DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 28, 2023

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

RE: CCN: 245485
Cycle Start Date: May 2, 2023

Dear Administrator:

On May 10, 2023, we informed you that we may impose enforcement remedies.

On June 1, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 2, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 2, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Johnson Memorial Hosp & Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING **02 - NEW BUILDING** B. WING _____	**05/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	**1290 LOCUST STREET DAWSON, MN 56232**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/30/2023. At the time of this survey, Johnson Memorial Hospital and Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/04/2023

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	K 000		

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.

Johnson Memorial Hospital and Home is a one-story building with partial basement under the "A" wing. The building was constructed in 2018 and was determined to be of Type V (111) construction.

The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The building is separated

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K 000	Continued From page 2 from the adjacent hospital and assisted living by 2 hour fire barriers and is separated into smoke compartments by two 2 hour fire barriers and 3 smoke barriers. The facility has a capacity of 56 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the emergency emergenct lights per NFPA 101 (2012 edition), Life Safety Code or NFPA 99 (2012 edition), section 19.2.9.1 and section 7.9. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 05/30/2023 at 1:15 PM, it was revealed by a review of available documentation that an emergency light test log could not be located to show that a 30 second monthly test and 90 minute annual test has been conducted for the past year. An interview with the Maintenance Director	K 291	CFR:NFPA 101 All emergency lighting in the facility will be tested of at least 1-1/2 hour duration in accordance with 7.9. 18.2.9.1, 19.2.9. The facility will conduct a 30 second monthly functional test and a 90-minute functional test annually. On 5/31/2023, all emergency lighting was tested for the 30 second functional test by the Facilities Manager. The monthly 30 second functional test was added to the Facilities Manager's testing calendar. On 6/1/2023, the Maintenance Staff were educated on functional testing requirements including updates to the policy, the maintenance of battery-operated emergency lights and corresponding audit tools.	6/30/23

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K 291	Continued From page 3 verified this deficient finding at the time of discovery.	K 291	On 6/30/2023, the annual 90-minute emergency lighting function test was completed. The Monthly and Yearly Emergency Light Test policy was updated to include the reference to the Emergency Testing Log. Emergency lighting compliance logs will be reviewed monthly by Facilities Manager and/or Safety/Risk Coordinator or designee. Compliance will be monitored by the Safety Committee on a quarterly basis x 12 months.	

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E 000	Initial Comments On 5/30/23 through 6/1/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 5/30/23 through 6/1/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54852228C (MN92615) and H54855588C (MN86542). The following complaints were reviewed: H54852227C (MN92278) with a deficiency cited at F609. 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	F 000		

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

Electronically Signed | 07/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to report potential abuse within 2	F 609	The facility ensures that all allegations of abuse, neglect, exploitation, mistreatment	7/23/23

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F 609	Continued From page 2 hours for 1 of 3 residents (R27. who was identified with a bruise on his abdomen of unknown origin. Findings include: R27'S 4/13/23, quarterly Minimum Data Set (MDS) identified R27 had severe cognitive impairment and required extensive assistance with all cares. R27 had diagnosis of diabetes, high cholesterol, depression, anxiety, and cognitive decline. R27's undated care plan identified R27 is a vulnerable adult due to impaired cognition and memory loss and He needs assistance with activities of daily living (ADL's). R27's progress notes entered on 3/27/23, at 12:45 a.m., identified registered nurse (RN)-C documented she had been notified on 3/26/23 at around 8:30 p.m., that R27 had bruising on his abdomen that extended down the left side. RN-C documented R27's abdomen was distended and R27 reported pain. RN-C had called the on-call physician and R27 was sent to emergency department for further evaluation. R27 had a CT scan completed, with the results showing the injury to have an unknown etiology. R27 received IV fluids and an injection of an antibiotic prior to returning to the facility. RN-C updated the director of nursing (DON) at 10:30 p.m.. Review of the report to the State Agency (SA) identified it was submitted on 3/27/23 at 2:40 a.m., that a nurse aide reported R27 had a large bruise on his abdomen extending from his umbilicus down to his left side. Upon assessment of the bruise, there was abdominal distention as	F 609	are reported immediately according to CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) On 3/26/2023 R27 was assessed in the adjoining onsite hospital emergency room for the noted umbilical region bruising. CT scan results noted bruising was related to an unknown origin. The resident has a history of unilateral inguinal hernias, diabetic requiring insulin administration, and fragile skin status making R27 prone to bruising. The reporting nurse stated verbally to the Director of Nursing that she was aware of the 2-hour reporting requirement not met. The reporting nurse s contract has ended and is not employed at the facility. On 6/22/2023 The facility policy for Vulnerable Adult Abuse and Prohibition Plan was reviewed and remains appropriate with no changes. On 6/27/2023 mandatory education was provided to all licensed nurses reviewing Vulnerable Adult Abuse Prohibition Plan and specifically the 2-hour reporting requirements related to F609 reporting of alleged violations. Each Nursing Department staff meeting x 6 months will review the content of the Abuse Prohibition Plan and the specific reporting requirements. All new employees are educated on the Vulnerable Adult Prohibition plan and the reporting requirements. The facility will continue to assess and document skin status on each resident	

