Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2023

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

RE: CCN: 245241
Cycle Start Date: November 17, 2022

Dear Administrator:

On December 7, 2022, we notified you a remedy was imposed. On January 5, 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 December 31, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 21, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 31, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2023

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

Re: Reinspection Results
Event ID: 7ZVX12

Dear Administrator:

On January 5, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
December 7, 2022

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

RE: CCN: 245241
Cycle Start Date: November 17, 2022

Dear Administrator:

On November 17, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 21, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 21, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 21, 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:

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by January 21, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Northfield Hospital Long Term Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 17, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
December 7, 2022

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

Re: State Nursing Home Licensing Orders
Event ID: 7ZVX11

Dear Administrator:

The above facility was surveyed on November 14, 2022 through November 17, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	**2000 NORTH AVENUE NORTHFIELD, MN 55057**

(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 From 11/14/22 through 11/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk	E 006		12/31/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/16/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 11/17/2022

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E 006	Continued From page 1 assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	**2000 NORTH AVENUE NORTHFIELD, MN 55057**

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E 006	Continued From page 2 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Preparedness Plan (EPP) included an all-hazards facility-based and community-based risk assessment. This had the potential to affect all all 30 residents and the staff of the facility. Findings include: On 11/17/22, at 11:36 a.m. during a review or the facility's EPP, the documents lacked a facility-based and community-based risk assessment, utilizing an all-hazards approach for the long term care (LTC) facility. During an interview on 11/17/22, at 11:40 a.m. the emergency management director (EMD) stated the long term care facility risk assessment was included in the hospital-wide risk assessment and the EPP did not include a facility based risk assessment that was specific to the LTC. Per phone message from the director of nursing (DON) on 11/18/22, at 11:54 a.m. the DON stated the administrator advised her using the hospital resources allows a quicker and larger response, they are not a stand-alone facility, and the LTC facility falls under the same leadership, and the same EPP.	E 006	The LTCC Administrator and Director of Nursing have been permanent members of the NH+C Emergency Management Task Force (EMTF) who develops the organization procedures and policies for a response to a disaster or emergency and has annually completed a hazard and vulnerability assessment which included the LTCC. On December 9, 2022, the LTCC Administrator, Director of Nursing and Assistant Director of Nursing completed an independent LTCC Hazard and Vulnerability Assessment for the LTCC. Using the LTCC Hazard and Vulnerability Assessment the LTCC Administrator, Director of Nursing and the NH+C Safety Director developed the LTCC Emergency Management Policy which outline the unique relationship with NH+C and the LTCC to ensure that there is an integrated response that meets the needs of the LTCC community. The policy was completed December 14, 2022. Communication and review of the policy will be completed by December 31, 2022, to the LTCC staff members. Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	**2000 NORTH AVENUE NORTHFIELD, MN 55057**

(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 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a emergency policy or procedure which outlined a means for sheltering for all residents, staff and volunteers who would remain in the facility if an evacuation could not be	E 022	The LTCC Administrator and Director of Nursing have been permanent members of the NH-C Emergency Management Task Force (EMTF) who develops the organization procedures and policies for a	12/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	2000 NORTH AVENUE NORTHFIELD, MN 55057

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E 022	Continued From page 4 executed. This has the potential to affect all 30 residents currently residing within the facility and staff working at the facility. Findings include: During review of the facility's emergency preparedness plan (EPP) on 11/17/22, at 11:36 a.m. the plan lacked indication of how the facility determined the quantity of food and fuel that would be required to shelter in place and failed to specify the quantities needed of such items. Shelter in Place policy mentioned the hospital and clinics, but not the long term care facility. During interview on 11/1/7/22 at 11:40 a.m. the emergency management director provided the policy for the hospital, and acknowledged the facility was not mentioned, and acknowledged the quantities of supplies of food and fuel needed were not included in the plan.	E 022	response to a disaster or emergency and has annually completed a hazard and vulnerability assessment. The LTCC Administrator and Director of Nursing developed a LTCC Shelter in Place policy that outlines the process / procedures for the LTCC. The policy was completed December 14, 2022. Annually the Director of Culinary Services works with our food service vendor to enter into an Emergency Preparedness plan that covers the LTCC meals. In addition, we have an Emergency Preparedness of the Culinary Services Department Policy that was updated to change the name of our Culinary Services from Nutrition Services only but was current to include LTCC during the survey. The updated date is December 15, 2022. NH+C has an agreement with Culligan to supply emergency water, this was also current during our survey. NH+C also has an Emergency Generator system and fuel supply. The facility was not aware of the request for these procedures / policies during the survey and could have provided them. Communication and review of the new LTCC Shelter in Place policy will be completed by December 31, 2022, to the LTCC staff members. Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5)	E 023		12/31/22

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E 023	Continued From page 5	E 023		

§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:
(i) Preserves patient information.
(ii) Protects confidentiality of patient information.
(iii) Secures and maintains the availability of records.

*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and

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E 023	Continued From page 6 secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to develop and implement emergency preparedness policies and procedures which addressed a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. This had the potential to affect all 30 patients currently being served by the agency. Findings include: During review of the Emergency Management Policy on 11/17/22, the EPP policies did not include a policy for a system of medical documentation that preserved medical information, protects confidentiality of patient information, and secures and maintains availability of records. During interview on 11/17/22, at 11:36 a.m. the emergency management director (EMD) stated the EPP included tracking residents with a medication list, diagnoses, and identifying arm band, but there was no policy or procedure regarding system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The Emergency Management Policy dated June 2022, indicated the facility would respond to a disaster and establish procedures to transfer medical records, but did not include the procedures.	E 023	The LTCC Administrator and Director of Nursing have been permanent members of the NH+C Emergency Management Task Force (EMTF) who develops the organization procedures and policies for a response to a disaster or emergency and has annually completed a hazard and vulnerability assessment. The LTCC Administrator, Director of Information Technology Solutions and the Director of Health Information Management developed a LTCC Emergency Preparedness Communication Plan - Resident Medical Informatio Policy to meet this deficiency. The policy was completed December 14, 2022. Communication and review of the policy will be completed by December 31, 2022, to the LTCC staff members. Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	

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E 024	Continued From page 7	E 024		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for	E 024		12/31/22

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E 024	Continued From page 8 integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness plan (EPP) addressed the use of volunteers in an emergency including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This had the potential to affect all 30 residents who resided in the facility. Findings include: On 11/17/22, at 11:36 a.m. the facility's Emergency Preparedness Plan was reviewed with the emergency management director (EMD), and the policies and procedures did not include the use of volunteers in an emergency, or other emergency staffing strategies that utilized volunteers to address surge needs in an emergency. During interview on 11/71/22, at 11:40 a.m. the EMD stated the EPP did not contain a policy or procedure that addressed the training of and use of volunteers during an emergency or other emergency staffing strategies that involved the use of volunteers.	E 024	The LTCC Administrator and Director of Nursing have been permanent members of the NH+C Emergency Management Task Force (EMTF) who develops the organization procedures and policies for a response to a disaster or emergency and has annually completed a hazard and vulnerability assessment. The LTCC Administrator and Director of Nursing working with the Hospital Medical Staff office developed a LTCC Disaster Privileging for Volunteers policy to meet this deficiency. The policy was completed December 14, 2022. Communication and review of the policy will be completed by December 31, 2022, to the LTCC staff members. Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	
E 042 SS=C	Integrated EP Program CFR(s): 483.73(f) §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.102(e), §485.68(e), §485.625(f),	E 042		12/31/22

