Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 20, 2025

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: CCN: 245604
Cycle Start Date: February 6, 2025

Dear Administrator:

On February 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by May 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

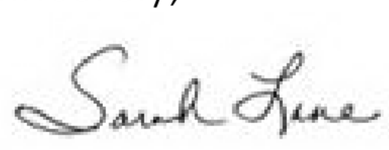
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
February 20, 2025

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Re: State Nursing Home Licensing Orders
Event ID: 83LJ11

Dear Administrator:

The above facility was surveyed on February 3, 2025 through February 6, 2025 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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/3/25 to 2/6/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/3/25 to 2/6/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with NO deficiencies cited: H56046260C (MN108323). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		3/21/25

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

Electronically Signed — 02/28/2025

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

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F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure toileting and personal care were provided in a dignified manner for R1 who was left exposed and nude on the toilet while facing a window to facility courtyard. The window was not closed for privacy. In addition, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who utilized an indwelling catheter. Findings include: R1 R1's quarterly Minimum Data Set (MDS), dated 11/25/24 identified R1 with intact cognition, impairment of one side for upper extremities and required partial to moderate assistance with toileting and upper body dressing. In addition, R1 had diagnoses of spinal stenosis (narrowed space around the spinal cord causing irritation and compression of the spinal cord), heart failure, and arthritis. During observation on 2/4/25 at 8:08 a.m., R1 was sitting on the toilet naked. R1 was left alone by nursing assistant (NA)-C while NA-C left room to obtain supplies. The bathroom had a shower curtain as a separator between the bathroom and resident's bedroom which was left opened. The window of bedroom faced facility courtyard, and the window blinds were not closed for privacy. R1 faced the courtyard and shrugged, reaching for a small towel to cover her breasts. Trained medication aide (TMA)-A walked into room and saw R1 on the toilet, walked to the window, and	F 550	1. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retained on the dignity policy by 3/21/25 or upon their next scheduled shift after. 2. Ongoing compliance will be monitored by the Nurse Managers and DON by randomly auditing cares of 1 resident 1x/week for 4 weeks, then 2x/month for 2 months. Audits can be visual or interviewing residents. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 550	Continued From page 3 closed the blinds to the courtyard. "I closed the curtains[blinds] because [R1] was being exposed. I would be super embarrassed." TMA-A stated, "I could tell [R1] was uncomfortable". During interview with NA-C on 2/4/25 at 8:13 a.m., NA-C stated she had worked for an agency and that "I left the window shade open. I left to get wipes. Yes, I left her on the toilet naked." Also, "the window blinds were open enough for anyone outside the window to see inside the room.". During interview with R1 on 2/4/25 at 8:20 a.m., R1 stated, "there was a curtain. I usually ask to have the blinds closed. It is not a pleasant thing being left alone on the toilet naked and feeling exposed here." R1 stated NA-C was "new" and was "not prepared" to assist with bathing. R1 stated, "I have given up a lot of my dignity while being here. It does bother me when I am left exposed but don't say anything because it doesn't change." During interview with DON on 2/4/25 at 12:41 p.m., DON stated, "That is unacceptable. We want [R1] to be comfortable. I would offer a drape or something to cover her body before leaving the room." During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated, "I would not leave anyone naked on the toilet and leave the room. I would cover them and shut the blinds for privacy and dignity. I would be very upset if someone did that to me." R18 R18's quarterly (MDS) dated 12/6/24, identified	F 550		

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F 550	Continued From page 4 R18 had moderate cognitive impairment, was dependent on staff for toileting and lower body dressing and had an indwelling catheter (tube to drain urine from the bladder into a collection bag). During observation and interview on 2/3/25 at 6:03 p.m., R26 was in wheelchair while nursing assistant (NA)-A transported him to his room. NA-A wheeled R26 down the hall past another resident and staff member into R26's room. A large urine drainage bag was visible from under R26's wheelchair and was uncovered. NA-A stated he had been assigned to assist R26 from facility's dining room to his bedroom. NA-A stated the drainage bag "should be covered" and was unable to locate a privacy cover in the residents' room. NA-A stated importance of covering the bag was "privacy". During interview with director of nursing (DON) on 2/4/25 at 12:47 p.m., DON stated urine drainage bags, "should always be covered. We have dignity covers and pillowcases to cover up the urine drainage bags." Undated facility policy titled Quality of Life-Dignity stated, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." And "Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered".	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must--	F 582		3/21/25

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F 582	Continued From page 5 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually	F 582		

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F 582	Continued From page 6 resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 3 residents (R30) reviewed whose Medicare Part A coverage ended and they remained in the facility. Findings include: R30's Notice of Medicare Non-Coverage (CMS-10123) dated 10/22/24, indicated R30's last covered day of Medicare A would be 10/22/24, and was signed by family member (FM)-B on 10/17/24. R30's SNF Beneficiary Protection Notification Review form dated 10/22/24, indicated R30 had not been provided a SNFABN as "resident won appeal". R30's Notice of Medicare Non-Coverage (CMS-10123) dated 11/7/24, identified R30's last covered day of Medicare A would be 11/7/24, and was signed by family member (FM)-B on 11/4/24. R30's Census record dated 2/1/25, indicated R30's primary payer source switched from	F 582	1. The Director of Life Coach Services will be re-educated on when SNFABN or NOMNIC are to be issued by 3/21/25. 2. R30 will have SNF ABN issued by 3/21/25. 2. Resident charts will be audited for any additional missed SNFABN or NOMNIC forms. Any missed forms will be issued by 3/21/25. 3. Ongoing compliance will be monitored by the Life Coach Director by auditing 2 resident charts per month for 3 months of residents that were discharged from Skilled Services. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the Director of Life Coach Services will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 582	Continued From page 7 Medicare A to private pay on 11/8/24, and they stayed in the facility until current. R30's medical record was reviewed and did not indicate a SNFABN had been given prior to R30's Medicare Part A coverage ending. During an interview on 2/4/25 at 11:38 a.m., licensed social worker (LSW)-A confirmed she had reviewed R30's medical record and found that a SNFABN had not been given to R30 prior to his Medicare Part A coverage ending. LSW-A stated she oversaw giving SNFABNs to residents and thought it had been missed for R30. A policy regarding SNFABNs was not received.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		3/21/25

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F 583	Continued From page 8 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: During observation and interview, the facility failed to ensure 3 of 3 (R14, R19, R149) resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. Findings include: During observation on 2/3/25 at 7:25 p.m., an unattended laptop identified three residents and their care sheet information. The care sheet information contained their names, diagnoses, assistance needs for dressing and showering, oxygen status, diet, toileting, repositioning, and special instructions such as preferences. Two staff walked past the unattended laptop. During interview with nursing assistant (NA)-B on 2/3/25 at 7:29 a.m., NA-B stated, "that should not be open for anyone to see. Privacy is why." During interview with NA-A on 2/3/25 at 7:33 p.m., NA-A stated he was responsible for the	F 583	1. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retained on the HIPAA policy by 3/21/25 or upon their next scheduled shift after. Training will include information on electronics. 2. Privacy screens for monitors and laptops in the hallways of resident care areas will be applied by 3/21/25. 3. Ongoing compliance will be monitored by the Nurse Managers and DON by randomly auditing 1 computer in public areas 1x/week for 4 weeks, then 2x/month for 2 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 583	Continued From page 9 unattended laptop. NA-A stated unattended laptop contained visible, "patient confidentiality [information]" and "it should not be left open for everyone to see." During interview with Trained Medication Aide (TMA)-A on 2/4/25 at 7:55 a.m., TMA-A pointed to laptop and stated, "It has their [resident] information on the screen and people can walk by and look at the information. We always must close the screen for privacy." During interview with director of nursing (DON) on 2/4/25 at 12:39 p.m., DON stated, "that should not occur due to a HIPPA (Health Insurance Portability and Accountability Act) violation. Someone could walk by and see the private information." During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated, "patient information should not be visible to stop [others] from being nosey". Undated facility policy titled HIPAA Privacy Policies and Procedures state "all staff and associates act in an appropriate and compliant manner to protect patient information under the HIPAA privacy regulations."	F 583		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the completed	F 641	1. Re-education on restraint coding will be conducted with MDS nurse by 3/21/25.	3/21/25

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F 641	Continued From page 10 Minimum Data Set (MDS) was accurately coded to reflect actual restraint use for 4 of 4 residents (R2, R15, R26, R41) reviewed for MDS accuracy. In addition, the facility failed to accurately complete a Brief Interview for Mental Status (BIMS) assessment for 1 of 4 residents (R17) reviewed for MDS accuracy. Findings include: Restraint Use The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, outlined a section labeled, "SECTION P: RESTRAINTS AND ALARMS," which directed to record the frequency a resident was restrained by any of the listed devices during the seven-day look-back period. A definition of physical restraint was provided which outlined, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." R2's quarterly MDS dated 1/10/25, indicated R2 had severely impaired cognition and was dependent on staff for transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R2's order summary dated 8/5/24, indicated R2 had bilateral mobility bars that were used for turning, repositioning, and bed mobility. During an observation on 2/3/25 at 1:23 p.m.,	F 641	Re-education of how to complete BIMS correctly will be completed with Director of Life Coach Services by 3/21/25 as well. 2. Grab bar assessments will now be completed with admission, quarterly, significant change and annual assessments. 3. MDS nurse educated by 3/21/25 to reach out to facility DON/Nurse Managers should she have difficulty finding information in EMR to verify documentation completion prior to submitting MDS assessments. 4. Assessments for R2, R15, R41, R17 & R26 will be corrected by 3/21/25. 5. Current resident MDS assessments will be reviewed for accuracy and will be corrected as needed by 3/21/25. 6. Ongoing monitoring will be completed by by the MDS Director by reviewing all MDS done each month x 3 months to verify accuracy of side rails coded as restraints based on assessments and documentation. After 3 months, 3 assessments per month will randomly be audited x 3 months. Data from these reviews will be sent to DON/Administrator who will bring this information to the next schedule QAPI meeting.	

