56 a.m., administrator stated they were unaware of the broken handrails, and indicated the facility used an electronic system to track preventative maintenance and report issues and expected staff to inform maintenance staff regarding eh broken rails, and expected the maintenance staff to round and complete audits as scheduled to ensure they were in good repair for the safety of residents and to provide a homelike environment. During observation on 2/7/24 at 10:20 a.m., R40 continued walking as previously described.	F 924		

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F 924	Continued From page 50 During interview on 2/7/24 at 10:32 a.m., housekeeper (HSK)-A stated they wiped down the handrails daily but did not notice they were broken. A facility work order document undated, included five completed requests for handrail maintenance since 4/2/23, and lacked indication requests were placed for the broken rails noted previously. A maintenance task document undated, indicated handrails were to be checked monthly to ensure they held 25 pounds of pressure. Past handrail maintenance inspection reports were requested but not provided.	F 924		

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	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/08/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/08/2024. At the time of this survey, THE ESTATES AT LYNNHURST found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/29/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE ESTATES AT LYNNHURST is a 2-story building with a partial basement. The facility was constructed at two different times. The original building was constructed in 1962 and was determined to be of Type II (222) construction. In 1967, an addition was constructed	K 000		

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K 000	Continued From page 2 to the northeast and was determined to be of Type II (222) construction. Because the original building and the one addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		3/15/24

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K 353	Continued From page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(5), 5.2.2.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head in the Kitchen serving as initial suppression for the stove was found to grease / debris loaded. 2. On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by observation the Basement of the structure that cabling was zip-tied to the sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	The sprinkler head in kitchen has been cleaned from grease/debris. The cabling in basement was removed from being tied to the sprinkler system piping. All other sprinkler heads have been assessed to ensure no grease/debris. All other sprinkler system piping inspected to ensure no cabling attached to the piping. Education initiated to maintenance department regarding checking sprinkler heads quarterly with quarterly sprinkler system inspection from vendor and not tying anything to the sprinkler system piping. The facility will audit 3 sprinkler heads to ensure they are free from grease/debris weekly for 4 weeks, then PRN based on results. The facility will audit sprinkler system piping to ensure no cabling/cords are attached to the piping weekly for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Maintenance Director and/or designee will be responsible party.	
K 374	Subdivision of Building Spaces - Smoke Barrie	K 374		3/15/24

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K 374 SS=F	Continued From page 4 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by observation that fire / smoke barrier doors on the Main Floor did not properly close and seal the opening, allowing the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	The fire/smoke barrier door has been repaired to ensure it properly closes and seals. All other fire/smoke barrier doors have been inspected to ensure proper closure and sealing. Education initiated to maintenance department to check fire/smoke barrier doors for proper closure and sealing at minimum monthly during fire drills. The facility will audit 2 fire/smoke barrier doors to ensure proper closure and sealing weekly for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input	

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K 374	Continued From page 5	K 374	on the need to increase, decrease or discontinue the audits. Maintenance Director and/or designee will be responsible party.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 4.7.6, 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted for 10 of the past 12 months. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	The facility has completed a fire drill on 2/28/2024 and has completed the appropriate documentation for the fire drill. The facility will conduct fire drills per regulation. Education initiated to maintenance department on completing fire drills quarterly resulting in 1 per shift and completing the fire drill report. The facility will audit 1 fire drill to ensure they are completed per regulation and the fire drill report is completed, monthly for 3 months, then PRN based on results.	3/15/24

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K 712	Continued From page 6	K 712	The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Maintenance Director and/or designee will be responsible party.	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741		3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/08/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain policies associated to smoking per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that the facility presented multiple smoking policies for review - making it unclear which policy being adhered or enforced. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 741	The facility will be utilizing Monarch Healthcare Management “Resident Smoking Policy” and the other smoking policy has been removed from the life safety book. Residents have this policy as part of their admission agreement. Education initiated to staff regarding the Monarch Healthcare Management “Resident Smoking Policy”. The facility will audit the life safety book to ensure the Monarch Healthcare Management “Resident Smoking Policy” is in the book weekly for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Maintenance Director and/or designee will be responsible party.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/08/2024**

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

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K 923	Continued From page 8 within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.2.1. Thls deficient finding could have a widespread impact on the residents within the facility.	K 923	The Med Gas (O2) Room has been secured. Education initiated to staff to ensure the Med Gas (O2) room is always left secured. The facility will audit to ensure the Med	

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	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/08/2024**

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

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K 923	Continued From page 9 Findings include: On 02/08/2024 between 10:00 AM and 2:00 PM, it was revealed by observation that the Med Gas (O2) Room was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Gas (O2) room is secured weekly for 4 weeks, then PRN based on results. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Maintenance Director and/or designee will be responsible party.	