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F 609	Continued From page 3 well as some pain. A smaller bruise localized at center of umbilicus had been reported at an earlier date, but bruising had significantly spread throughout the day. The report further identified staff had reported the concern to the on-call physician and R27 was transported to the emergency department for further evaluation with orders to have a CT scan performed. The facility completed the report to the SA more than 6 hours after the injury was reported to RN-C. Interview on 5/31/23 at 3:06 p.m., with DON identified she had been updated around 10:30 p.m., that a nursing assistant had reported a bruise to RN-C. DON stated "I see we have a delay in reporting". DON identified that she would have expected RN-C to complete a State Agency report within 2 hours of notification of the bruise and further revealed that RN-C recognized her error when they spoke after the incident. RN-C was unavailable for interview during the survey. Review of the May 2023, Abuse policy identified the administrator, DON, or designee were to report potential abuse within 2 hours.	F 609	weekly. Any changes to skin status such as bruising will be documented in the Risk Management area and be immediately reported to the Director of Nursing, Administrator, or designee to determine if a facility self-report should be submitted to the state agency per the Vulnerable Adult Abuse Prohibition Plan. The Risk Management Report in Point Click Care will reflect any changes in skin status for assessment and be monitored daily during the morning report. Audits will be conducted daily x 4 weeks; then weekly x 4 weeks; then bi-monthly x 3 months; then quarterly x 3 months for compliance. The Director of Nursing, Administrator or designee will be responsible for ongoing compliance. The QAPI committee will review monthly and provide further recommendations as applicable.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		7/7/23

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F 657	Continued From page 4 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review identified the facility failed to revise the care plan for 1 of 1 resident (R17) with known diagnoses of anxiety and depression who was currently in a traumatic life event with her family member who was in the process of actively dying. Findings include: R17 was admitted in July of 2019, with diagnoses of major depressive disorder, post-concussional syndrome, and heart disease, and anxiety disorder. R119's progress notes identified on 4/25/23, R199 was admitted to hospice. The hospice nurse, hospice aide and hospice social worker were to visit weekly.	F 657	The Facility completes a comprehensive Care Plan and revises according to CFR(s): 483.21(b)(2)(i)-(iii). The Licensed Social Worker completes a Trauma Assessment upon admission and at least Quarterly to Determine any mental health resources that may be required by a resident. The resident care plan is updated if any new or revised interventions are recommended. On 5/31/2023 the Licensed Social Worker reviewed and revised R17 s plan of care and visited with R17 on 6/1/2023 to offer any additional mental health services. R17 declined any mental health services on 7/1/2023 but will be offered	

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F 657	Continued From page 5 R17's 12/27/21, care conference note identified the physician had encouraged R17 to see a mental health counselor when he last saw her. R17's undated, current care plan identified R17 suffered from depression, insomnia, migraines, diabetes, sleep apnea, and post-concussion syndrome. R17's PHQ-9 (mood assessment) identified she had several days with poor appetite and half or more days with little energy and feeling down. R17 had a history of not taking her medications or doing self-cares when she was at home. R17 had expressed sadness over her health. Staff were to take a calm, unhurried approach when dealing with R17, and allow her time to vent her concerns and feelings. R17 appears anxious in new situations. Staff were to offer calm, slow explanation and reassurance. Staff were also to observe her mood and adjustment to the care center. There was no mention of R17's situation dealing with grief over R199's hospice diagnoses or to offer mental health services. There was no mention social services was to provide 1:1's for coping with the situation. Observation on 5/31/23 at 10:50 a.m., identified R17 was asleep in her room. Interview on 5/31/23 at 10:56 a.m., with licensed practical nurse (LPN)-A identified R199 went on hospice "about a week ago". At that time R17 was noted to be more withdrawn, quiet in her room, was sleeping more. R199's hospice was discussed at the morning stand-up meetings (IDT meetings). The social worker (SW)-A attended the meetings daily. LPN-A was not aware if SW-A had visited R17 with the sudden change to	F 657	grief/mental health related services on a weekly basis during the LSW's 1:1 visits. R17's primary care provider will be updated with any change to the PHQ9 or as needed. On 6/5/2023 The LSW conducted a review of each residents progress notes to identify any current trauma or mental health needs. On 5/31/23, the LSW reviewed the Trauma policy for Trauma informed care and revised the policy on 7/1/2023 to include additional mental health services. On 6/5/2023 The LSW conducted a review of each resident s progress notes to identify any current trauma or mental health needs. There were no current trauma or mental health needs identified during the review. On 7/3/2023 the LSW communicated to Nursing Staff to report at the daily Interdisciplinary team meetings and/or to the LSW of any residents experiencing a trauma or mental health need. The interdisciplinary team will report/review any resident trauma related issues or mental health service needs at the daily interdisciplinary team meeting. The LSW will conduct an audit of 5 residents per week x 12 weeks and monthly thereafter x 6 months to review compliance of reporting for any trauma or mental health event.	