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F 641	Continued From page 11 bilateral grab bars were observed affixed to R15's bed. During an interview on 2/4/25 at 10:04 a.m., NA-D stated she was the aide working with R2 today and was not aware of either having any restraints. NA-G stated R2 was not able to get out of bed whether the grab bars were in place or not. NA-G stated she felt the side rails were not stopping him from moving or attempting to get out of bed though. R15's quarterly MDS dated 11/15/24, indicated that R15 had moderately impaired cognition and required substantial assistance with transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R15's Grab Bar Assessment dated 3/21/24, indicated the assessment was done on the resident's admission to the facility, and bilateral grab bars were used to assist the resident with moving side to side. The assessment indicated the grab bars "does not limit resident's freedom of movement" or the resident's "sensory stimulation". During an interview and observation on 2/4/25 at 9:59 a.m., R15 stated she used the grab bars to pull herself out of bed and confirmed she didn't feel they were restrictive or stopped her from moving in any way. Bilateral grab bars were observed affixed to R15's bed. R26's quarterly MDS dated 12/5/24, indicated R26 had severely impaired cognition and required substantial assistance with transferring out of bed. The MDS indicated in section, "P0100.	F 641		

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F 641	Continued From page 12 Physical Restraints," that R15 had bed rails that were used as restraints daily. R26's order summary dated 8/4/24, indicated R26 had bilateral mobility bars that were used for turning, repositioning, and bed mobility. During an observation on 2/4/25 at 9:49 a.m., bilateral grab bars were observed affixed to R26's bed. During an interview on 2/4/25 at 10:04 a.m., nursing assistant (NA)-G stated she was the aide working with R26 and R15 today and was not aware of either having any restraints. NA-G stated she had observed both residents utilize the grab bars, and although neither resident could get out of bed independently, did not think the grab bars would stop them from attempting to do so. R41's quarterly MDS dated 1/10/25, indicated R41 had intact cognition and required supervision for transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R41's Care Conference Review form dated 1/14/25, included the section, "restraint review", with "grab bars- not restraint" written next to it. During an observation and interview on 2/3/25 at 1:52 p.m., R41's bed was observed with affixed bilateral grab bars. R41 stated she did not use the grab bars, was able to sit up by herself, and denied being restrained while at the facility. During an interview on 2/4/25 at 10:15 a.m., NA-C stated R41 was able to carry out most of her cares by herself with supervision and set up	F 641		

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F 641	Continued From page 13 help. NA-C stated she had observed R41 independently get out of bed and R41 didn't utilize the grab bars when doing so. R2's, R15's, R26's, and R41's medical records were reviewed, and evidence of restraint use was not found. During an interview on 2/4/25 at 12:05 p.m., registered nurse (RN)-G stated she was the offsite MDS coordinator for the facility. RN-G stated if a grab bar does not inhibit a resident's ability to move freely, it does not meet the qualification for restraint and should not be coded on the MDS. At 1:34 p.m., RN-G stated she was dependent on assessments that had been uploaded into the electronic medical record to determine if a resident was using a restraint as she was remote. RN-G stated she was not able to find grab bar assessments for R2, R15, and R26, so she had coded it as a restraint but confirmed she had not further clarified with the onsite staff whether this was true. RN-G stated she would put in a correction for R41 as she had found a document stating the grab bars were not restraining her. BIMS Assessment The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, indicates Section C of the MDS is used to assess for signs of delirium as well as determining a resident's attention, orientation, and ability to recall information. The manual indicates the BIMS assessment should be stopped after completing C0300C, if all responses up to this point of the assessment	F 641		

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F 641	Continued From page 14 have been nonsensical. The manual then indicates if the interview was stopped, dashes should be coded in C0400A, C0400B, and C0400C and then coded as 99 in the BIMS summary score. The assessor should then code yes in C0600 and complete the Staff Assessment for Mental Status. R17's annual MDS dated 1/2/25, in Section C-Cognitive Patterns, C0100 was coded as 1, indicating that R27 should have a BIMS assessment completed. The MDS sections C0200-C0400 were then all coded as zero, indicating none, no answer, or could not recall. C0500 of the R40's MDS indicated a BIMS summary score of 0/15. A Staff Assessment for Mental Status was not completed. The MDS indicated that there was no evidence of an acute change in mental status from the resident's baseline. R17's progress note dated 1/2/25 at 11:22 a.m., indicated all questions under C0200 and C0300 of the BIMS assessment had been asked to R17 with all "non[-]sensical" answers. During an interview on 2/4/25 at 1:36 p.m., RN-G stated the facility staff member completing the BIMS assessment for R17 had called her as they were unsure how to complete it as R17 was sometimes understood. RN-G stated she had them attempt the assessment, but it looked like they had not stopped when he had given non-sensical responses so it auto-populated the score and then a staff assessment was not completed.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/21/25

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F 656	Continued From page 15 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 16 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an individualized comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 2 residents (R42) who required staff assistance with activities of daily living (ADLs) including prevention of pressure ulcers and care needs. Findings include: R42's significant change Minimum Data Set (MDS) assessment dated 12/23/24, indicated R42 had intact cognition. R42 required moderate staff assistance with personal hygiene and oral hygiene, maximum assistance from staff for upper body dressing, and was dependent on staff for bed mobility, sit to lying, lying to sitting on side of bed, footwear, lower body dressing and toileting. MDS indicated no behaviors present or rejection of care exhibited. R42's pertinent diagnoses included: displaced intertrochanteric fracture of right femur (a broken hip bone that has shifted or separated), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the heart), Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance and coordination) and weakness. Section M "Skin Conditions" indicated R42 was at risk for developing pressure ulcers	F 656	1. Nurse Managers will be re-educated on comprehensive care plan policy including need to address all cares in the care plan by 3/21/25. Nurse Managers and IP/Wound Care nurse will also implement a check list for new resident skin concerns to help ensure care plans are updated with any new cares. 2. R42 is no longer a resident at the facility. 3. Nurse Managers and IP/Wound nurse will review all current resident's care plans and update as needed to include detailed information on all cares provided by 3/21/25. 4. When a resident□s care plan includes bath/shower more than 1x/wk, EMR will include documentation requirement by nursing staff to verify whether task was completed or not. When resident chooses to receive a bath/shower 1x/wk, documentation of skill check will continue to be required as verification this was completed. 5. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retained on the importance of complete and accurate documentation including resident refusal by 3/21/25 or upon their next scheduled shift after.	

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F 656	Continued From page 17 and had one or more unstaged pressure ulcer at Stage 1 or higher. Furthermore, "M0300 Current Number of Unhealed Pressure ulcers at Each Stage" under section G; Unstageable-Deep tissues: suspected deep tissue injury in evolution, indicated one unstageable pressure ulcer with suspected deep tissue injury in evolution that was present upon admission/entry or reentry. R42's care plan, printed 2/3/25, indicated the following: - "NURSING: The resident has potential for pressure ulcer development r/t [related to] advanced age, pain, weakness, immobility, use of anticoagulant, Foley catheter. Braden = 15" with the following interventions - "Administer treatments as ordered and monitor for effectiveness." - "Follow facility policies/protocols for the prevention/treatment of skin breakdown." - "Obtain and monitor lab/diagnostic work as ordered. Report results to MD [medical doctor] and follow up as indicated." - "Staff to assist with routine toileting and skincare for incontinence." - "Treat pain as per orders prior to treatment/turning etc. to ensure The resident's comfort." - "NURSING: The resident has indwelling Foley [urinary] catheter R/T urinary retention. Foley catheter to be removed on 11/22/24 for voiding trial, he F/U [follow up] with Urology on 12/4/24." - "CATHETER: Catheter - Change catheter bag, and cath kit (syringe & basin) once weekly, initial and date new supplies Q [every] Friday." - "CATHETER: last changed: (SPECIFY Date).	F 656	6. Ongoing monitoring will be completed by the DON by auditing a resident□s documentation of task completion as well as audit of a resident comprehensive care plans 2x/month for 3 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 656	Continued From page 18 Change catheter (FREQ). (SPECIFY Size) (SPECIFY Type)" -"CATHETER: The resident has (SPECIFY Size) (SPECIFY Type of Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door." - "Check tubing for kinks [# TIMES] each shift." -"NURSING: The resident has an ADL selfcare and mobility deficits r/t R hip FX S/P IM nailing [right hip fracture after surgical repair], weakness, difficulty in walking, pain, Parkinson's disease, orthostatic hypotension, Foley catheter, precaution for WBAT RLE (weight bearing as tolerated right lower extremity)." -"TOILET USE: The resident requires is dependent on mechanical stand lift Ax2 [assist of 2] to transfer on/off toilet and dependent on staff to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. He has Foley Catheter, that will be removed on 11/22/24 for voiding trial. He F/U with Urology on 12/4/24." -"TRANSFER: The resident requires Mechanical Lift Ax2 with 3rd staff on standby assistance for transfers." R42's care plan lacked identification of history of pressure injury, resident specific interventions for prevention of pressure ulcers, removal of catheter and possible fluctuating ability to transfer. R42's care sheet, printed 2/5/25, identified the following: -"Repo[reposition]: Q 2 hours from side to side-encourage [R42] to stay off back, has open area to coccyx" -"Toilet: Toilet upon waking, after meals, before bed and NOC [night] as tolerated. Wheelchair to	F 656		