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E 042	Continued From page 9 §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based	E 042		

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E 042	Continued From page 10 risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility which elected to participate in a coordinated emergency preparedness plan (EPP) as part of a healthcare system's unified and integrated emergency preparedness (EP) program failed to incorporate the system's coordinated emergency preparedness program to address facility specific requirements. This had the potential to affect 30 clients residing in the facility. Findings include: The EPP was reviewed with the emergency management director (EMD) on 11/17/22, at 11:36 a.m. The facility elected to have a unified and integrated EP program as part of an integrated healthcare system. The EMD presented the EP program developed by the integrated healthcare system. The EMD stated the plan encompassed the hospital, clinics, and long term care (LTC) facility. During review of the Emergency Management Policy on 11/17/22, at 11:36 a.m. the unified and integrated plan did not include documentation that verified the long term care center (LTC) participated in the development of the plan. In	E 042	The LTCC Administrator and Director of Nursing have been permanent members of the NH+C Emergency Management Task Force (EMTF) who develops the organization procedures and policies for a response to a disaster or emergency and has annually completed a hazard and vulnerability assessment. On December 9, 2022, the LTCC Administrator, Director of Nursing and Assistant Director of Nursing completed an independent LTCC Hazard and Vulnerability Assessment for the LTCC. Using the LTCC Hazard and Vulnerability Assessment the LTCC Administrator, Director of Nursing and the NH+C Safety Director developed the LTCC Emergency Management Policy which outline the unique relationship with NH+C and the LTCC to ensure that there is an integrated response that meets the needs of the LTCC community. The policy was completed December 14, 2022. Communication and review of the policy will be completed by December 31, to the LTCC staff members. Plan of Correction will be completed	

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E 042	Continued From page 11 addition, he unified EPP did not include an LTC-based risk assessment as a separately certified facility within the health system. During interview on 11/17/22, at 11:40 a.m. the EMD stated the plan included the entire integrated system and did not document the LTC participated in the development of the plan. Per phone message from the director of nursing (DON) on 11/18/22, at 11:54 a.m. the DON stated the administrator advised her using the hospital resources allows a quicker and larger response, they are not a stand-alone facility, and the LTC facility falls under the same leadership, and the same EPP.	E 042	December 31, 2022. The Administrator has responsibility for this plan of correction.	
F 000	INITIAL COMMENTS On 11/14/22 to 11/17/22,a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be unsubstantiated: H52415759C (MN85072). 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		

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F 000	Continued From page 12 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide hearing services for 1 of 1 (R13) residents who had a decline in hearing. Findings include: R13's quarterly MDS dated 10/6/22, indicated R13 had intact cognition, moderate difficulty with hearing, ate independently, required extensive assistance of one staff for dressing and personal hygiene, and extensive assistance of two staff for bed mobility and transfers. R13's diagnoses included obesity, diabetes, edema (fluid) in her lower extremities, high blood pressure, chronic kidney disease, and osteoarthritis (low bone density).	F 685	Plan of correction for R13 included Assistant Director of Nursing scheduled a audiology evaluation at Allina Clinic on December 19, 2022. All residents have the potential need for hearing services and are assessed upon admission, quarterly and PRN. IDT determined no outstanding unmet needs on December 12, 2022. Systemic changes include Director of Nursing developing a Hearing Services Instruction which outlines a two week time frame for scheduling an appointment with In-House, if they are not available the Assistant Director of Nursing wil contact a local provider to see if an earlier appointment can be obtained. Residents needs for services will be	12/31/22

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F 685 Continued From page 13

R13's Care Area Assessment (CAA) dated 2/3/22, indicated R13 triggered for communication impairment due to hearing loss and needing to raise voice when speaking to R13.

R13's care plan dated 6/9/22, indicated R13 had moderate hearing impairment. The care plan note indicated Interventions included using an amplifier (pocket-talker). The care plan also indicated R13 had weekly visitors and frequently spoke to family and friends on the phone. The care plan also indicated R13 did not participate in activities but enjoyed one to one visits.

R13's care plan dated 10/20/22, was identical to the care plan dated 6/9/22, with the date changed and therefore indicated the same concern and interventions for R13's communication and hearing, including a request for an audiology consult.

R13's care conference note dated 5/6/22, indicated R13's hearing amplifier was not working well.

R13's provider note dated 7/1/22, indicated family member (FM)-A was interested in pursuing hearing aids for R13. Medical doctor (MD)-A indicated he would advise staff to coordinate an audiology appointment for R13 to be evaluated for hearing aids.

R13's care conference note dated 7/20/22, indicated R13 stated her hearing amplifier was no longer working well and R13's family wanted to wait to replace it since In-House Audiology was scheduled to see R13 in September 2022.

F 685

discussed at daily IDT metings and Director of Nursing will monitor compliance weekly ongoing to ensure services are being met and evaluated beginning December 12, 2022. Nursing and Social Services will be trainined on new instruction by December 31, 2022.

Plan of Correction will be completed December 31, 2022. The Director of Nursing has responsibility for this plan of correction.

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F 685	Continued From page 14 Review of emails exchanged between the assistant director of nursing (ADON)-A and In-House Audiology were as follows: -9/20/22, from ADON-A to In-House Audiology -Any updates (on rescheduling the audiologist to come to the facility)? A family member was upset because they thought the resident (R13) was going to be evaluated this month. -9/20/22, from In-House Audiology to ADON-A -We are still looking for another facility to pair you with. Unfortunately, there is not a definitive date yet. -9/21/22, from In-House Audiology to ADON-A -We have found another facility to pair your facility with. We are waiting for them to complete care request forms before we can schedule a date. -10/12/22, from ADON-A to In-House Audiology -Just checking to see if there has been any progress on the paperwork from the paired facility. -10/19/22, from In-House Audiology to ADON-A -We are still waiting for the forms and cannot reschedule a visit yet. We are also seeing if there are any hearing aid dispensers (someone specializing in fitting a person with hearing aids but does not perform a complete audiology evaluation) we could pair with the facility. No further correspondence was received regarding R13's rescheduled audiology appointment or finding another audiologist for R13 to go to. R13's care conference note dated 10/12/22, indicated R13 stated her hearing amplifier was no longer working well. In-House Audiology was supposed to come to the facility in September;	F 685		

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F 685	Continued From page 15 however, because only two residents, including R13, were approved for services, they would not come. The care plan indicated, in-house was attempting to combine services with another facility in the area and R13's family had been notified of the delay. In addition the care plan indicated family expressed concern that R13's poor hearing was "affecting her quality of life and wellbeing" and the facility was hindering R13's from it. R13's family was advised to set up an "outside" appointment and transportation for R13 if they preferred not to wait for In-House Audiology services. The notes did not indicate the facility offered to assist R13 to find an "outside" audiologist or provide transportation to an "outside" appointment. During an interview on 11/14/22, at 4:34 p.m. FM-A stated R13 had been trying to get hearing aids for a long time but the facility stated not enough residents in the facility required an audiology appointment and therefore, the audiologist would not come. FM-A stated R13's decreased ability to hear was affecting her relationship with her family. R13 would become "teary" when family would visit, and she was unable to hear and participate in conversations. R13 stated it was "a very big deal" because she couldn't hear everything everyone was saying during family gatherings and felt left out. It also affected R13's ability to watch TV. During an observation and interview on 11/16/22, at 1:38 p.m. two attempts at knocking loudly on R13's door went unanswered. R13 was lying in bed with her amplifier on her stomach and the television volume up to where she could not hear the knocking or hold a conversation. R13 stated she needed new foam ear covers for the headset	F 685		