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F 657	Continued From page 6 R199's health. Staff were to monitor her moods for changes. She was unaware of any other interventions. Mental Health services had been offered before and R17 had declined at that time. To her knowledge, no staff have offered mental health counseling again after R199's new admission to hospice. Interview and R17's progress notes review on 5/31/23 at 11:56 a.m., with registered nurse (RN)-A identified SW-A attended daily stand-up meetings and was aware of R17's family situation. RN-A stated had the SW provided services for R17, there would be a progress note made. She agreed there was no progress note made to indicate SW-A had visited R17. RN-A agreed R17 was at risk for worsening depression and anxiety. RN-A agreed the facility should offer SS and MH in a potential emotional crisis time for this resident. Interview on 5/31/23 at 11:43 a.m., with SW-A identified he was aware of R199's hospice situation and that R17 was her family member. SW-A identified he had not been down to see her, no had he identified R17 needed medically related social services to prevent worsening of her depression and anxiety. R17's 1/16/23, quarterly Minimum Data Set (MDS) progress note identified R17 would be free from discomfort or adverse reactions related to antidepressant therapy through next review. R17 continued to stay in her room most of the time, will come out to meals, and special activities of her choice. R17's 4/5/23, annual MDS identified R17 had feelings of being down, depressed or hopeless 1	F 657	The audit results will be reported to QAP monthly x 6 months for review and further recommendations. The LSW or designee will be responsible for ongoing compliance	

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F 657	Continued From page 7 day during the look-back period, was noted to be tired or have little energy over half the days reported, and had poor appetite or was noted to be overeating at least half of the days reported during the look-back period. R17 was unavailable for interview as she was dealing with R199's end of life process. Review of the December 2022, Behavioral Health Services policy identified staff were to identify residents with mental and emotional care needs based off of physician orders, diagnoses, and mental health history, and care plan those interventions.	F 657		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically related social services and/or obtain mental health counseling and notify the provider for 1 of 1 resident (R17) whose family member (R199) was in the process of actively dying. This had the potential to exacerbate R17's already existing anxiety and depression. Findings include: R17 was admitted in July of 2019, with diagnoses of major depressive disorder, post-concussional syndrome, and heart disease, and anxiety	F 745	The facility provides medically related social services to attain and or maintain the highest practicable, physical, mental and psychosocial well-being of each resident according to the provisions of Medically Related Social Services CFR(s): 483.40(d). Medically related social services interventions are reviewed on an ongoing basis by the Interdisciplinary team (IDT). When the LSW is aware of a potential mental health need for a resident, the LSW will visit the resident and determine	7/7/23

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F 745	Continued From page 8 disorder. R119's progress notes identified on 4/25/23, R199 was admitted to hospice. The hospice nurse, hospice aide and hospice social worker were to visit weekly. R17's 12/27/21, care conference note identified the physician had encouraged R17 to see a mental health counselor when he last saw her. R17's undated, current care plan identified R17 suffered from depression, insomnia, migraines, diabetes, sleep apnea, and post-concussion syndrome. R17's PHQ-9 (mood assessment) identified she had several days with poor appetite and half or more days with little energy and feeling down. R17 had a history of not taking her medications or doing self-cares when she was at home. R17 had expressed sadness over her health. Staff were to take a calm, unhurried approach when dealing with R17, and allow her time to vent her concerns and feelings. R17 appears anxious in new situations. Staff were to offer calm, slow explanation and reassurance. Staff were also to observe her mood and adjustment to the care center. There was no mention of R17's situation dealing with grief over R199's hospice diagnoses or to offer mental health services. There was no mention social services was to provide 1:1's for coping with the situation. Observation on 5/31/23 at 10:50 a.m., identified R17 was asleep in her room. Interview on 5/31/23 at 10:56 a.m., with licensed practical nurse (LPN)-A identified R199 went on hospice "about a week ago". At that time R17	F 745	with IDT any medical providers additional resources required. On 5/31/2023 the Licensed Social Worker reviewed and revised R17 s plan of care and planned to visit with R17 the next day. On 5/31/2023 PM Nurse visited with R17 to acknowledge the condition of her sibling and offer support. On 6/1/2023 the LSW visited with R17 and offered mental health services and grief support. The resident declined both services at that time. On 6/5/2023 and 6/7/2023 R17's primary care provider's saw resident and no mental health concerns or additional orders for services were received. The LSW reviewed and revised care plan to visit R17 weekly x 6 weeks to assess mental health needs and update provider as needed. On 6/23/2023 a PHQ-9 for R17 was conducted with no change in mental status from the previous assessment on 4/5/2023. When traumatic life events are identified for a resident during daily report or IDT, upon the completion of trauma assessment and a need for LSW or Mental Health Services is identified, LSW will discuss with resident and offer support or services as needed. Follow up will be reported and communicated through resident record. Provider will be updated and notified to address any potential mental health need or services. When incident of trauma has been identified the Social Worker or designee will complete a PHQ-9 to assess if there	