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F 656	Continued From page 19	F 656		

Bathroom assist of 2 with walker to toilet"
-"Transfer Method: Assist of 1 with Walker for all transfers."

R42's care sheet lacked need for air mattress, cushion in wheelchair or other interventions to prevent reoccurrence of deep tissue injury or pressure ulcer. Furthermore, lacked evidence that R42's deep tissue injury/pressure ulcer had healed on coccyx.

On 2/03/25 at 2:11 p.m., R42 was observed seated in his wheelchair with a cushion on the chair. R42 stated he had a "sore" on his "bottom," and was unsure when it started but knew he had it at the hospital. R42 indicated the staff were doing wound care on it. R42 stated he was unsure of if it was getting better or worse as he was unable to see it.

R42's Order Recap Report, printed 2/4/25, indicated the following order:
-"1. Cleanse with NS (nasal saline), pat dry 2. Apply skin prep to surrounding tissue and allow to dry. 3. Cover with a foam dressing 4. Change 3x week and PRN (as needed), D/C (discontinue) when healed as needed for DTI [deep tissue injury] sacrum and in the morning every Mon, Wed, Fri" with a start stated of 12/16/24 with and end date of 1/14/25.

R42's February's Medication Administration and Treatment Record (MAR/TAR), printed 2/5/25, indicated the following:
-"Complete weekly skin check and bath (according to shower schedule) every day shift every Friday with a progress note with findings"

R42's January 2025 MAR/TAR, printed 2/5/25,

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F 656	Continued From page 20 indicated the following: -"Complete weekly skin check and bath (according to shower schedule) every day shift every Friday with a progress note with findings" -On 1/3/25, 1/17/25, 1/31/25 indicated it was completed by a check mark. -On 1/10/25, the box was left blank -On 1//24/25, the box was marked with a "9" which indicates "other/see progress notes" R42's January MAR/TAR lacked evidence of wound care order for listed above which was started on 12/16/14, and discontinued on 1/14/25. R42's progress notes, dated 12/16/24 to 2/5/25, revealed the following: -1/31/25 at 11:04 a.m.: "skin check completed with no new skin issues." -1/29/25 at 1:03 p.m.: "uses the urinal and tolerates well" -1/25/25 at 11:05 p.m.: "continent of bowel and bladder" -1/24/25 at 1:48 p.m.: "shower was not done today." -1/23/25 at 9:11 a.m., "[R42] scored 22 on Braden, which is not at risk for skin impairment. His appetite is improved and he is much stronger moving more and is able to lift himself off the bed and up off the wheelchair. His continence is improved, though he does wear a brief for dribbling or "possible accidents.". His skin is intact, incision to rt [right] upper chest healed and steri strips are peeling off. His RT hip incision is healed and no redness noted. His bottom is pink and he still is having barrier cream applied." -1/20/25 at 1:12 p.m.: "is voiding well following removal of Foley catheter." -1/19/25 at 12:13 p.m.: "continent of bowel and bladder"	F 656		

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F 656	Continued From page 21 -1/17/25 at 12:29 a.m.: : shower not given today ...shower to be done tomorrow." -1/9/25 at 11:02 a.m.: "Resident has appointment with Urology today regarding his urinary retention and Foley catheter use. Catheter removed at 0940 [9:40 a.m.,] per order." -12/30/24: "[R42] scored 15 on Braden he is at risk for skin breakdown related to his inability to independently move in bed or reposition himself without sliding in bed is not able to lift clear of mattress and chair surfaces. Has redness to bottom/coccyx area and redness to groin which is treated with nystatin powder and Barrier cream to bottom." -12/20/24 at 2:25 p.m.: "Coccyx/perineal area MASD [moisture associated skin damage], 1 x 0.5 cm slough appearing area to right gluteal cleft. Foam dressing applied and barrier cream applied." -12/16/24 at 8:02 p.m.: "He has an open area to sacrum/coccyx are[a] ...he is chairfast and non ambulatory at this time and moves feebly on his own, he will root around in the bed to get off his side to his bed and to move around in bed with friction possible, He scored 12 on his Braden which he is high risk for Skin impairment. At this time there are orders for wound care daily and 3 times weekly ...Care Plan updated." R42's progress notes lacked ongoing assessment of pressure ulcer and interventions placed to prevent further development of pressure ulcers. R42's Weekly Wound Tool, dated 12/16/24, identified a suspected deep tissue injury (SDTI) located on sacrum with slough tissue present which was described as 100% thin white slough with a serous scan amount of drainage with no	F 656		

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F 656	Continued From page 22 odor measuring at 25 millimeter (mm) in length by 8 mm in width with no tunneling or undermining. The peri-wound (tissue surrounding the wound) was described as red but blanching with defined edges with the treatment (listed above) being started. R42's electronic medical record (EMR) lacked any further weekly wound tool assessment completed. On 2/04/25 at 10:17 a.m., licensed practical nurse (LPN)-B stated she was responsible for the wound assessments. LPN-B stated skin checks are to be completed weekly by nurses on the floor and a progress note entered in the EMR. LPN-B stated if a skin issue was identified, they put it on the 24-hour sheet, let her know along with the clinical coordinators for follow up. LPN-B stated she does a Weekly Wound Tool assessment weekly on residents with wounds which is the expectation. LPN-B stated she does not update the care plan as the care coordinators update the care plan. On 2/05/25 at 10:35 a.m., registered nurse (RN)-C stated if a wound was identified during a skin check, the wound nurse, family and provider would be notified. Furthermore, they would initiate interventions needed. RN-C stated floor nurses did not update the care plan. On 2/05/25 at 10:41 a.m., RN-F stated they did not remember doing any wound cares with R42 since he had returned from the hospital and stated they worked with RN-F numerous times. RN-F stated the only wound that they had known of was a healed incision on his hip. RN-F stated, "I was not aware of that one," when asked about	F 656		

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F 656	Continued From page 23 a wound on his coccyx when returning from the hospital. RN-F indicated R42 did have some "moisture related issues in his groin area but not his coccyx of sacrum." R42 was assessed by RN-F at 10:53 a.m., and did not have a pressure sore on his coccyx. On 2/05/25 at 11:01 a.m., nursing assistant (NA)-F stated nursing assistants got their information from the care plan. NA-F stated they pulled up a document on the computer that pulls resident information from the care plan for their care guide/sheet. NA-F reviewed R42's sheet and stated R42 care sheet indicated that R42 did not have a cushion in wheelchair or air mattress. Furthermore, indicated had an open area to coccyx. On 2/04/25 at 9:28 a.m., LPN-A indicated when any skin issue was noted on a skin assessment, the wound nurse was notified after documenting anything found in a progress note. LPN-A stated "they" (clinical coordinators) updated the care plan. During a follow up interview on 2/05/25 at 9:55 a.m., LPN-B she was able to review R42's EMR and stated R42's care plan had not been updated to reflect identification of DTSI on 12/16/24. LPN-B stated no wound assessments had been completed except for the initial assessment on 12/16/24, and no progress notes indicated the sacrum wound was monitored. LPN-B stated the progress notes lacked documentation of details of skin assessments the MAR indicated were completed. LPN-B stated the clinical care coordinators updated the care plans. On 2/05/25 at 12:20 p.m., director of nursing	F 656		