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F 685	Continued From page 16 because they were worn through. During an interview on 11/17/22, at 10:36 a.m. nursing assistant (NA)-A stated R13 used a pocket-talker with headphones all the time to be able to hear. NA-A also stated, although she used the pocket-talker, R13's television was always loud because she still had a hard time hearing it. During an interview on 11/17/22, at 12:49 p.m. audiology coordinator (AC) for In-House Audiology stated facilities were scheduled in groups and two residents was not enough for the audiologist to see. The AC stated she suggested R13 go elsewhere because she did not know how long the appointment would be postponed for and AC's "hands were tied." During an interview on 11/18/22, at 10:20 a.m. audiology sales director (SD) for In-House Audiology stated they were not able to send an audiologist to a facility for just one or two residents and advised the facility to find an audiologist in the community for R13. The SD stated although the contract between the facility and In-House Audiology did not include a minimum number of residents required for an onsite visit, she liked to have 10 residents before they would send an audiologist. The SD further stated the contract with the facility was signed prior to her employment. During an interview on 11/17/22, at 11:30 a.m. ADON-A stated FM-A first told her R13 wanted hearing aids in July 2022. ADON-A contacted In-House Audiology who said they would come to the facility in September 2022; however, because only two residents were approved for audiology consults, In-House Audiology cancelled the	F 685		

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F 685	Continued From page 17 appointment. In-House Audiology had since been attempting to find another facility to combine resident appointments with. ADON-A stated she suggested FM-A find an audiologist through R13's county worker. ADON-A stated R13 used the pocket talker daily but still had her television turned up loud because she had a hard time hearing it. ADON-A stated the second resident who needed an audiology appointment, had one coming to the facility the following day; however, ADON-A did not ask if they could also see R13. The facility Admission Contract (undated) indicated the facility would assist residents in arranging services of a specialist or physician by request or physician order, allied health services, and transportation. Part 3 of the assessment indicated an audiologist was a type of staff provided by the facility to support and care for the residents.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure 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	F 686		12/31/22

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F 686	Continued From page 18 by: Based on interview, observation and document review, the facility failed to comprehensively assess and perform wound care according to professional standards for 1 of 1 resident (R10) reviewed for pressure ulcers. Additionally, the facility failed to assess and implement interventions to promote comfort and reduce pain while performing wound care for R10. Further, the facility failed to ensure proper hand hygiene and glove use was maintained during the wound care for R10. Findings include: R10's significant change Minimum Data Set (MDS), dated 10/21/22, identified R10 had moderate cognitive impairment and required extensive assistance from one staff to complete activities of daily living (ADLs). Further, the MDS indicated R10 had not taken any PRN (as needed) pain medication during the look-behind period of 7 days. The MDS further indicated R10 had a stage 3 pressure ulcer. R10's provider orders lacked wound care orders. R10's wound assessment notes dated 9/16/22, indicated R10 had a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) pressure ulcer, but did not identify the location of the wound. The note indicated the wound bed consisted of 100% slough and had undermining. The surrounding tissues was described as bright red and warm. On this date, the wound measured 2.8 centimeters (cm) in	F 686	Plan of correction for R10 included continued treatment, wound nearly healed, skin pink. Resident was admitted with a Stage 3 pressure injury. All residents have the potential for skin breakdown and are assessed with weekly skin assessment, Tissue Tolerance and Braden Risk asessments completed on all residents on December 16, 2022, and preventative measures in place. Systemic changes included the develoopment of an LTCC Instruction on Care of Wound Injuries which was completed December 16, 2022. Training for all of the licensed nursed to include: EduCare training on Medication and Treament-Wound Care, review of the new LTCC Instruction on Care of Wound Injuries and completing a clinical competency on dressing change and measuring a wound. The education will be completed by December 31, 2022. Director Nursing or the Assistant Director of Nursing will audit three times a week for three months than weekly on going until December 31, 2023. The audits will be shared at the QAA Committee meetings. Plan of correction will be completed by December 31, 2022. The Director of Nursing has responsibility for this plan of correction.	

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F 686	Continued From page 19 length (L), 0.5 cm in width (W), and .2 cm in depth (D). R10's care plan dated 10/27/22, indicated skin breakdown with a stage 3 pressure injury to coccyx, with an intervention which indicated to document the area of skin break down each day and with each dressing change. Additionally, the care plan indicated clinical monitoring for pain, and identified the pain site as, right side ribs. Interventions included offer non-pharmaceutical interventions such as repositioning. The care plan lacked mention of right hip pain after a fall on 11/14/22, and pain management interventions for the right hip. R10's pain assessment on 11/17/22, at 12:55 p.m. indicated R10 had no pain. However, during interview prior to the dressing change on 11/17/22, at 12:44 p.m. R10 indicated pain in the right hip rated as 8/10 on the pain scale, which indicates severe pain. R10's provider orders dated 10/6/22, indicated Tylenol (used for pain management) 650 milligrams (mg) BID (twice daily) p.o. (orally) for pain and an order for Tylenol 650 mg PRN (as needed) for mild discomfort every four hours PRN with max dose of 4 times daily. R10's Medication Administration Record (MAR) dated 11/17/22, indicated Tylenol 650 mg was administered at 7:34 a.m. and 4:59 p.m. , and a PRN dose was administered at 2:08 p.m. R10's provider note dated 10/14/22, indicated R10 had a stage 3 coccyx pressure ulcer with prior tunneling resolved. The wound care orders were to cleanse the wound with wound cleanser	F 686		

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F 686	Continued From page 20 and apply a Mepilex dressing (an absorbent dressing for treating wounds). There were no corresponding orders on the provider order sheet. During observation on 11/17/22, at 12:44 p.m. with registered nurse (RN)-G, R10 stated, "Tylenol is not helping me. I'm hurting terribly. As soon as I try to move my foot, then my right hip hurts." RN-G did not assess R10's pain, nor provide pain management interventions prior to performing wound care. RN-G turned R10 on to her right side that R10 stated was hurting, to perform wound care. The resident again stated she was uncomfortable. RN-G continued preparations to perform wound care. RN-G stated the wound care should be performed every 48 hours, with wound cleanser and a Mepilex dressing. RN-G was observed performing wound care, and started by removing the existing dressing. RN-G removed her gloves after removing the bandage, and donned new gloves without performing hand hygiene. RN-G described the wound as clean and stated it measured 2 centimeters (cm) in length (L) by 1 cm in width (W). She was not observed to measure the wound with a measurement device. When asked how she measured the wound, she said she had not measured it. RN-G doffed her gloves, did not perform hand hygiene and left the room to obtain a measuring device. When RN-G returned, she donned clean gloves, and measured the wound. It measured 1 cm L x .2 cm W. RN-G then used wound cleanser to clean the wound, and without changing gloves or performing hand hygiene opened the clean Mepilex dressing and applied it, touching the dressing face with her dirty gloves. During interview in 11/17/22, at 12:44 p.m. RN-G	F 686		

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stated she does not do hand hygiene between gloves changes, and did not between cleaning the dirty wound and applying the clean dressing. RN-G acknowledged performing hand hygiene would help prevent wound infection. R10 acknowledged she should have performed hand hygiene between dirty and clean steps in wound care, and should have assessed R10's pain and provided pain management interventions prior to performing wound care, and stated when Tylenol for pain management is ineffective, the provider should have been updated. Additionally, RN-G stated she had not assessed R10's pain because she was focused on performing wound care. RN-G stated she normally measures wounds with a device, instead of estimating the measurements.