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F 745	Continued From page 9 was noted to be more withdrawn, quiet in her room, was sleeping more. R199's hospice was discussed at the morning stand-up meetings (IDT meetings). The social worker (SW)-A attended the meetings daily. LPN-A was not aware if SW-A had visited R17 with the sudden change to R199's health. Staff were to monitor her moods for changes. She was unaware of any other interventions. Mental Health services had been offered before and R17 had declined at that time. To her knowledge, no staff have offered mental health counseling again after R199's new admission to hospice. Interview and R17's progress notes review on 5/31/23 at 11:56 a.m., with registered nurse (RN)-A identified SW-A attended daily stand-up meetings and was aware of R17's family situation. RN-A stated had the SW provided services for R17, there would be a progress note made. She agreed there was no progress note made to indicate SW-A had visited R17. RN-A agreed R17 was at risk for worsening depression and anxiety. RN-A agreed the facility should offer SS and MH in a potential emotional crisis time for this resident. Interview on 5/31/23 at 11:43 a.m., with SW-A identified he was aware of R199's hospice situation and that R17 was her family member. SW-A identified he had not been down to see her, no had he identified R17 needed medically related social services to prevent worsening of her depression and anxiety. R17's 1/16/23, quarterly Minimum Data Set (MDS) progress note identified R17 would be free from discomfort or adverse reactions related to antidepressant therapy through next review. R17	F 745	has been any change in resident s psychosocial well-being and report findings to resident s primary care provider. LSW or designee will offer supportive mental health services to residents and arrange for services as directed. Residents care plans will be reviewed and revised to reflect any interventions needed. The LSW will conduct an audit of 5 residents per week x 12 weeks and monthly thereafter x 6 months to review compliance of reporting for any trauma or mental health event. The audit results will be reported to QAPI x 6 months for review and further recommendations. The LSW or designee will be responsible for ongoing compliance	

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F 745	Continued From page 10 continued to stay in her room most of the time, will come out to meals, and special activities of her choice. R17's 4/5/23, annual MDS identified R17 had feelings of being down, depressed or hopeless 1 day during the look-back period, was noted to be tired or have little energy over half the days reported, and had poor appetite or was noted to be overeating at least half of the days reported during the look-back period. R17 was unavailable for interview as she was dealing with R199's end of life process. Review of the December 2022, Behavioral Health Services policy identified staff were to identify residents with mental and emotional care needs based off of physician orders, diagnoses, and mental health history, and care plan those interventions.	F 745		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		6/10/23

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F 812	Continued From page 11 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 dietary personnel (dietary aide (DA)-A) followed appropriate infection control technique while preparing and serving food during 1 of 1 meal service observed. Findings include: Observation on 5/30/23 at 11:59 a.m., of DA-A preparing and serving food in the Prairie Lane kitchenette identified DA-A was observed picking up a hamburger bun for the noon meal with her bare hands. DA-A reached into the bag containing buns with her bare hand, placed the bun on the plate, opened the bun, and grabbed the tong and placed a burger onto the bun. DA-A then proceeded to touch each serving handle as she scooped the rest of the meal items onto the plate then handed the plate to another staff to deliver the meal to R19. DA-A was observed to open a drawer and obtain a serving spoon, then grab another plate without washing her hands and reach into the bag of buns with her same bare hand and place the bun on the plate and open the bun. DA-A continued to touch the serving utensils to add the other food items to the plate before handing the plate off to another staff for delivery to R43. DA-A obtained another plate without stopping to wash her hands and reached into the bag and grabbed another bun with her bare hand, place the bun on the plate, open the	F 812	The facility stores, prepares and sanitarily serves according to CFR(s): 483.60(i)(1)(2) On 6/1/2023 the policy for Sanitation & Infection Control was reviewed by the Certified Dietary Manager (CDM) with no changes noted. On 6/1/2023 communication to all Dietary Staff was distributed to require that all staff review and sign off that they had reviewed the Sanitation & Infection Control Bare Hand Contact with Food and Use of Plastic Gloves policy. On 6/1/2023, the Dietary Manager immediately counseled the server on the policy to prevent reoccurrence by the individual. The Food Service Manager or designee will conduct observation audits at one meal/day x 4 weeks and then at least weekly x 4 weeks with random audits thereafter to ensure compliance is observed and the adherence to the Sanitation & Infection Control Bare Hand Contact with Food and Use of Plastic Gloves Policy. The Food Service Manage, or designee will be responsible for monitoring ongoing compliance.	

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F 812	Continued From page 12 bun and add the hamburger, touch each serving handle as she scooped the rest of the food items onto the plate before handing the plate to another staff to deliver to R37. DA-A was then stopped and asked about touching the buns with her bare hands. DA-A reported she could not pull the buns out with a tong but could try. DA-A then revealed that "sometimes" she wore a glove, and then stated, "...I guess I can do that". Interview on 5/30/23 at 2:42 p.m., with food service manager identified DA-A was aware that gloves or utensils should be used when handling food for consumption. She confirmed staff should never be touching resident food and it was her expectation that staff either used gloves or utensils during preparation of a meal plate. Interview on 6/1/23 at 9:11 a.m., with administrator identified her expectation would be that staff would use a utensil or gloved hands to handle food that was to be consumed according to the facility policy. Review of 4/2023, Sanitation & Infection Control - Bare Hand Contact with Food and Use of Plastic Gloves policy identified staff were to use gloves when handling food directly with their hands to prevent contamination of the food being served. Staff could also use barriers like tongs, deli paper or spatulas to prevent contamination and food borne illness. Staff were to use a barrier anytime hands would be touching food directly.	F 812	Audit Findings will be reported monthly to the QAPI committee x 6 months for further review and recommendations.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may	F 849		7/27/23

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F 849	Continued From page 13 do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately	F 849		

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F 849	Continued From page 14 notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by	F 849		

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F 849	Continued From page 15 the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates	F 849		

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F 849	Continued From page 16 with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have an integrated	F 849	The facility provides Hospice Services according to CFR(s): 483.70(o)(1)-(4)	