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F 656	Continued From page 24 (DON) stated she would expect care plans to reflect residents' care. DON reviewed R42's care plan and stated R42's care plan lacked specific interventions for pressure ulcer prevention such as turning and repositioning, type of mattress, history of pressure injury, etc. A facility policy titled Person-centered Care Planning, dated 4/2024, indicated "person-centered care plan will be sued by al personnel involved in the care of the resident." Furthermore, "comprehensive care plans must be reviewed and revised quarterly and as needed by the interdisciplinary team."	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine bathing was completed in accordance with identified wishes for 1 of 4 residents (R7) reviewed for activities of daily living (ADLs) and who was dependent on staff for their bathing care. Findings include: R7's quarterly Minimum Data Set (MDS), dated 12/12/24, identified R7 had severe cognitive impairment but demonstrated no delusional or rejection of care behaviors. Further, the MDS identified R7 was dependent on staff for personal hygiene care.	F 677	1. ADL protocol updated to include need to document care needs 2. Nurse Managers will ensure R7 is on the weekly bath/shower schedule2x/wk along with reviewing EMR has task scheduled 2x/wk by 3/21/25. They will also review all current residents and ensure resident's preferred frequency of bath/shower is correct on the shower/bath schedule and EMR. 3. CNA's will be retrained on where to locate resident bath/shower information by 3/21/25. 2. When a resident□s care plan includes bath/shower more than 1x/wk, EMR will	3/21/25

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F 677	Continued From page 25 On 2/3/25 at 5:31 p.m., R7 was asked about her baths at the care center. R7 stated aloud, "I'm missing those," while making a back and forth motion using her hands. R7 struggled with word-finding but reiterated, when pointedly asked, she was not getting her baths every week adding aloud, "Yea [affirm]." R7's care plan, dated 9/16/24, identified R7 had a self-care deficit and needed assistance with ADLs due to weakness and other past medical history or conditions. The plan listed a goal which read, "Will be clean and neatly dressed with assistance," along with multiple interventions including, "Bathing: Assist X1." The care plan lacked information on how often bathing was scheduled or preferred. On 2/4/25 at 9:41 a.m., nursing assistant (NA)-D was interviewed. NA-D explained they had worked with R7 prior, including for bathing, and stated the staff followed a "shower list" which was on their internal computer system. NA-D stated R7 was scheduled for a twice-a-week shower and preferred only female caregivers with it. NA-D verified R7 was supposed to be getting a twice weekly shower and stated she (R7) had been scheduled with that for many months now. NA-D stated they always strived to get R7's shower done but added doing so could be more challenging in the Summer months with staffing. NA-D stated all showers or baths would be charted in the medical record and the nurse's do a corresponding skin check but only "one of the two days." NA-D stated the care center had recently adjusted to only five NA working on the morning shift and, as a result, there were times when they'd be on the unit "by myself" and	F 677	include documentation requirement by nursing staff to verify whether task was completed or not. When resident chooses to receive a bath/shower 1x/wk, documentation of skill check will continue to be required as verification this was completed. 3. Agency CNAs will begin documenting care in EMR by 3/21/25. 4. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retained on the importance of complete and accurate documentation including resident refusal by 3/21/25 or upon their next scheduled shift after. 5. Ongoing monitoring will be completed by the DON by auditing a random resident□s documentation of task completion as well as audit a resident comprehensive care plan 2x/month for 3 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 677	Continued From page 26 residents would then get only "quick bed baths" and no showers. NA-D stated if baths or showers weren't completed, they could try to re-schedule them but with the workload, it would be tough adding aloud, "We don't have time to do an additional shower." NA-D stated they felt R7 was consistently getting her second evening-shift shower but then expressed aloud, "I don't always know if they do it." R7's POC (Point of Care) Response History, dated 2/4/25, identified a 14-day look-back period. The data provided space to record what level of bathing assistance R7 needed (i.e., independent, supervision, dependent) along with a date and time for each episode. The data had two recorded data points, on 1/22/25 and 1/29/25, however, both of these were recorded as, "Not applicable." R7's progress notes, dated 1/1/25 to 2/3/25, identified the following note(s) recorded under a label, "Nurse's Note." On 1/13/25, R7 was recorded as having received a shower and skin check. R7 was recorded as having 1+ edema to her foot. On 1/20/25, R7 was recorded as having received a shower and skin check. On 1/27/25, R7 was recorded as not having a shower. The note had dictation which read, "Shower not completed today." The note lacked any rationale or reason why the shower was not done. The completed progress note(s) and medical record both lacked any further evidence R7 was	F 677		

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F 677	Continued From page 27 receiving a twice weekly shower and/or bath as was scheduled per the direct care staff. On 2/4/25 at 2:32 p.m., registered nurse manager (RN)-A was interviewed. RN-A reviewed R7's medical record and verified R7 was scheduled to receive a twice weekly shower. RN-A stated they were unsure why the nurse' charted the shower was not completed on 1/27/25, and verified the NA should be charting all completed showers or baths in the record (i.e., POC). RN-A acknowledged the lack of charting or documentation to show the second shower was being completed and expressed staff typically didn't chart a second skin check note when multiple baths are scheduled. RN-A stated staff had "not consistently" reported issues with getting showers or baths completed but expressed some days were "very challenged" with workload and call-ins. RN-A stated they were not "personally" checking or auditing charting to ensure it was completed but expressed showers and baths should be done and recorded as the lack of them "can cause all kinds of skin problems." A provided Standard ADL Protocol, undated, identified a procedure for each respective discipline to complete ADLs. This included for the NA, "Offer weekly bath or shower per individual preferences, [NA] to be present during tub bath or shower." The policy lacked information on how completed baths or showers would be recorded or tracked.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/21/25

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F 684	Continued From page 28 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess potential signs of constipation to determine what, if any, proactive interventions were needed to promote comfort and reduce the risk of complication (i.e., impaction) for 1 of 1 residents (R41) who reported being constipated. Findings include: R41's admission Minimum Data Set (MDS), dated 1/10/25, identified R41 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS identified R41 did not have constipation. On 2/3/25 at 1:51 p.m., R41 was interviewed and stated she had recently moved into the care center from the hospital. R41 stated her bowels were "not too good" and complained of feeling constipated adding, "I get stuffed up a lot." R41 stated staff were aware of this and, when she'd ask, they would give her medication to have a bowel movement. R41 stated she didn't recall anyone ever talking with her about what proactive interventions could be done such as prune juice or fiber supplements. R41 stated she'd be willing to hear what options she had as her usual pattern for a movement was every-other-day.	F 684	1. Nurse Managers will be re-trained on completing the Continence Evaluation thoroughly, including both pharmacological and non-pharmacological measures, by 3/21/25. 2. Care plan and medications for R41 and all other current resident care plans and medication orders will be reviewed and updated as needed for appropriateness of bowel regime by 3/21/25. Updates will include both pharmacological and non-pharmacological measures. 3. Ongoing compliance will be monitored by DON by auditing the Continence Evaluation and care plan of 1 resident weekly for 4 weeks then 2x/month for 2 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 684	Continued From page 29 R41's most recent Continence Evaluation, dated 1/9/25, identified a section labeled, "Bowel Continence Evaluation," which outlined R41 had no history of bowel incontinence or fecal impaction, and she was able to sense the urge to defecate. The evaluation a subsection labeled, "Elimination Assist," had spaces to mark what, if any, assist item (i.e., laxatives, prune juice/fiber) was used. These were all left unchecked and only a single check was placed next to the option, "f. None." The evaluation continued and identified R41 remained on antibiotics and had evidence of diverticulitis (inflammation of small pouches [diverticula] that form in the wall of the large intestine). The evaluation concluded with a section labeled, "Plan," which placed a checkmark next to the option, "h. Other," and outlined R41 was able to participate in a bowel and bladder program with dictation, "Usually continent, toilet per her request and PRN [as needed]." R41's elimination care plan, dated 1/15/25, identified R41 had urge incontinence of bladder. The care plan listed multiple interventions including barrier cream as ordered, encourage fluids during the day, laxatives as ordered, and monitor bowel pattern/consistency. The listed interventions were all last implemented or revised on 1/15/25. When interviewed on 2/4/25 at 9:41 a.m., nursing assistant (NA)-D stated they had worked with R41 "only a few times" but recalled the "overnight nurse" reporting R41 had been asking for a suppository. NA-D stated they last heard this "about a week and a half ago" adding they had last helped R41 to the toilet with a bowel movement the same morning the suppository	F 684		

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F 684	Continued From page 30 was given. NA-D stated R41's stool then was "putty consistency." NA-D stated R41 would, at times, still toilet herself so staff always asked her if she had a bowel movement, too. Further, NA-D stated all bowel movements were charted in the electronic system (i.e., Point Of Care). R41's POC (Point Of Care) Response History, dated 2/4/25, identified a 20-day look back period and listed the consistency staff had recorded for each bowel movement R41 had on their respective shift including: On 1/20/25, R41 had a recorded formed bowel movement. On 1/24/25 (four days later), R41 had two recorded bowel movements with one being labeled, "Loose/Diarrhea." On 1/26/25, R41 had two recorded formed bowel movements. On 1/29/25 (three days later), R41 had a formed bowel movement. R41's Medication Administration Record (MAR), dated 1/2025, identified R41's provided and recorded medications for the period. This identified R41 received the following: On 1/23/25, R41 received Biscolax suppository (used for constipation) at 6:08 a.m. and the results were recorded, "I [ineffective]." Later, on 1/23/25, R41 was given a dose of Sorbitol (can be used as a laxative) which was recorded, "E [effective]." On 1/30/25, R41 received another Biscolax	F 684		