When interviewed on 11/15/22, at 11:17 a.m. the director of nursing (DON) stated her expectations were for nurses to perform hand hygiene between donning and doffing gloves, and expected nurses to change gloves between performing dirty and clean steps in performing wound care, and expected wound measurements were obtained using a measurement device. The DON further stated she expected nurses to implement pain management assessments and interventions when a resident complained of pain.

The Hand Hygiene policy dated June 2022, indicated hand hygiene must be performed when moving from a dirty patient care task to a clean task, and before and after gloves are used.

The Chronic Non-Healing Wound Care policy dated August 2019, indicated pre-medicate for pain, if necessary. The policy further indicated measure the wound with a single-use plastic

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F 686	Continued From page 22 measuring guide.	F 686		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review risks and benefits of the use of bed rails with residents or their representatives. The facility also failed to ensure residents were assessed for the risk of entrapment and obtain informed consent for 4 of 4 residents (R9, R13, R15 and R19) who had bed rails on their beds. Findings include:	F 700	Plan of correction included completing a comprehensive side rail utilization assessment for R9, R13, R15 and R19 by the Director of Nursing / Assistant Director of Nursing on December 12, 2022. The Director of Nursing and Assistant Director of Nursing will complete assessments on all unit residents by December 31, 2022 to identify the requests and needs of each resident for the use of bed rails. Systemic	12/31/22

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R9's significant change Minimum Data Set (MDS) dated 9/15/22, indicated R9 had moderate cognitive deficits. R9 required extensive assistance of two staff for bed mobility and total assistance for all other activities of daily living (ADLs). R9's diagnoses included diabetes, dementia, obesity, stroke with left-sided paralysis, rheumatoid arthritis, and arthropathy (joint disease-causing swelling, pain, and stiffness) of the right shoulder.

R9's Care Area Assessment (CAA) dated 9/26/22, indicated R9 triggered for cognitive impairment due to dementia with cognitive loss. R9 was unable to use the call light appropriately and required cues and reminders. R9 triggered for ADLs and required extensive to total assistance including being fed by staff at meals.

R9's care plan dated 9/28/22, indicated R9 required total assistance with ADLs due to cognitive decline and a diagnosis of dementia. Interventions included dressing and grooming R9 and using a Hoyer lift (mechanical lift using a sling and two staff members) for transfers. R9 was totally dependent in mobility and required extensive to total assistance for repositioning. R9 was at risk for safety awareness and weakness as evidenced by recent falls. Interventions included repositioning R9 every two hours, maintaining R9's limbs in functional alignment.

R9's temporary care plan dated 10/7/22, indicated R9 had a wound on his coccyx (tail bone) caused by friction. Interventions included continuing with R9's toileting and repositioning schedule.

R9's Physical Device Assessment (PDA) dated

F 700

changes included Director of Nursing developing a Bed Rail Policy, Bed Rail informed Consent Form and a Side Rail Utilization Assessment, utilizing the FDA's "A Guide to Bed Safety" which were completed December 16, 2022. Maintenance Department completed the annual preventative maintenance and the zones of entrapment assessment on December 14, 2022. The Director of Maintenance tracks the annual assessment on a spreadsheet and will ensure this work continues to be done annually. Staff will review the policy on bed rails and the guide to bed safety. This education will be completed by December 31, 2022. Director of Nursing will complete side rail usage audits three times a week for three months then monthly ongoing. The audits will be presented to the QAA Committee.

Plan of Correction will be completed December 31, 2022. The Director of Nursing has responsibility for this plan of correction.

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8/25/22, indicated R9 used half side rails, a lift, and a wheelchair. The devices were used collectively for support, to improve balance and stability, or to redistribute weight from the lower limbs to help alleviate joint pain or compensate for weakness. The PDA lacked an assessment of R9's risk for entrapment or ability to use the bed rails safely.

R13's quarterly MDS dated 10/6/22, indicated R13 had intact cognition, ate independently, required extensive assistance of one staff for dressing and personal hygiene, and extensive assistance of two staff for bed mobility and transfers. R13's diagnoses included obesity, diabetes, edema (fluid) in her lower extremities, high blood pressure, chronic kidney disease, and osteoarthritis (low bone density).

R13's CAA dated 2/3/22, indicated R13 triggered for ADL assistance secondary to requiring extensive assistance of staff. R13 required food be brought to her and placed near her. R13 also occasionally required food to be opened and proper utensils provided. R13 required a Hoyer lift for all transfers. R13 also triggered for pressure ulcers secondary to a pressure ulcer on her coccyx (tail bone) due to limited mobility and required extensive assistance for bed mobility. R13's CAA indicated R13 was at risk for skin shear and slide down in bed when repositioned due to obesity and weakness.

R13's care plan dated 10/20/22, indicated R13 had significant debility and deconditioning at baseline with chronic pain and dysfunction of both shoulders related to arthritis. R13 also had a right arm fracture a year ago, was bed-bound and required an EZ positioner (device used to

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reposition in bed) in bed for repositioning. R13 was also at high risk for pressure ulcers due to decreased mobility. Interventions included repositioning R13 every two hours. Staff were to ensure they handled R13 at her lower back and upper leg and not her buttocks during turning and repositioning to avoid skin tears. R13 was also at risk for altered skin integrity due to obesity, immobility, and non-compliance with turning and repositioning.

R13's PDA dated 1/25/22, indicated R13 used half side rails for turning and repositioning and an EZ lift (a device requiring the resident to be able to stand) for transfers. Although R13 was no longer able to use an EZ lift for transfers, requiring total assistance with a Hoyer lift, a new PDA was not completed to ensure R13's continued ability to use the half side rails safely.

R13's care conference note dated 7/20/22, indicated R13 used two quarter side rails on her bed to assist with positioning.

R13's care conference note dated 10/12/22, indicated R13 used two quarter side rails on her bed to assist with positioning.

R15's annual MDS dated 9/15/22, indicated R15 had mild cognitive deficits, was independent with eating but required extensive assistance of one staff for all other activities of daily living (ADLs). R15's diagnoses included a pathological (due to a medical condition, not trauma) fracture, spinal stenosis (narrowing of the vertebral openings) and spinal spondylosis (degenerating disks).