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F 849	Continued From page 17 hospice care plan and educate facility staff on what services hospice was to provide, and what services the facility was to provide under the hospice contractual agreement for 1 of 2 residents (R16). Findings include: R16's 5/1/23, Significant Change, Minimum Data Set (MDS) identified R16's primary diagnoses were heart failure and cancer. R16 was totally dependent for most all cares, had no instances of walking or moving with staff assistance. R16's progress notes identified R16 was admitted to hospice on 4/25/23. Observations on 5/30/23 at 3:44 p.m., and again on 5/31/23 at 2:38 p.m., identified R16 was asleep in bed and made no effort to arouse when her name was called. Interview and document review on 5/31/23 at 2:40 p.m. with licensed practical nurse (LPN)-B identified R16 was having ascites (fluid collects in spaces within your abdomen) prior to her admission to hospice. R16's family had not wanted any extraordinary measures. R16 was being made comfortable with pain medication regularly. Prior to hospice admission, R16 was beginning the dying process and sleeping quite often and exhibited difficulty with staff attempting to arouse her. LPN-B stated she was aware hospice staff were coming to the facility. She thought the hospice aide bathed R16 2 times per week. She had a schedule for the nurse posted on the wall. The schedule taped to the wall in the nursing station listed Wednesdays as "Dawson". There was no indication what hospice nurse was	F 849	On 6/1/2023 The facility contacted the Hospice agency to provide the facility with a detailed hospice visitation calendar for R16. The updated calendar was received on 6/1/2023 and communication of the visitation and specific tasks to be performed for each resident was communicated to staff. On 6/1/2023 R16 s care plan was updated with the integrated hospice care plan and visitation schedule as provided by the hospice agency. On 6/1/2023 and ongoingly each hospice resident will be reviewed on admission to ensure that the hospice visitation calendar and specific hospice tasks performed for each visit are documented in the resident s record. On 6/30/2023 the DON provided communication to each contracted hospice agency that an integrated care plan and visitation calendar are required for each hospice client. On 6/30/2023 the DON reviewed and revised the Hospice Program policy. All Nursing Staff received communication on 6/30/2023 that any resident on hospice will have a calendar located at the nurses station and the resident s Kardex will reflect hospice visitation schedule including what care hospice will provide. Review of the changes will be conducted with Nursing staff at the 7/27/2023 Nursing Meetings.	

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F 849	Continued From page 18 scheduled to come, not delineation if that was the aides schedule. LPN-B then asked another unidentified facility aide staff about the hospice aide schedule. LPN-B was advised R16 had a schedule taped to her bathroom door. Review of the calendar taped to the bathroom door identified the word "staff" was written in on Tuesdays. When asked how she knew who (hospice or the facility) provided specific delegated cares or what hospice staff was scheduled and at what times they would come to the facility, LPN-B was unaware. If hospice staff failed to come as scheduled, she was "sure they would alert" the facility. Review of the hospice care plan with LPN-B identified she was unsure where the document was located. After some time, LPN-B located the hospice care plan in R16's paper chart where it noted: 1) The hospice aide was to visit 1 x per week, and only provide bathing and personal cares for 5 additional visits for "acute personal care" as needed. 2) The hospice nurse was to visit 1 x per week for "symptom management" with an addition 5 visits as needed for "acute symptom management". The advanced care plan portion identified the hospice aide would provide specific cares such as assisting R16 with dressing, bathing, changing her oxygen tubing, provide simple dressing changes, and notifying the hospice nurse if R16 had a change in status , increase in confusion, and skin concerns. The hospice aide was to notify the "clinician" if vital noted were: 1) Temperature over 100 degrees Fahrenheit, 2) Pulse over 100 beats per minute, 3) Respirations over 25, 4) Blood pressure below 90/60 millimeters of mercury (mm/hg) or above 140/90 mm/hg, 5) Increase in weight over 2 pounds (lbs) per day	F 849	On 6/30/23 the Charge Nurse Orientation checklist was revised to include the hospice section related to hospice care planning and delegation of duties. Ongoing education will be provided quarterly to all nursing staff on ensuring hospice care plans are updated. Any resident electing hospice benefit will be audited on admission to hospice and when changes occur requiring additional hospice services. The hospice nurse will continue to attend care conferences during the hospice benefit period to ensure that the integrated care plan and visitation schedule is followed. Audits will be initiated when a resident is admitted to hospice, weekly x 4 weeks; then bimonthly x 3 months, then quarterly x 3 months. The results of the audits will be reported to QAPI for review and further recommendations. Audits will be conducted by the DON or designee to ensure ongoing compliance.	