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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 684	Continued From page 31 suppository with results listed, "E." The MAR lacked any ongoing medications to promote regualar bowel movements (i.e., Senna). Further, R41's medical record was reviewed and lacked evidence R41 had been reassessed to determine what, if any, proactive interventions were needed (i.e., medication, prune juice, fiber) to promote more regular bowel movements and reduce the need for ongoing PRN use despite multiple as-needed laxatives being given over the past few weeks. On 2/4/25 at 2:37 p.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R41's medical record. RN-A explained R41 was mostly independent within her room and could, if she wanted, take herself to the bathroom. RN-A acknowledged R41's charted bowel movements (via POC) had some periods with multiple days between and R41 had been given as-needed laxatives. RN-A stated a comprehensive assessment of R41's bowel patterns and needs would be done "initially [by] the floor nurse." RN-A stated they had just spoke with the nurse prior who was going to be "looking into that [R41's bowels]." RN-A stated any re-assessment would be in the progress notes or on a subsequently completed Continence Evaluation, however, expressed the new charting system was "more limited" on spacing to record items such as interventions or dictation. RN-A stated nobody had reported any concerns to them about R41's bowels or potential constipation and expressed it was important to ensure it was evaluated as constipation could "cause a lot of health issues." A facility' provided Protocol For Bowel	F 684		

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F 684	Continued From page 32 Management, undated, listed a purpose to ensure each resident had a bowel movement at least every 72 hours (three days). A procedure was listed which outlined how as-needed medications would be provided and listed, "Should the same resident require nursing intervention for bowel evacuation 3 or more times in one month, the nurse will inform the resident's primary physician." However, the policy lacked direction on how a comprehensive bowel management program would be assessed or documented.	F 684		
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 by: Based on observation, interview and document review, facility failed to provide 2 of 2 residents (R5, R37) with care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and underlying soft tissue) who were identified as risk for pressure ulcers/pressure injuries.	F 686	1. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retained on skin integrity and preventing skin breakdown by 3/21/25 or upon their next scheduled shift after. 2. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will also be retrained on documentation by 3/21/25 or	3/21/25

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F 686	Continued From page 33 Findings include: R5 R5's annual Minimum Data Set (MDS) dated 12/31/24 identified R5 with intact cognition, was dependent on staff for all toileting, bathing, and dressing and did not reject care. In addition, R5 was identified as at risk of developing a pressure ulcer/pressure injury. R5's electronic medical record (EMR) nursing assistant task form titled "TRANSFER: SELF PERFORMANCE-How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)" and documented from 1/22/25, to 2/4/25, identified R5 as requiring, "TOTAL DEPENDENCE-Full staff performance". R5's EMR nursing assistant task for titled, "BED MOBILITY: SUPPORT PROVIDED-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture" and documented from 1/22/25, to 2/4/25, identified R5 as requiring "One person physical assist". R5's nursing assistant care sheet identified R5 as requiring "Repo[repositioning]: Q 2 hours and PRN-AVOID lying on RT side". During observation on 2/3/25 at 2:47 p.m., R5 lying in bed on her back watching television. During observation and interview with R5 on 2/3/25 at 5:44 p.m., R5 laying in bed on her back watching television. R5 stated, "I don't recall when they asked me to turn or get off my back. It hasn't been since lunch time today. I am pretty	F 686	upon their next scheduled shift after. 3. EMR will be updated to include task to document 2 hour check/reposition for R5, R37 and any other current residents this applies to. Other residents affected will be identified by Nurse Manager/DON reviewing current resident's care plans and skin assessments. This will be updated by 3/21/25. 4. Ongoing compliance will be monitored by the Nurse Managers and DON by randomly auditing cares of 1 resident 1x/week for 4 weeks, then 2x/month for 2 months. Audits can be visual or interviewing residents. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 686	Continued From page 34 stiff". During observation and interview with R5 on 2/3/25 at 7:20 p.m., R5 lying on bed on her back. "They don't move or turn me. Haven't done it all day. They don't even ask me." During interview with nursing assistant (NA)-A on 2/3/25 at 7:26 p.m., NA-A stated he was R5's nursing assistant for the evening shift from 2:30 p.m. to 11:00 p.m., "I don't know when [R5] was last turned." NA-A stated "[R5] can get pressure sores so she needs to turn." NA-A stated expectation of nursing assistants to follow the nursing assistant care sheet to inform them of what the residents require with cares including turning and repositioning. NA-A stated expectation of nursing assistants to document cares and refusals in the EMR under Tasks. During interview with licensed practical nurse (LPN)-A on 2/4/25 at 8:27 a.m., LPN-A stated she was familiar with R5. LPN-A stated, "[R5] moves a little in the bed but not completely." LPN-A stated expectation of nursing assistants to follow the nursing assistant care sheet to inform them of what the residents requires with cares including turning and repositioning. LPN-A stated R5 required assistance to turn and reposition "at least every 2-3 hours". LPN-A stated she was not aware of when R5 was turned or repositioned last. R37 R37's quarterly MDS dated 11/11/24 identified R37 with significant impairment to cognition, impairment to lower extremities, was dependent on staff for all efforts of self-care, had diagnoses of Alzheimer's, dementia, depression, and bipolar	F 686		

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F 686	Continued From page 35 and did not reject care. In addition, R37 identified as a risk of developing a pressure ulcer/pressure injury. R5's nursing assistant care sheet identified R37 as requiring "Repo: Q 2 hours and PRN. Offer/enc to lay down in bed for at least short period of time after breakfast & lunch bathroom". During observation on 2/3/25 at 1:38 p.m., 2:13 p.m., 2:20 p.m., R37 sleeping on recliner lying on her back. At 5:42 p.m., R37 still sitting in recliner sleeping lying on her back but the lights to the room were turned off. During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated expectation of nursing assistants to use the nursing assistant care sheet to inform them of what the residents requires with cares including turning and repositioning. NA-E stated R37 "is not on turning repositioning program. Usually, we wait about 2 hours to try to get them [residents] to shift weight because if they are in the same spot too long the skin can break down." Also, "we [aides] don't document it anywhere". During interview with registered nurse (RN)-B on 2/5/25 at 12:36 p.m., RN-B stated expectation of staff to reposition residents per care sheet. RN-B stated progress note from nurses should reflect refusals. RN-B verified EMR lacked documentation for both R5 and R37 were turned, repositioned, or provided range of motion exercises. "If it is not documented then we cannot be sure that the ROM or turning or repositioning was done". In addition, RN-B stated both R5 and R37 were high risk for skin breakdown if not turned or repositioned regularly.	F 686		

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F 686	Continued From page 36 During interview with director of nursing (DON) on 2/4/25 at 10:03 a.m., DON stated expectation of nursing assistants to document in the Task section of EMR "on what they do for the resident like turning, toileting, etcetera". During interview with DON on 2/5/25 at 1:57 p.m., DON stated, "expectation is we should still be offering to offload[sic] should be documented in progress note for refusals". DON stated, "[residents] are dependent on staff for turning and repositioning and transfers. We do not have a system in place to actually see if [residents] are being turned and repositioned every 2-3 hours." DON stated R5 and R37 were considered high risk for pressure ulcers and their EMRs lacked documentation of refusals. Facility policy requested for pressure ulcer prevention and not received.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and, if needed, develop proactive interventions to reduce the risk of further falls and	F 689	1. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retrained on the Fall protocol by 3/21/25 or upon their next scheduled shift after.	3/21/25

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F 689	Continued From page 37 injury for 2 of 2 residents (R44, R26) reviewed who had sustained falls at the care center. Findings include: R44 R44's admission Minimum Data Set (MDS), dated 12/4/24, identified R44 had severe cognitive impairment, demonstrated no behavioral symptoms (i.e., physical, verbal, rejection of care) and required assistance for nearly all activities of daily living (ADLs). Further, the MDS outlined R44 had sustained a fall within the month prior to admission, however, sustained no falls since she admitted to the care center. R44's care plan, revised 12/20/24, identified R44 was at risk for falls with dictation, "NURSING: The resident is at risk for falls [related to] weakness, impaired mobility ... [as evidenced by] H/O [history of] fall prior to admission." The plan listed a goal which read, "The resident will be free of falls through the review date," along with several interventions including anticipating/meeting R44's needs, ensure the call light is within reach, encouraging participation is activities which promote exercise, and ambulating R44 twice daily. The care plan interventions each listed a date implemented and, if applicable, revision. This identified only one revision to a single intervention on 12/20/24, the remainder of interventions being listed as having the same start-date as the problem statement. On 2/3/25 at 3:53 p.m., R44's family member (FM)-A was interviewed. FM-A stated R44 had sustained a few falls since she admitted to the care center from her prior assisted-living setting.	F 689	2. Nurse Managers will begin to enter a progress note summarizing IDT review of all Fall reports by 3/21/25. 3. R 44 is no longer a resident at facility. R26 fall report from 1/17/25 will be reviewed in IDT by 3/21/25 and care plan will be updated based on review as needed. 4. Nurse Managers will review falls from 1/1/25-present to ensure they have been reviewed in IDT as well as that current care plan and fall interventions are appropriate and documented. Any resident falls identified that have not been reviewed in IDT will be reviewed in IDT and documented as such by 3/21/25. Any care plan changes based on review of fall will be done as needed by 3/21/25. 5. Ongoing compliance will be monitored the DON auditing 2 fall investigation reports per month for 3 months as well as an audit of 2 resident charts per month for 3 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 689	Continued From page 38	F 689		

FM-A stated they were not sure exactly what, if any, new interventions were being done between the falls. Later, on 2/5/25 at 8:54 a.m., R44 was observed seated in a standard wheelchair which had metallic anti-roll brakes installed. R44 was in the television room by the central nursing station and she appeared calm and responded aloud, "Good," when asked about her day so far. R44 was unsure how long she had lived at the care center and responded again aloud, "Pretty good."