R15's Care Area Assessment (CAA) dated 9/27/22, indicated R15 triggered for cognitive

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impairment due to a diagnosis of dementia with short- and long-term memory loss. R15 triggered for ADL function due to requiring extensive assistance of two staff for ADLs. R15 was non-ambulatory and used a wheelchair. R15 also triggered for pressure ulcers due to limited mobility. Staff assisted R15 with repositioning and were educated on proper techniques to prevent shearing and friction injuries.

R15's care plan dated 9/29/22, indicated R15 became short of breath upon exertion and required extensive assistance of one staff for ADLs. R15 preferred staff to do her ADLs for her and did not initiate cares. R15 had a mobility deficit and used two side rails for positioning. R15 was also at risk for pressure ulcers due to decreased mobility, an inability to walk, and urinary incontinence. Interventions included repositioning or offloading R15 every 2.5 hours because R15 was unable to make meaningful and significant body position changes both in bed and in her wheelchair.

R15's PDA dated 9/15/22, indicated R15 used half side rails (bed rails) for positioning in bed. The PDA lacked an assessment of R15's risk for entrapment or ability to use the bed rails safely.

R19's quarterly MDS dated 10/6/22, indicated R19, was cognitively intact. R19 was independent with eating and personal hygiene and required supervision with set up only for all other ADLs. R19's diagnoses included osteoarthritis (inflammation of the joints) of the knee, anxiety, and edema (fluid retention).

R19's care plan dated 10/20/22, indicated R19 required varying levels of assistance with ADLs

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F 700	Continued From page 27 due to cognitive impairment, anxiety, and forgetfulness. Interventions included staff assisting R19 with ADLs including incontinence care, and linen changes when R19 was unable to complete them independently due to cognitive impairment, weakness, or anxiety. The care plan also indicated R19 was no longer independent with bed mobility as noted in her care plan dated 5/31/22, due to decreased functional mobility and chronic pain. The care plan further indicated R19 had an altered level of orientation related to a moderate cognitive deficit evidenced by poor decision making, need for reminders and cues. R19's PDA dated 1/25/22, indicated R19 used half side rails. The PDA lacked an assessment indicating R19's ability to use the bed rails or risk of entrapment. During an observation and interview on 11/14/22, at 3:31 p.m. R9 was lying in bed watching TV with both half side rails up on his bed. R9 stated there must be a reason for the bed rails but he did not know why they were there. R9 stated he did not know if he wanted or needed the bed rails, but he would hit his elbow on them when he reached for items on the bookshelf next to his bed and it "drives me to drink." During an observation and interview on 11/14/22, at 4:17 p.m. R15 was in her wheelchair next to her bed. Two half side rails were up on her bed. R15 stated she used the bed rails to roll onto her side, however, she did not want them up all the time because it made it more difficult for R15 to get out of the bed. R15 stated she would have to scoot to the end of the bed to get around them. During an interview on 11/16/22, at 2:10 p.m. R15	F 700		

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F 700	Continued From page 28 stated she did not know if she would be able to lower the bed rails by herself and had never been shown how to. During an interview on 11/17/22, at 10:19 a.m. registered nurse (RN)-A stated bed rail assessments were completed every three months. RN-A also stated all residents including R9, R13, R15 and R19 always had both top bed rails up. During an interview on 11/17/22, at 11:43 a.m. the assistant director of nursing (ADON)-A stated all resident beds had the top bed rails up all of the time. ADON-A stated all facility residents used the bed rails to reposition themselves and were assessed annually. Although the bed rails could be lowered if a resident insisted, having them up was a standard procedure. ADON-A stated, the residents were not at risk for entrapment between the bed rail and the mattress because the bed rail could only be placed in the completely up-right position and was not adjustable. ADON-A was not sure if the gap between the bed rails and the mattresses had been measured to ensure proper spacing. During an interview on 11/17/22, at 3:57 p.m. the director of nursing (DON) stated residents were assessed for the use of bed rails upon admission and annually. The DON further stated she was unsure if the bed rails and mattresses had been assessed for the possibility of entrapment. A facility policy on Bed Rails was requested but not provided.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		12/31/22

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F 758		F 758		

Continued From page 29

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a 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

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F 758	Continued From page 30 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 orders for as needed (PRN) psychotropic medication (medication that affects behavior, mood, thoughts or perception, including lorazepam) were either discontinued after 14 days or indications for extending the medication for use greater than 14 days was provided, for 1 of 3 residents (R10) reviewed for unnecessary medications. Findings include: R10's significant change Minimum Data Set (MDS) dated 10/21/22, identified R10 had moderate cognitive impairment and required extensive assistance from one staff to complete activities of daily living (ADLs). Further, the MDS indicated R10 scored a "4" (score indicates minimal depression) on the completed PHQ-9 screening tool for depression, and consumed antianxiety medication on a frequency of 2 times during the look-behind period of 7 days. R10's History and Physical dated 9/16/22, indicated R10 was admitted to the facility on 9/16/22. R10's provider orders dated 9/20/22, identified	F 758	The plan of correction included provider discontinuing Lorazepam PRN for R10 on November 29, 2022 after the provider review. Residents who receive PRN psychotropic medications have the potential for medications to be prescribed by the provider longer than 14 days so systemic changes were made. Director of Nursing developed a Psychotropic Medication Management Components document and a Consultant Pharmacist Mediation Review sheet as a communication tool to provider of recommendations and suggested course of actions. Stop dates included in orders for review or discontinue of PRN psychotropics after 14 days. Director of Nursing and Assistant Director of Nursing and pharmacist re-educated on regulation on November 23, 2022. To monitor performance the Director of Nursing and Assistant Director of Nursing developed a Scheduled Psychotropic Medication List to track GDR's. The Director of Nursing will audit weekly toe ensure compliance ongoing. Plan of Correction will be completed	

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F 758	Continued From page 31 R10's physician-ordered medications included lorazepam (a psychotropic antianxiety medication) .5 milligrams (mg) to be taken orally (p.o,) at bedtime (HS) as needed (PRN). The start date of the medication was 9/20/22. R10's provider note dated 9/22/22, included a medication review of all R10's medications including the lorazepam. The note further indicated a staff report which documented R10 was lethargic on 9/21/22, and staff were concerned about a physical decline, and "Daughter, Becky" felt is was due to her lorazepam use." The provider changed the order for lorazepam to indicate no administration after midnight, but did not add clinical indications to extend use beyond 14 days. R10's provider noted dated 9/29/22, included a medication review. The provider did not contain a documented rationale for continued use to extend PRN lorazepam use beyond 14 days. R10's provider note dated 10/6/22, included a medication review including lorazepam .5 mg po PRN. The provider did not contain a documented rationale for continued use to extend PRN lorazepam use beyond 14 days. R10's pharmacy progress note dated 10/19/22, indicated PRN lorazepam was prescribed prior to facility admission and R1 was not using it every night. The pharmacist recommended the provider consider a Trazodone trial in place of lorazepam for sleep. R10's provider note dated 10/25/22, indicated medications were reviewed. The provider did not contain a documented rational to extend PRN	F 758	December 31, 2022. The Director of Nursing has responsibility for this plan of correction.	