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F 849	Continued From page 19 or over 5 lbs in a week, 6) Oxygen level (SpO2) below 80% with activity or less than 89% at rest. Hospice did note the facility staff would provide cares when the hospice staff was not present and facility staff were to be educated on what to do when hospice staff were not present. Hospice was to document their visits in the facility medical record. LPN-B stated hospice visits were not documented in the facility medical record. Continued interview with LPN-B identified LPN-B reviewed the facility care plan. The facility care plan section for hospice identified R16 had a terminal prognosis related to an abdominal mass, carotid (artery in neck), and had a history of facial cancer. Staff were to: 1) Maintain her comfort by adjusting her Activities of Daily Living (ADL) to compensate for her changing abilities. 2) Consult with the physician (MD) and social services to have hospice care for the resident when in the facility. 3) Observe R16 closely for signs of pain, administer medications as ordered and notify the MD if breakthrough pain occurred. 4) Update hospice for unrelieved pain, a change in status LPN-B was unaware of any specific cares she was to provide except medication administration. She could not recall specific education related to R16's needs while hospice staff were not present. There was no specific delegation as to what days the aide or nurse would provide and what days those staff were scheduled to come to the facility. There was also no identification education was provided to all staff responsible for R16's care while they were at the facility and what cares facility staff were to ensure occurred if not	F 849		

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F 849	Continued From page 20 provided by the hospice staff. LPN-B agreed the facility failed to delineate what services they were to provide and what services hospice was to provide per the contractual agreement with hospice. LPN-B agreed she had no specific education provided by hospice per the contractual agreement. Hospice staff were unable to be interviewed during the survey. Review of the November 2022, Hospice Nursing Facility Services agreement identified the facility was to ensure hospice patients were kept comfortable, clean, and well groomed. The facility was to provide services that would be provided by the hospices primary provider in coordination with hospice. The facility was to fully inform the hospice patient what services were to be provided by the facility. The facility was to, in coordination with hospice in developing a plan of care unique to the resident's needs. The facility was to ensure the facility care plan reflected both the hospice care plan and description of facility services to be provided by the facility. Hospice was to provide orientation and ongoing training to facility staff to facilitate safe and effective care.	F 849		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		7/24/23

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F 867	Continued From page 21 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such 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.	F 867		

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F 867	Continued From page 22 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity 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	F 867		

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F 867	Continued From page 23 assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including 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 data submitted to the QAPI committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 48 residents. Review of the monthly QAPI meetings from May 2022, through April 2023 identified the facility departments were submitting data to be reviewed by the committee. 2 examples of failure to analyze and document that process identified: 1) In June 2022, an aim was identified where all staff would be compliant with personal protective	F 867	The facility conducts QAPI/QAA improvement activities according to QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) The facility has established a QAPI program and meets monthly. There were no residents directly affected by the cited deficiency although all residents would have the potential to be affected by the cited deficiency. On 6/2/2023 the facility Quality Assurance Performance Improvement Plan was	

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F 867	Continued From page 24 equipment (PPE) use. Quarter (Q)-4 in 2022 identified 90% eyewear rate, Q1 in 2023, 89%, Q2 in 2023 had an 89% audit rate with a goal for 100% compliance. The QAPI committee identified eye protection "continued to be an issue". There was no documentation to support the QAPI committee analyzed the data brought forward, how they were going to achieve their compliance, if further education was needed, or if specific staff required retraining etc. 2) Numerous other areas were identified in monthly QAPI meetings, such as labeling of medications identified for Q3 in 2022, which had a 21% efficacy rate. There was no documentation the QAPI committee had analyzed the data to determine why their goal was not being achieved, what barriers were causing the low efficacy rate, or what needed to be done to ensure compliance. There was no indication to support the QAPI committee was analyzing the data brought forth during each month from May 2022 through April 2023 to show how they were going to achieve their compliance, if further education was needed, or for example if only specific staff may have required additional retraining, etc. This remained consistent with all other areas brought forth in each monthly QAPI meeting throughout the past year. Interview on 6/01/23 at 9:27 a.m., with the administrator regarding the QAPI program identified the committee spoke about the elements brought forth to QAPI. She was unaware of any further documentation to support the committee had documented how they analyzed the data brought forth to the QAPI committee for monitoring to ensure they were able to reach their goals, what barriers may be present, or how they would ensure their	F 867	reviewed and revised to update the plan for identifying performance improvement projects, approach to systematic analysis and action, communication from executive leadership, QAPI committee, entire management team, staff, residents/family council and other key stakeholders as designated. The annual care center evaluation will be conducted including the QAPI self-assessment tool. The policy changes were approved by the JMHS Board of Directors on 6/26/2023. On 7/3/2023 the Quality Assurance Performance Improvement LTC policy was reviewed and revised. On 7/7/2023 communication was sent to all JMHS staff to review the updated QAPI plan and Quality Assurance Performance Improvement plan/policies. Education on the QAPI program will be provided at the July 2023 Staff Meetings and at the August 2023 staff quarterly education sessions. On 7/13/2023 The QAPI committee will review policy revisions. The committee will further conduct systemic analysis and action plans including root cause analysis for each QAPI measure being reviewed. Performance improvement teams which include both frontline staff and management will be formed as applicable. The Director of Quality and Administrator will review the progress of all QAPI activities monthly to ensure effective analysis and action.	