R44's medical record was reviewed which identified R44 had sustained multiple falls since the care plan had last been revised (12/20/24), and these included:

R44's progress note, dated 12/23/24 at 11:44 p.m., identified R44 had been found on the floor at 11:20 p.m. when R44 turned on their call light to alert staff. The note outlined, "Resident found on floor sitting on buttocks next to her bed. Gripper sock on right foot, left foot bare." R44 denied pain and had confusion per baseline. The note continued, "First[,] resident stated she was getting up to use the toilet, then stated she was getting up to get a drink of water." The note identified R44 was assisted to the restroom and provided water, along with a voicemail left for R44's family member and the provider adding, "Will continue to monitor." The note lacked any further information on what, if any, future interventions would be done to reduce R44's risk of falls.

R44's corresponding incident report titled, "#20 Unwitnessed Fall," dated 12/23/24, identified text from the completed progress note and outlined R44 was oriented to person only. The report listed multiple sections to record various data points

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F 689	Continued From page 39 including pre-disposing factors, environmental factors, and statements from staff about the event. The report included spacing to record what, if any, actions (i.e., interventions) were assessed or implemented after the event; however, this was left blank with no new interventions being listed or rationale for the lack thereof. A subsequent Fall Risk Evaluation, dated 12/26/24, identified R44 scored 19.0 which was labeled, "At Risk." The evaluation identified a total of nine (9) questions to be answered by the evaluator including level of consciousness, history of falls, vision status, and medication (changes). However, the completed evaluation lacked information on what, if any, proactive interventions had been assessed or implemented to reduce R44's risk of continued falls. R44's progress note, dated 1/2/25 at 10:30 p.m., identified R44 was again found sitting on the floor. The note outlined, "Noted to be sitting on floor next to wheel chair near locked exit door in hallway. No injury noted. Later stated that she wanted to go outside." The note identified R44's family member and provider were contacted. However, again, the note lacked information to identify what, if any, additional interventions were determined or assessed to reduce R44's risk of continued falls and injury. R44's corresponding incident report titled, "#23 Unwitnessed Fall," dated 1/2/24, identified text from the completed progress note and the space to record R44's mental status was left blank and not completed. The report placed a checkmark next to a pre-disposing environmental factor of, "Other (Describe)." However, the report lacked further information on what this factor had been or was. The report, again, listed multiple sections	F 689		

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F 689	Continued From page 40 to record various data points but, again, lacked information on what, if any, actions (i.e., interventions) were assessed or implemented after the event. A subsequent Fall Risk Evaluation, dated 1/8/24, identified R44 scored 18.0 which was labeled, "At Risk." The evaluation, again, identified nine (9) questions to be answered by the evaluator including level of consciousness, history of falls, vision status, and medication (changes). However, the completed evaluation lacked information on what, if any, proactive interventions had been assessed or implemented to reduce R44's risk of continued falls. On 2/5/25 at 10:31 a.m., registered nurse manager (RN)-B was interviewed, and they explained when a fall happens, the floor staff respond and assess them for pain or injury then help them back to a surface. The staff ask the resident several questions, such as what happened, and then document them on the incident reports located in the system's risk management section. The report then is uploaded to the system for others, including management and leadership, to see and update. RN-B stated a Fall Risk Evaluation is also triggered and completed by the floor staff in the record. RN-B stated the report should then be reviewed by the interdisciplinary team (IDT) "as soon as possible" to help determine what, if any, new ideas or interventions are needed. RN-B then reviewed R44's reports in the system (dated 12/23/24, and 1/2/25), and verified the section labeled, "Action," would be where new interventions or rationale would be recorded. RN-B then expressed aloud, "I am just going to be honest with you," and stated they were not sure if all R44's fall reports had been brought to	F 689		

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F 689	Continued From page 41 IDT for review. RN-B reviewed R44's fall on 12/23/24, and verified it lacked any new interventions being recorded or outlined. RN-B stated the lack of completion with the report could possibly be related to being "pulled to the floor so much" due to staff call-ins, adding aloud, "Often, I don't [get them done]." RN-B stated it was "a chore and a struggle" to get all assigned things, such as fall reports and admissions, done timely, adding they felt at times new interventions had been done but just "not been documented." RN-B verified both of R44's reviewed falls, dated 12/23/24, and 1/2/25, did not have the report completed and lacked documentation to support what, if any, new interventions had been assessed or implemented but reiterated they felt things were discussed but "not formally in IDT." RN-B verified they didn't recall reviewing R44's falls with IDT but expressed they recalled adding the wheelchair brakes at some point. RN-B reviewed R44's fall care plan and verified it had not been revised since 12/20/24, despite R44 having two falls since then. RN-B again attributed the lack of updated care plan to being pulled repeatedly to the floor but verified it should be updated with any new interventions adding, "We're supposed to review that on a regular basis and update it." RN-B stated it was important to ensure falls were assessed and new interventions developed and recorded as, "We want to keep our residents safe." R26 R26's quarterly MDS dated 12/5/24, indicated R26 had severely impaired cognition and required assistance for nearly all ADLs. The MDS indicated R26 had no falls since the prior MDS	F 689		

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F 689	Continued From page 42 assessment. R26's progress note dated 8/11/24 at 1:00 p.m., indicated R26 was found lying on the floor next to his bed and could not communicate to staff what had happened. R26's quarterly fall risk assessment dated 12/5/24, indicated R26 was at a "high risk" for falls based on an assessment of factors such as mental state, history of past falls, ambulation status, medications, and predisposing diseases. R26's care plan dated 12/12/24, indicated R26 was at risk for falls related to dementia, heart failure, and a previous stroke. The care plan included multiple fall interventions such as Anti-rollback breaks and a dropped wheelchair seat, encouraging proper footwear, keeping the wheelchair by the bed/recliner when R26 was not using it, encouraging R26 to use a call light to call for assistance, etc. The care plan did not indicate any fall interventions had been added or revised since 9/11/24. R26's Fall Scene Investigation Form dated 1/16/25 at 11:50 p.m., indicated R26 had an unwitnessed fall from his bed. The form included possible environmental factors or causes that staff had assessed such as R26's call light was in reach, bed wheels were locked, glasses were off, and R26 was wearing gripper socks. The form indicated that R26 was unable to account for his fall. The form indicated R26's new/immediate fall interventions that were implemented were a wheelchair placed close to the bed, "doing safety checks", and reminding R26 to call for help. The form included a section for "IDT Team Review Notes" which was left blank.	F 689		

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F 689	Continued From page 43 R26's progress note dated 1/17/25 at 12:23 a.m., indicated R26 was found lying on the floor of his room with his bedding partially on the floor. The note indicated that R26 was unable to account for his fall. During an interview on 2/4/25 at 1:12 p.m., RN-F stated she was R26's and R44's nurse today. RN-F stated she was unsure if either resident had fallen recently but if they had she would expect these new fall interventions to be put on their care plan as that is how they communicate changes from shift to shift. During an interview on 2/5/25 at 12:33 p.m., RN-B stated she thought a fall investigation form had been filled out for R26's fall on 8/11/24, and given to the director of nursing (DON) but was unsure if the fall had been reviewed by IDT. The 8/11/24, fall scene investigation form was requested and not received. RN-B stated after reviewing the 1/17/25, Fall Scene Investigation Form, she did not think IDT had reviewed the fall as that part of the form was left blank. RN-B stated the expectation was that R26's care plan and nursing assistant care sheet be updated to reflect each fall and new interventions and that was not completed for R26. A facility' provided Accident: Managing Resident Falls policy, reviewed 4/2024, identified the center would evaluate and analyze hazards and/or risks for potential resident' falls on admission, quarterly and as needed. The policy outlined, "The IDT will monitor for accidents and recommend modifications to improve accident interventions." A section labeled, "Resident Fall Guideline," listed a procedure for a fall including providing first aid	F 689		