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F 758	Continued From page 32 lorazepam use beyond 14 days. R10's provider note dated 10/28/22, did not review lorazepam. During interview on 11/17/22, at 3:23 p.m. the pharmacist (PH)-A stated PRN psychotropic medications required an end date or no more than 14 days, or the provider was required to review the PRN psychotropic medication every 14 days and provide indications why the medication should be extended beyond 14 days. The PH-A stated she mentions the PRN medications in her monthly reviews, but the providers should review the PRN psychotropic medications also, on a frequency of every 14 days. Unnecessary Drugs and Psychotropic Medications Policy dated 7/28/22, indicated PRN psychotropic medications are limited to 14 days and only for necessary, specific clearly documented circumstances. Provider may document a rationale for a longer duration in the medical record.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		12/31/22

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F 812	Continued From page 33 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure refrigerated foods were disposed of after expiration date and properly labeled and dated when the original packaging was opened in the kitchen. This deficient practice had the potential to affect all 30 residents identified by the facility who received food from the kitchen. Findings include: During the initial tour of the kitchen on 11/14/22, at 1:49 p.m. with the director of culimary services (DCS) the following areas of concern were noted: The refrigerator for produce was observed to have: - one open bag of slided mushrooms with an expiration date of 10/31/22. - Cranberries in a plastic storage bin that was not labeled nor dated. - An open bag of green beans that was not labeld nor dated. - Three open bags of celery that were not labeled nor dated. - An open bag of cucumbers that were not labeled nor dated. - An open box of lemons that was not dated. - An open box with 4 heads of cauliflower that was not dated.	F 812	On November 14, 2022 after the tour from the MDH surveyor all coolers, freezers and dry storage were checked and all expired food removed and labeling corrected. On November 15, the Director of Culinary Services contacted our food vendor to place an expiration date on all exterior and interior packaging (boxes, and plastic bags, etc). The NH+C Food Procurement, Receiving, Storage, Cooking, Holding, Cooling, Reheating and Serving policy was reviewed and revised on December 15, 2022. The procedure for receiving and storage of food products was reviewed by all staff that receive product during the daily huddle and by reading / signing off on a written document. This was completed by December 12, 2022. The Director of Culinary Services and the Chef will complete daily audits of the coolers, freezers and dry storage until December 31, 2022. If 100% compliance the audits will move to weekly for a month. If 100% compliance the audits will move to monthly until December 31, 2023. The audits will be submitted to the LTCC Administrator for presentation at the QAA Committee meeting.	

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F 812	Continued From page 34 - An open box of oranges that was not dated. - Bins of potatoes, peas, carrots, and green beans prepped for service that were not dated. - An open bag of sliced potatoes that was not dated - An open bag of parsnips that was not dated. - An open bag of beets that was not dated. The kitchen freezer contained the following items that were opened and not dated: - A bag of chicken pieces. - A bag of cut potatoes. - Six baggies of pancakes. - A plastic bin each of potato wedges , carrots, beans, corn, and peas. - A bag of frozen corn. On top of an oven, there were three open bags of buns that were not dated. During an interview on 11/14/22, at 1:49 p.m. during the kitchen tour, the DCS stated she would ensure all food was dated when it arrived in the future, and should have been dated before it was stored. During an interview on 11/16/22, on 10:58 a.m. the registered dietician (RD) stated all the open food in the refrigerators and freezers should be labeled and dated. She further stated, the kitchen staff were required to know the expriation dates of the food to ensure it was not outdated. Further, the RD stated each item in the refrigerators and freezers should be labeled with it's contents to know what each container contains. The RD stated expired mushrooms can cause illness. A food storage policy was requested but not provided.	F 812	Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		12/31/22

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F 880	Continued From page 36 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an infection prevention and control surveillance system was created and implemented to identify, track, and analyze all resident infections to prevent the spread of communicable diseases and infectious organisms. This had the potential to affect all 30 residents, staff and visitors in the facility. Findings include:	F 880	The LTCC policy on Surveillance for Infections has been updated December 12, 2022, with increased frequency of review of the infection log by the Infection Preventionist and Director of Nursing. This includes direction to include all infection symptoms along with the reporting requirements and investigation of trends. The MH+C Antimicrobial Stewardship Program policy was updated on December 15, 2022 to include the	

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F 880 Continued From page 37

Review of the facility Antimicrobial Days of Therapy Report dated 8/1/22, to 11/17/22, indicated:

-August 2022, indicated 3 residents received antibiotics, 4 received an antifungal, 9 received an antiviral and 1 received an antibiotic ointment.
-September 2022, indicated 2 residents received antibiotics, 6 received an antifungal, 1 received an antiviral and 1 received an antibiotic ointment.
-October 2022, indicated no residents received an antibiotic, 7 received an antifungal, and 1 received an antiviral.
-November 2022, indicated 1 resident received an antibiotic, 3 received an antifungal, 1 received an antiviral, and 1 received an antibiotic ointment.

Review of the facility Infection Logs indicated a date (unknown if sign/symptom or medication start date), resident name, symptoms, and medical record number. The log did not include tracking of signs or symptoms of an infection until a resident was started on an antibiotic. The log lacked information including signs or symptoms for residents with possible or confirmed viral, fungal, or other infections not treated with an antibiotic. The log also lacked resident room numbers or a way to analyze facility infections to identify outbreaks, types of infections, clusters, or the possible spread of infections.

During an interview on 11/17/22, at 1:00 p.m. infection preventionist (IP) stated because she was the IP for multiple facilities and worked only four hours per week as the facility IP, the administrator, director of nursing (DON), and assistant directors of nursing (ADONs) also assisted with infection control duties. Residents prescribed new antibiotics were discussed by the

F 880

process of Infection Preventionist notifies the providers on a bug-drug mismatches and reporting requirements to the LTCC QAA. On December 12, 2022, the Surveillance log for infections was updated with resident room numbers, date when treatment started, date when treatment was ended and date the symptoms were resolved. On December 8, 2022 the Infection Preventionist was given a floor plan of the LTCC to help in identifying geographical patterns/clusters of illness/infections. The LTCC Administrator, Infection Preventionist, the Director of Nursing, and the Assistant Director of Nursing all completed the CDC's TRAIN module 4 - Infection Surveillance of the "Nursing Home Infection Preventionist Training Course". This was completed by December 15, 2022. All LTCC nursing staff will review the policy "LTCC Surveillance of Infections" by December 31, 2022. The following audits will start December 19, 2022 as outlined below:
-Daily audits during IDT meetings to ensure all of symptomatic residents are logged on the Infection Control log. These will be completed by the Director of Nursing or the Assistant Director of nursing. The daily audits will be completed for two weeks.
-If there is 100% compliance the audits will move to weekly for a month.
-If there is 100% compliance they will move to monthly untild December 31, 2023.
-The results will be reviewed at the quarterly QAA committee.