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F 867	Continued From page 25 monitoring over their affected areas were identified to be able to reach their goals for oversight. Interview on 6/01/23 at 10:31 a.m., with the QAPI coordinator (QC)-A identified she had no documentation to support the data brought forth to the QAPI committee was being analyzed to identify how they would achieve compliance. The committee did identify numerous areas where auditing was being completed. For example, with hand hygiene, education had been provided, but there was no documentation to support the QAPI committee had analyzed concerns to see if their education was effective, if continuing education was needed to be provided, or how the facility was going to achieve their perspective department goals. Review of the 2022 Quality Plan policy identified the governing board had the ultimate authority and accountability for the quality of care delivered. The administrator was to provide staff support to the QAPI program and review recommendations made. The administrator was to provide staff support to the QAPI program and review recommendations made through that process. The administrator was to delegate each department to actively participate in the program with objectives to problem identification, implementation of corrective action, and evaluation of the effectiveness of the program through ongoing monitoring and data collection.	F 867	On 7/20/2023 the Director of Quality will attend the Resident Council meeting to review and discuss the current QAPI program. Monthly monitoring of the improvement s efforts will be conducted by the Director of Quality, Administrator or designee and be reported to the JMHS Quality Committee of the Board of Directors and the JMHS Board of Directors on a quarterly basis.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		7/15/23

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F 883	Continued From page 26 §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 already been immunized; (iii) The resident or the resident's representative	F 883		

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F 883	Continued From page 27 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 ensure 5 of 5 residents (R7, R16, R17, R26, and R45) were appropriately vaccinated against pneumonia upon admission. Furthermore, the facility failed to have a method or system to ensure the facility offer or provided any initial or updated vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations. This had the ability to affect all 48 residents. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-64 years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the PCV-20 at least 1 year after prior PCV-13, b) the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years after first dose of PPSV-23.	F 883	The facility provides Influenza and Pneumococcal Immunizations according to CFR(s): 483.80(d)(1)(2) 6/6/2023 The facility reviewed all residents and their vaccination status according to current CDC vaccination guidance and vaccine availability. All eligible residents were given or signed a declination of the PSV20 or any outstanding vaccination at that time. The admission checklist was reviewed and contains an item that indicates to review resident vaccinations and provide as necessary. On 6/6/2023 the facility vaccination policy LTC Resident Vaccinations was reviewed and revised to reflect the current vaccination guidance and procedure for ensuring that residents are offered vaccinations upon admission and when there are any changes to the vaccine guidance. If a resident requires an updated vaccination, vaccines are	

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	245485	A. BUILDING _____ B. WING _____	C 06/01/2023

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F 883	Continued From page 28 Staff were to review the pneumococcal vaccine recommendations again when the resident turns 65 years old. 2) Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose Review of 5 sampled residents for vaccinations identified: 1) R17 was under 65 with immunocompromising diagnoses and was admitted to the facility in July of 2019. R17 had received the PCV-13 on 11/14/17, prior to her admission. R17 should have been offered and/or provided the PCV-20 at least 1 year after prior PCV13, OR the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 AND PPSV-23 (dose 2) at least 5 years after first dose	F 883	available within the attached clinic, hospital, or LTC facility available 24 hours a day and the resident will be offered the vaccine by nursing and scheduled to receive either by a hospital, clinic or care center nursing staff. The facility Infection Preventionist (IFP), DON or designee will continue to review CDC guidance for any updates on a weekly basis. The IFP, DON or designee will audit all residents on admission and monthly to ensure vaccination program compliance. Vaccination compliance will be monitored by the QAPI committee on a quarterly basis.	

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F 883	Continued From page 29 of PPSV-23. 2) R16 was over 65 and admitted to the facility in November of 2016. R16 had the PCV-13 on 3/11/16. R16 should have been offered and/or provided the PCV-20 at least 1 year after prior PPSV-23 OR the PCV-15 at least 1 year after prior PPSV-23. 3) R7 was over 65 and was admitted to the facility in September of 2022. R7 had previously received the PCV-13 on 2/20/17. R7 should have been offered and/or provided the PCV-20 at least 1 year after prior PCV-13 OR the PPSV-23 at least 1 year after prior PCV-13. 4) R45 was over 65 and was admitted to the facility in March of 2023. R45 had previously received the PCV-13 on 12/18/16 and the PCV-23 on 9/22/20 (after age 65). R45 should have been offered and/or administered the PCV-20 at least 1 year after prior PCV-13 OR the PPSV-23 at least 1 year after prior PCV-13. 5) R26 was admitted to the facility in February of 2023. R26 had the PCV-13 on 1/27/17. R26 should have been offered and/or provided the PCV-20 at least 1 year after prior PCV-13 OR the PPSV-23 at least 1 year after prior PCV-13. Review of the October, 2022 LTC Resident Vaccination policy related to the pneumococcal vaccine identified: 1) Residents were to be offered a pneumococcal vaccine upon admission. 2) A nurse was to review the resident's admission orders, vaccine history, diagnosis and was to administer either the 13-valent pneumococcal conjugate (Prevnar-13) or the 23-valent pneumococcal polysaccharide vaccine (Pneumovax) as indicated. Staff were then instructed to "Please see the CDC algorithm for scenarios and medical conditions at	F 883		

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F 883	Continued From page 30 https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf". 3) Residents will be assessed for pneumococcal vaccination annually. 4) Report any unexpected or significant adverse event to the physician and document in the medical record. Interview and LTC Resident Vaccination policy review on 5/31/23 at 9:46 a.m., with the infection preventionist (IP) identified she expected staff to follow the policy as described above. The IP was unaware of updated vaccination schedules per CDC. The IP stated the facility "didn't actually give vaccinations here. We require all residents go to the clinic for an annual visit". If the IP or assistant director of nursing (ADON) saw a resident was due for vaccines, they were to remind the clinic. The IP agreed the policy was outdated. The IP agreed since the facility kept no vaccinations onsite, admitting nursing staff staff would not have reviewed the outdated policy and if they had, would have thought the residents vaccines were current according to the policy. She was unaware the facility was required to offer and/or provide the vaccines and not rely on the clinic. Had those residents been offered the updated vaccination per the guidelines, the declinations would have been documented in the medical record. She agreed no declinations were noted. Interview on 5/31/23 at 11:36 a.m., with (RN)-A identified facility had no vaccinations kept at the facility to administer to residents. The facility was to offer vaccines upon admission to see what vaccination was due, then staff were to contact the clinic to notify them a resident needed an appointment to get a vaccine. She agreed the policy as is, was not updated and potentially	F 883		