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F 689	Continued From page 44 (if needed) and documenting it within the medical record. The policy directed, "IDT will review all falls including the fall scene investigation form and immediate interventions implemented. Interventions may be changed or added to further reduce the risk of additional falls."	F 689		
F 700 SS=D	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 observation, interview, and document review, the facility failed to comprehensively assess for entrapment risk and attempt alternatives before installation of grab bars for 1 of 3 residents (R15) reviewed who were observed	F 700	1. Nurse Managers will be retrained by 3/21/25 on the bed rail use policy and the necessity for the bed rail assessment and documentation of risk vs. benefit discussion & consent must occur prior to	3/21/25

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F 700	Continued From page 45 to have grab bars affixed to their beds. Findings include: R15's quarterly Minimum Data Set (MDS) dated 11/15/24, indicated that R15 had moderately impaired cognition and required substantial assistance with transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R15's Grab Bar Assessment dated 3/21/24, indicated the assessment was done on the resident's admission to the facility, and bilateral grab bars were used to assist the resident with moving side to side. The assessment included a section "Identify alternative methods/products attempted prior to the use of grab bars" which was left blank. The assessment indicated the risks and benefits of grab bar use had been explained to R15/her representative and consent was received. R15's order summary dated 8/5/24, included an order for bilateral mobility bars on the bed for turning, repositioning, and bed mobility. The medical record was reviewed and did not indicate appropriate alternatives to grab bars had been attempted before installation and how these alternatives failed to meet the R15's needs. The medical record also did not indicate R15 had been reviewed for risk factors for possible entrapment such as medical diagnosis, medications, cognition, or fall risk when considering grab bar use. During an interview and observation on 2/4/25 at	F 700	bed rails being applied to the bed. This bed rail assessment must include review of any alternative methods attempted or discussed with resident/family. 2. Bed rail assessment will be updated on R15 to include documentation of risk vs benefit discussion and any alternative methods attempted/discussed with resident/family. 3. An audit of resident files for those residents that utilize bed rails will be completed by the DON/Nurse Managers by 3/21/25 to ensure there is a bed rail assessment completed and risk vs. benefit discussion & consent documented. 4. Any residents with missing/incomplete bed rail assessments or documented risk vs benefit discussion and consent will be completed by 3/21/25. 5. Ongoing compliance will be monitored by the DON by completing an audit of 1 chart/week for 4 weeks, then 2 x/month for 2 additional months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 700	Continued From page 46 9:59 a.m., R15 stated she used the grab bars to pull herself out of bed and confirmed she didn't feel they were restrictive or stopped her from moving in any way. Bilateral grab bars were observed affixed to R15's bed. During an interview on 2/4/25 at 1:55 p.m., registered nurse (RN)-B, the unit manager, stated grab bars had been applied to R15's bed on admission and they had not attempted alternatives due to the resident's weight and R15 requiring two staff members to turn in bed. At 2:54 p.m., RN-B stated she had reviewed R15's medical record and found that the risk for entrapment associated with grab bar use had been reviewed with R15 when consent was received but she did not find that individualized entrapment risk factors had been reviewed for R15's grab bar use. RN-B stated that R15's history of right-sided weakness and being at risk for falls could make her a greater risk for entrapment but did not see that these had been assessed as entrapment risks. During an interview on 2/05/25 at 12:28 p.m., director of nursing (DON) stated a nursing assessment was completed to determine if a bedrail was appropriate for a resident prior to be applied along with a reviewing a pamphlet that reviews risks involved with the resident and/or family. DON stated the resident was assessed annually and if there was a significant change with the resident. The Bed Rail Use policy dated 4/24, indicated upon admission, readmission, or change of condition, residents will be screened to determine the need for special equipment or accessories (side rails, for example.) Staff will assess the	F 700		

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F 700	Continued From page 47 resident to identify appropriate alternatives and assess for risk of entrapment, review the risks and benefits with the resident and representative, obtain informed consent, and obtain a physician order, before installing bed rails.	F 700		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 725	1. DON and Administrator will review	4/11/25

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F 725	Continued From page 48 review, the facility failed to ensure sufficient nursing staff and leadership to meet assessed resident needs and facility processes for 2 of 2 residents (R5, R37) reviewed for pressure ulcer prevention, for R7, R42 reviewed for activities of daily living who were dependent on staff for their care, for R1 who was left exposed and nude on the toilet, and R18 who utilized an indwelling catheter reviewed for dignity. In addition, the facility failed to reassess and implement proactive interventions to reduce the risk of falls and injuries for R26 and R44 who sustained falls at the facility. Additionally, the facility failed to address ongoing staffing and long call light concerns identified during resident council meeting minutes. Also, during survey, one family (FM-A) and four residents (R4, R5, R14, and R33) expressed ongoing concerns with not enough staff and significant wait times for cares. These findings contributed to several associated deficiencies and the lack of sufficient and/or competent staff had the potential to affect all 45 residents within the care center. Findings include: Refer to F550. Based on observation, interview and document review, the facility failed to ensure toileting and personal care were provided in a dignified manner for R1 who was left exposed and nude on the toilet facing window to facility courtyard. The window was not closed for privacy. In addition, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who utilized an indwelling catheter. Refer to F656. Based on interview and document review, the facility failed to ensure an individualized comprehensive care plan was	F 725	current staffing pattern and resident acuity to determine if adequate staff are scheduled (both number and roles) by 3/14/25. 2 All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retrained on job and documentation expectations by 3/21/25 or upon their next scheduled shift after. 3. DON/Nurse Managers will review and update agency staff orientation material and training checklists and update as appropriate for clear expectations by 3/21/25. 4. Agency staff will begin to document in EMR by 3/21/25. 5. Call lights will be audited randomly 1x/wk for 3 months. 6. Residents will be asked at resident council about call light times and cares being provided as well as Director of Life Coach Services will interview 1 resident/week for 3 months for feedback on these items and submit this information to DON. 7. DON will audit documentation completion by reviewing documentation of 2 residents per week for 3 months. 8. Ongoing compliance will be monitored by DON/Administrator by reviewing data collected from call light audits, resident feedback, documentation audits and resident acuity weekly starting the week of 3/23/25. This information along with review of staffing patterns will be used to determine need for protocol adjustments and/or adjustments to staffing as needed. Data from these audits will also be reviewed by the QAPI team at the next	

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F 725	Continued From page 49 developed and maintained to ensure appropriate care was provided for 1 of 2 residents (R42) who required staff assistance with activities of daily living (ADLs) including prevention of pressure ulcers and care needs. Refer to F677. Based on interview and document review, the facility failed to ensure routine bathing was completed in accordance with identified wishes for 1 of 4 residents (R7) reviewed for activities of daily living (ADLs) and who was dependent on staff for their bathing care. Refer to F686. Based on observation, interview and document review, facility failed to provide 2 of 2 residents (R5, R37) with care, consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and underlying soft tissue) who were identified as risk for pressure ulcers/pressure injuries. Refer to F689. Based on observation, interview, and document review, the facility failed to comprehensively reassess and, if needed or able, develop proactive interventions to reduce the risk of falls and injury for 2 of 2 residents (R44, R26) reviewed who had sustained falls at the care center. R1 R1's quarterly Minimum Data Set (MDS), dated 11/25/24 identified R1 with intact cognition, impairment of one side for upper extremities and required partial to moderate assistance with toileting and upper body dressing. In addition, R1 medical diagnoses include spinal stenosis (narrowed space around the spinal cord causing irritation and compression of the spinal cord), heart failure, and arthritis.	F 725	scheduled meeting after completing the audits.	

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F 725	Continued From page 50	F 725		

R4
R4's admission MDS assessment, dated 1/6/25, indicated R4 had moderately impaired cognition. R4 required maximal staff assistance for dressing, bathing, toileting and bed mobility. R4 required moderate staff assistance for transfers and personal hygiene. In addition, R4's medical diagnoses include osteoporosis, seizures, muscle weakness, and history of breast cancer.

R5
R5's quarterly Minimum Data Set (MDS) dated 10/1/24 identified R5 with intact cognition, was dependent on staff for all toileting, bathing, and dressing and did not reject care. In addition, R5 identified as a risk of developing a pressure ulcer/pressure injury. R5's medical diagnoses include bipolar, anxiety, depression, and chronic pain.

R7
R7's quarterly MDS, dated 12/12/24, identified R7 with severe cognitive impairment, was dependent on staff for personal hygiene care and did not reject care. R7's medical diagnoses include stroke, peripheral vascular disease, diabetes, arthritis, aphasia (impairment in speaking), hemiplegia (paralysis on one side of body), and depression.