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F 880	Continued From page 38 nursing staff during daily huddles and the information was entered in the computer generating a report the IP reviewed daily. The IP stated she then filled out a form for each resident on a new antibiotic and kept it in a folder. The IP stated she would review nursing notes for resident signs and symptoms and ask nursing staff how the resident was doing; however, the IP stated she did not have a spreadsheet or other form to record and monitor the progress of the resident or identify clusters of infections among staff and/or residents. The IP stated she did not consult with the prescribing provider regarding antibiotic use or appropriateness but notified an ADON who relayed concerns to the provider. The IP stated she was also unsure what criteria the facility used to determine a resident's eligibility for antibiotic use. During an interview on 11/17/22, at 3:21 p.m. the director of nursing (DON) stated she was responsible for the infection control regulatory compliance for the facility but utilized the IP as a resource. The DON stated when a resident developed new signs or symptoms of an infection an ADON would evaluate the resident and discuss their status at the morning management meeting. The team then determined if the resident's signs or symptoms should be reported to the provider. The DON stated although a urine analysis and culture (UA/UC) were ordered after R19 exhibited altered mental status and urinated on her floor, her signs and symptoms of a possible urinary tract infection (UTI) were removed from the log when her UA/UC were negative for an infection. The DON further stated only residents diagnosed with an infection and started on antibiotics would be tracked on the Infection Log. The DON further stated the	F 880	Plan of Correction will be completed December 31, 2022. The Director of Nursing has responsibility for this plan of correction.Please see attachments. The Directed Plan of Correction is attached.	

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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 880	Continued From page 39 provider would determine if a resident was eligible for an antibiotic based on antibiotic use criteria; however, the DON did not know which criteria the provider's used. During an interview on 11/17/22, at 3:30 p.m. the administrator stated all residents who developed new signs or symptoms of an infection should have been tracked on the Infection Log regardless of whether or not they were diagnosed with an infection or started on antibiotics. The administrator further stated they had not been running a report of residents who were prescribed antimicrobial medications prior to this surveyor's request and was unaware that was possible. The facility Antimicrobial Stewardship Program policy dated 9/2020, indicated the IP conducted ongoing surveillance to "identify bug-drug mismatches" and communicate sensitivity findings to the prescriber. No other facility policy regarding infection surveillance was provided.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00566	A. BUILDING: ____ B. WING ____	C **11/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE C	**2000 NORTH AVENUE** **NORTHFIELD, MN 55057**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/14/22 to 11/17/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

The following complaint was found to be unsubstantitated: H52415759C (MN85072).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to comprehensively assess and perform wound care according to professional standards for 1 of 1 resident (R10) reviewed for pressure ulcers. Additionally, the facility failed to assess and implement interventions to promote comfort and reduce pain while performing wound care for R10.	2 900	Corrected	12/31/22

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2 900	Continued From page 3 Further, the facility failed to ensure proper hand hygiene and glove use was maintained during the wound care for R10. Findings include: R10's significant change Minimum Data Set (MDS), dated 10/21/22, identified R10 had moderate cognitive impairment and required extensive assistance from one staff to complete activities of daily living (ADLs). Further, the MDS indicated R10 had not taken any PRN (as needed) pain medication during the look-behind period of 7 days. The MDS further indicated R10 had a stage 3 pressure ulcer. R10's provider orders lacked wound care orders. R10's wound assessment notes dated 9/16/22, indicated R10 had a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) pressure ulcer, but did not identify the location of the wound. The note indicated the wound bed consisted of 100% slough and had undermining. The surrounding tissues was described as bright red and warm. On this date, the wound measured 2.8 centimeters (cm) in length (L), 0.5 cm in width (W), and .2 cm in depth (D). R10's care plan dated 10/27/22, indicated skin breakdown with a stage 3 pressure injury to coccyx, with an intervention which indicated to document the area of skin break down each day and with each dressing change. Additionally, the care plan indicated clinical monitoring for pain, and identified the pain site as, right side ribs.	2 900		

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2 900	Continued From page 4	2 900		

Interventions included offer non-pharmaceutical interventions such as repositioning. The care plan lacked mention of right hip pain after a fall on 11/14/22, and pain management interventions for the right hip.

R10's pain assessment on 11/17/22, at 12:55 p.m. indicated R10 had no pain. However, during interview prior to the dressing change on 11/17/22, at 12:44 p.m. R10 indicated pain in the right hip rated as 8/10 on the pain scale, which indicates severe pain.

R10's provider orders dated 10/6/22, indicated Tylenol (used for pain management) 650 milligrams (mg) BID (twice daily) p.o. (orally) for pain and an order for Tylenol 650 mg PRN (as needed) for mild discomfort every four hours PRN with max dose of 4 times daily.

R10's Medication Administration Record (MAR) dated 11/17/22, indicated Tylenol 650 mg was administered at 7:34 a.m. and 4:59 p.m. , and a PRN dose was administered at 2:08 p.m.

R10's provider note dated 10/14/22, indicated R10 had a stage 3 coccyx pressure ulcer with prior tunneling resolved. The wound care orders were to cleanse the wound with wound cleanser and apply a Mepilex dressing (an absorbent dressing for treating wounds). There were no corresponding orders on the provider order sheet.

During observation on 11/17/22, at 12:44 p.m. with registered nurse (RN)-G, R10 stated, "Tylenol is not helping me. I'm hurting terribly. As soon as I try to move my foot, then my right hip hurts." RN-G did not assess R10's pain, nor provide pain management interventions prior to performing wound care. RN-G turned R10 on to

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2 900	Continued From page 5 her right side that R10 stated was hurting, to perform wound care. The resident again stated she was uncomfortable. RN-G continued preparations to perform wound care. RN-G stated the wound care should be performed every 48 hours, with wound cleanser and a Mepilex dressing. RN-G was observed performing wound care, and started by removing the existing dressing. RN-G removed her gloves after removing the bandage, and donned new gloves without performing hand hygiene. RN-G described the wound as clean and stated it measured 2 centimeters (cm) in length (L) by 1 cm in width (W). She was not observed to measure the wound with a measurement device. When asked how she measured the wound, she said she had not measured it. RN-G doffed her gloves, did not perform hand hygiene and left the room to obtain a measuring device. When RN-G returned, she donned clean gloves, and measured the wound. It measured 1 cm L x .2 cm W. RN-G then used wound cleanser to clean the wound, and without changing gloves or performing hand hygiene opened the clean Mepilex dressing and applied it, touching the dressing face with her dirty gloves. During interview in 11/17/22, at 12:44 p.m. RN-G stated she does not do hand hygiene between gloves changes, and did not between cleaning the dirty wound and applying the clean dressing. RN-G acknowledged performing hand hygiene would help prevent wound infection. R10 acknowledged she should have performed hand hygiene between dirty and clean steps in wound care, and should have assessed R10's pain and provided pain management interventions prior to performing wound care, and stated when Tylenol for pain management is ineffective, the provider should have been updated. Additionally, RN-G	2 900		

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2 900	Continued From page 6	2 900		

stated she had not assessed R10's pain because she was focused on performing wound care. RN-G stated she normally measures wounds with a device, instead of estimating the measurements.

When interviewed on 11/15/22, at 11:17 a.m. the director of nursing (DON) stated her expectations were for nurses to perform hand hygiene between donning and doffing gloves, and expected nurses to change gloves between performing dirty and clean steps in performing wound care, and expected wound measurements were obtained using a measurement device. The DON further stated she expected nurses to implement pain management assessments and interventions when a resident complained of pain.

The Hand Hygiene policy dated June 2022, indicated hand hygiene must be performed when moving from a dirty patient care task to a clean task, and before and after gloves are used.