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F 883	Continued From page 31 misleading to staff. Per the policy, she would would have considered the above-mentioned resident's were up-to-date if they received one of the PCV-13 or PCV-23. She agreed they need to be offered upon admission and if a resident was admitted on the weekend, this could not occur as facility staff were unable to send a resident to the clinic as it would be closed. They also wait for a yearly health assessment performed at the clinic for those staff to identify if residents needed further vaccination. She agreed that would delay administration. Interview on 5/31/23 at 1:56 p.m. with the director of nursing (DON) and IP identified the DON agreed the policy was not up-to-date with the CDC guidelines for pneumo-vaccination. She agreed waiting a year for residents to have their annual exam was not following guidance and delaying vaccination. She agreed the facility system needed to be "revamped" as only some residents were admitted fully vaccinated. The IP identified the pneumo-vaccination changes went into effect last march, however, she didn't have time to update her policy. The IP and DON agreed they had no system to ensure residents were vaccinated appropriately upon admission. Interview on 6/01/23 at 9:27 a.m., with the administrator identified she agreed staff failed to vaccinate residents per the current CDC guidelines. She also agreed it was the facility's responsibility to provide the vaccines and not rely on the adjoining clinic to identify the residents were not either offered the vaccine upon admission or administered the vaccines per the schedule to be fully vaccinated against the pneumococcal virus.	F 883		

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F 944	Continued From page 32	F 944		
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide mandatory training on the facility ' s QAPI Program that included the goals and various elements of the program or how the facility intended to implement the program, staff's role in the facility ' s QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility ' s QAPI program. Findings include: Interview on 5/31/23 at 2:57 p.m. with licensed practical nurse (LPN)-B and LPN-C identified neither could recall any annual training provided by the facility on the QAPI program or its components. There were aware of what a performance improvement project (PIP) was, but not identify what PIP the facility was conducting. They also could not specify what QAPI areas or programs the QAPI committee was working on, what activities the QAPI program was monitoring, how they could communicate any concerns they identified to assist the QAPI committee. The facility hosted quarterly skills fairs, however they could not recall any QAPI being discussed at the skills fairs either.	F 944	QAPI Training will be provided to all staff according to CFR(s): 483.95(d) The facility has established a QAPI program and meets at least quarterly. The facility has conducted an orientation to the Quality Program activities during new employee orientation. There were no residents directly affected by the cited deficiency although all residents would have the potential to be affected by the cited deficiency. 6/30/2023 The orientation packets for new employees were updated to include QAPI education. QAPI education will be provided to all staff on an ongoing quarterly basis by the Director of Quality, Staff Education Coordinator or designee. QAPI dashboards will be posted in staff areas for ongoing awareness of QAPI activities. PRN and/or contracted staff will be required to attend or review the quarterly QAPI education provided. 7/7/2023 communication was sent to all staff regarding the QAPI program as well	7/24/23

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F 944	Continued From page 33 Review of sampled staff training identified the following staff had no QAPI training noted as provided on the facility's plan for the following staff reviewed: 1) LPN-B 2) Trained medication aide-(TMA)-A Interview on 5/31/23 at 5:36 p.m., with the staff education coordinator identified she was unaware of the requirement to train staff on all components identified in the QAPI program. Interview on 6/01/23 at 9:27 a.m., with the administrator identified she was unaware the facility needed to provide mandatory training on the facilities QAPI program. Interview on 6/01/23 at 10:31 a.m., with the QAPI coordinator (QC)-A identified she had not provided any training to facility staff regarding the QAPI program. Review of the 2022 Quality Plan policy identified the governing board had the ultimate authority and accountability for the quality of care delivered. The administrator was to provide staff support to the QAPI program and review recommendations made. The administrator was to provide staff support to the QAPI program and review recommendations made through that process. The administrator was to delegate each department to actively participate in the program with objectives to problem identification, implementation of corrective action, and evaluation of the effectiveness of the program through ongoing monitoring and data collection. There was no mention the facility was required to train all staff on activities of the QAPI committee.	F 944	as the current measures in the JMHS Friday FYI Ongoing education will be provided at each Mandatory Department Meeting in July to ensure that all staff including prn/contracted staff are informed of organization s ongoing QAPI program and any PIP areas being analyzed. The Director of Quality, Staff Education Coordinator or designee will conduct 5 staff audits per week x 12 weeks of staff to determine their knowledge of the QAPI/PIP programs, committee and how to report QAPI items. Audit findings will be reported to the QAPI committee monthly for review.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2023

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

RE: CCN: 245485
Cycle Start Date: May 2, 2023

Dear Administrator:

On June 28, 2023, we notified you a remedy was imposed. On August 7, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 27, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 27, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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