The Chronic Non-Healing Wound Care policy dated August 2019, indicated pre-medicate for pain, if necessary. The policy further indicated measure the wound with a single-use plastic measuring guide.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to

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2 900	Continued From page 7 residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure an infection prevention and control surveillance system was created and implemented to identify, track, and analyze all resident infections to prevent the spread of communicable diseases and infectious organisms. This had the potential to affect all 30 residents, staff and visitors in the facility. Findings include: Review of the facility Antimicrobial Days of Therapy Report dated 8/1/22, to 11/17/22, indicated:	21375	Corrected	12/31/22

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21375	Continued From page 8	21375		

-August 2022, indicated 3 residents received antibiotics, 4 received an antifungal, 9 received an antiviral and 1 received an antibiotic ointment.
-September 2022, indicated 2 residents received antibiotics, 6 received an antifungal, 1 received an antiviral and 1 received an antibiotic ointment.
-October 2022, indicated no residents received an antibiotic, 7 received an antifungal, and 1 received an antiviral.
-November 2022, indicated 1 resident received an antibiotic, 3 received an antifungal, 1 received an antiviral, and 1 received an antibiotic ointment.

Review of the facility Infection Logs indicated a date (unknown if sign/symptom or medication start date), resident name, symptoms, and medical record number. The log did not include tracking of signs or symptoms of an infection until a resident was started on an antibiotic. The log lacked information including signs or symptoms for residents with possible or confirmed viral, fungal, or other infections not treated with an antibiotic. The log also lacked resident room numbers or a way to analyze facility infections to identify outbreaks, types of infections, clusters, or the possible spread of infections.

During an interview on 11/17/22, at 1:00 p.m. infection preventionist (IP) stated because she was the IP for multiple facilities and worked only four hours per week as the facility IP, the administrator, director of nursing (DON), and assistant directors of nursing (ADONs) also assisted with infection control duties. Residents prescribed new antibiotics were discussed by the nursing staff during daily huddles and the information was entered in the computer generating a report the IP reviewed daily. The IP stated she then filled out a form for each resident on a new antibiotic and kept it in a folder. The IP

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21375	Continued From page 9	21375		

stated she would review nursing notes for resident signs and symptoms and ask nursing staff how the resident was doing; however, the IP stated she did not have a spreadsheet or other form to record and monitor the progress of the resident or identify clusters of infections among staff and/or residents. The IP stated she did not consult with the prescribing provider regarding antibiotic use or appropriateness but notified an ADON who relayed concerns to the provider. The IP stated she was also unsure what criteria the facility used to determine a resident's eligibility for antibiotic use.

During an interview on 11/17/22, at 3:21 p.m. the director of nursing (DON) stated she was responsible for the infection control regulatory compliance for the facility but utilized the IP as a resource. The DON stated when a resident developed new signs or symptoms of an infection an ADON would evaluate the resident and discuss their status at the morning management meeting. The team then determined if the resident's signs or symptoms should be reported to the provider. The DON stated although a urine analysis and culture (UA/UC) were ordered after R19 exhibited altered mental status and urinated on her floor, her signs and symptoms of a possible urinary tract infection (UTI) were removed from the log when her UA/UC were negative for an infection. The DON further stated only residents diagnosed with an infection and started on antibiotics would be tracked on the Infection Log. The DON further stated the provider would determine if a resident was eligible for an antibiotic based on antibiotic use criteria; however, the DON did not know which criteria the provider's used.

During an interview on 11/17/22, at 3:30 p.m. the

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21375	Continued From page 10	21375		

administrator stated all residents who developed new signs or symptoms of an infection should have been tracked on the Infection Log regardless of whether or not they were diagnosed with an infection or started on antibiotics. The administrator further stated they had not been running a report of residents who were prescribed antimicrobial medications prior to this surveyor's request and was unaware that was possible.

The facility Antimicrobial Stewardship Program policy dated 9/2020, indicated the IP conducted ongoing surveillance to "identify bug-drug mismatches" and communicate sensitivity findings to the prescriber.

No other facility policy regarding infection surveillance was provided.

Suggested Method of Correction

The DON (Director of Nursing), Infection Preventionist (IP) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all signs or symptoms of possible infections and antimicrobial prescriptions. The DON, IP or designee could also review/revise facility policies and procedures to ensure roles and responsibilities for infection surveillance were clearly designated. The DON, IP or designee could educated staff on the policies and procedures and perform audits to ensure compliance.

Time Period for Correction: Twenty-one (21) days.

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21942	Continued From page 11	21942		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council within the past 12-months. This deficient practice had the potential to affect all 30 residents residing in the facility and their representatives. Findings include: During an interview on 11/16/22, at 9:36 a.m. the director of nursing (DON) stated the facility did not have a family council nor have they attempted to organize one that she is aware of. During an interview on 11/17/22, at 12:24 p.m. the director of social services (DSS) stated the facility had not had a family council since COVID-19 began approximately three years ago. Review of the facility Family Council meeting notes dated 3/27/19, indicated the group would	21942	Corrected	12/31/22

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21942	Continued From page 12 meet quarterly. The last family council occurred on 6/26/19. No further notes or communication regarding a family council were provided. A facility policy regarding family council was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21942		

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	245241	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	11/15/2022

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NORTHFIELD HOSPITAL LONG TERM CARE CENTER	**2000 NORTH AVENUE** **NORTHFIELD, MN 55057**

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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 11/15/2022. At the time of this survey, NORTHFIELD HOSPITAL LONG TERM CARE CENTER 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		12/16/2022

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

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
	245241	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**11/15/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. NORTHFIELD HOSPITAL LONG TERM CARE CENTER is a two-story building with the LONG TERM CARE CENTER being located on the lower level, having direct access and egress to grade. There is no basement below the LONG TERM CARE CENTER It was constructed in 2002 and was determine to be of Type I (332) construction	K 000		

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		12/14/22

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K 914	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical outlet receptacles in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/15/2022 at 1:00 PM, it was revealed by a review of available documentation that electrical outlet testing spreadsheet presented for review was missing information associated to the polarity testing of the outlets in resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	The Maintenance Department conducts an annual testing of each electrical receptacle at the resident bed location. The testing did not include testing of the Polarity. The inspection from was updated to include Polarity on December 12, 2022. The testing of all electrical receptacles for Polarity was finished on December 14, 2022. The Maintenance Director is repsonsible to ensure that the complete testing to include Polarity is completed annually. Plan of correction was completed on December 14, 2022.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to maintain documentation associated to the training of personal as it relates to gases in cylinders NFPA	K 926	All LTCC licensed nursing staff are required to show competency on how to administer oxygen as part of their initial LTCC orientation. All LTCC direct care	12/31/22

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K 926	Continued From page 4 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1 This deficient finding widespread impact on the residents within the facility. Findings include: On 11/15/2022 at 1:00 PM, it was revealed during documentation review that provided multi-page med-gas training document did clearly identify the specific training being presented to new staff at on-boarding and annual staff refresher. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 926	staff have to complete the EduCAre "OSHA-SNF" training during orientation and annually. Part o the training is focused on oxygen safety. Attached is the training transcripts and the staff completion list. All staff have to complete the training by December 31, 2022. This training will continue to be an annual training requirement. In addition to the OSHA training all the licensed nursing staff will be completing a Clinical Competency assessment by December 31, 2022. Plan of Correction will be completed December 31, 2022. The Administrator has responsibility for this plan of correction.	