R14
R14's quarterly MDS dated 11/29/24, identified R14's with intact cognition, was dependent on staff for all toileting and dressing and required substantial assistance with personal hygiene and bathing. In addition, R14 did not reject cares. In addition, R14 medical diagnoses include spinal cord compression, neurogenic bladder, diabetes,

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F 725	Continued From page 51 arthritis, paraplegia (paralysis on one side of the body), and depression. R18 R18's quarterly MDS dated 12/6/24 identified R18 with moderate cognitive impairment, was dependent on staff for toileting hygiene and lower body dressing, and did not reject care. In addition, R18 with indwelling catheter (tube to drain urine from bladder to a bag outside of the body). In addition, R18 medical diagnoses include diabetes, peripheral vascular disease, arthritis, and depression. R26 R26's quarterly MDS dated 12/5/24, identified R26 had severely impaired cognition and required assistance for nearly all ADLs. In addition, R26 did not reject cares. In addition, R26 medical diagnoses include dementia, heart failure, kidney disease, diabetes, aphasia (difficulty speaking), seizures, anxiety and depression. R33 R33's admission MDS dated 1/16/25 identified R33 with intact cognition, required substantial assistance with dressing, bathing, and mobility such as rolling from side to side in bed, lying to sitting, sitting to stand and transferring from bed to chair. In addition, R33 did not reject cares. R33's medical diagnoses include hip fracture, and Parkinson's Disease. R37 R37's quarterly MDS dated 11/11/24 identified R37 with significant impairment to cognition, impairment to lower extremities, was dependent on staff for all efforts of self-care. Also, R37 identified as a risk of developing a pressure	F 725		

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F 725	Continued From page 52	F 725		

ulcer/pressure injury. In addition, R37's medical diagnoses include Alzheimer's, dementia, depression, and bipolar and did not reject care.

R42
R42's Significant change in status MDS dated 12/23/24 identified intact cognition, no impairment in upper and lower extremity range of movements, was dependent on staff for mobility, toileting, and lower body dressing and required assistance with personal hygiene. R42's medical diagnoses include hip fracture, coronary artery disease, heart failure, urinary tract infection, and Parkinson's disease.

R44
R44's admission Minimum Data Set (MDS), dated 12/4/24, identified R44 had severe cognitive impairment, demonstrated no behavioral symptoms (i.e., physical, verbal, rejection of care) and required assistance for nearly all activities of daily living (ADLs). In addition, R44's medical diagnoses include dementia, hypertension, kidney disease, anxiety and depression.

Resident and family interview:
During interview with family member (FM)-A of R44 on 2/3/25 at 3:51 p.m., FM-A stated R44 had sustained a few falls since she admitted to the care center from her prior assisted-living setting, and the falls led him to believe the facility did not have enough staff to provide R44 with adequate supervision.

During interview with R4 on 2/3/25 at 5:12 p.m., R4 stated she, "feels the facility [sic] understaffed" and "it takes a long time and sometimes they don't come." R4 expressed frustration as when she admitted to the facility

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F 725	Continued From page 53 she needed more assistance from staff and "wasn't receiving it." During interview with R33 on 2/3/25 at 2:22 p.m., R33 stated she got "very frustrated" when she put her call light on for staff assistance as "it just takes forever". R33 stated she used her call light for staff assistance to get in and out of bed, any transfers, and to go to the bathroom. R33 stated the time of day did not impact how fast the call lights were answered. R33 stated it could take up to an hour for her call light to be answered. R33 stated facility's lack of call light response has caused her to "have an accident [incontinent of urine]" and added, "what if I fall and no one comes for how long?" During interview with R5 on 2/3/25 at 2:44 p.m., R5 stated, "not enough help to answer call lights". Staff interviews: During interview with trained medication aide (TMA)-A on 2/4/25 at 7:31 a.m., TMA-A stated "I don't feel there is enough staff to meet the needs of the residents. I have twenty-five residents. If aides show up it is four to five aides per morning shift. They recently reduced staffing to 'cut costs' apparently" and "people have missed showers" and answering call lights has been "delayed". During interview with licensed practical nurse (LPN)-A on 2/4/25 at 7:46 a.m., LPN-A stated, "I have twenty-one residents. They need help today. Normally I have more than that. Some days I don't have time to get my work done. Range of motion exercises (ROM's), sometimes I don't get to it." LPN-A stated they were "not surprised" if showers weren't done due to staffing.	F 725		

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F 725	Continued From page 54 During interview with licensed practical nurse (LPN)-B who was also the facility infection control/wound nurse, stated she was responsible to complete weekly wound assessments and document results in the resident electronic medical record (EMR). LPN-B stated an initial Weekly Wound Tool assessment had been completed for R42's wound on 12/16/24, and should have been completed weekly thereafter until healed. LPN-B stated she was out sick for thirteen days in December (2024) and "it fell off my radar.". Furthermore, LPN-B stated, "I get pulled to the floor a lot." During interview with registered nurse (RN)-B on 2/5/25 at 12:36 p.m., RN-B stated, "Staffing is always a concern here. If we have five aides working on a shift and three are agency aides, then the two facility aides have to chart on all of the residents because we don't allow the agency aides to document. It is too much." Also, RN-B stated, "due to staffing, the range of motion exercises and other personal cares won't be done." RN-B stated she had seen aides in the past "have a tendency to leave residents in their beds to eat meals" instead of assisting them up out of bed and transporting them to the dining room. During interview with RN-B on 2/5/25 at 10:31 a.m., (RN)-B reviewed R44's fall reports dated 12/23/24, and 1/2/25, and stated, "I am just going to be honest with you," and stated she was not sure if all of R44's fall reports had been brought to IDT for review. RN-B reviewed R44's fall on 12/23/24, and verified it lacked any new interventions being recorded or outlined. RN-B stated the lack of completion with the report could possibly be related to being "pulled to the floor so	F 725		

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F 725	Continued From page 55 much" due to staff call-ins adding, "Often, I don't [get them done]." RN-B stated it was "a chore and a struggle" to get all assigned things such as fall reports and admissions done timely, adding they felt, at times, new interventions had been done but just "not been documented." During interview with staffing coordinator (SC) on 2/5/25 at 10:09 a.m., SC stated she worked in the position for ten to eleven years. SC stated she directed staff concerns regarding low staffing to the DON. SC stated call lights "should be answered within ten to fifteen minutes. No more than fifteen minutes". SC stated she was expected to follow guidance from management to staff nursing assistants with one aide per 10 residents and, "it used to be one aide per 8 residents". SC stated she recently was informed that she was responsible for staffing both the skilled nursing facility and the assisted living facility portion of the building. During interview with director of nursing (DON) on 2/5/25 at 10:45 a.m., DON stated expectation of, "Call lights are to be answered as soon as the staff are able to answer them. Everybody should answer call lights. Not just one role. Time range acceptable ideally within half an hour to forty-five minutes. Half an hour is common. Things happen and we want to answer them right away. Sometimes we cannot. It is frustrating." DON stated staffing for 2/5/25, was "impacted" due to a call in from a nurse so the DON had to fill in for the empty shift and administer morning medications and treatments until a nurse from the evening shift agreed to come in early to relieve her. DON stated the facility did not have access to call light logs and did not do call light audits to determine length of time call lights were on.	F 725		

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F 725	Continued From page 56 Call lights: During continuous observation and interview on 2/5/25 starting at 9:20 a.m., the call light was illuminated outside room of R14. -At 9:39 a.m., registered nurse (RN)-D stood outside of room and did not answer it. RN-D entered another resident room. -At 9:40 a.m., RN-C walked past the room and entered another resident room. -At 9:41 a.m., Another staff member walked past the room. -At 9:43 a.m., RN-C walked to medication cart outside of R14's room and typed into computer and walked away. -At 9:44 a.m., RN-D obtained hand sanitizer from outside R14's room and walked across the hall to another resident room. -At 9:46 a.m., RN-D obtained surgical gloves from medication cart outside R14's room and walked back across the hall to another room. -At 9:46 a.m., a laundry staff person knocked on the door and brought in clean clothes to R14 room and said, "Oh I don't do that. Did you get your light on?" Staff walked outside of R14 room and saw the illuminated call light on above R14's door. Staff walked back into the room and spoke a few words and walked down the hall toward the nursing station. -At 9:48 a.m., laundry staff entered room again and brought in more clothes. Call light was still illuminated. At this time an activities staff member walked past R14's room. -At 9:50 a.m., RN-D walked past R14's room and entered another resident room. -At 9:51 a.m. nursing assistant (NA)-G walked out of another resident room and obtained an EZ stand from the hall and entered R14's room. NA-G stated, "Sorry I didn't know your light was	F 725		

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F 725	Continued From page 57 on". During interview with NA-G on 2/5/25 at 10:00 a.m., NA-G stated, "I don't know how long it was on. I help with answering call lights." NA-G stated R14 "had choir practice in activities. Since we are short staffed, I am working on another unit and part of this one. I have an agency aide with me so this is slowing things down and we can't answer all the lights when we should. There is no one to help us". NA-G stated, "I have to prioritize. That was unacceptable for her to wait that long. We are responsible for answering call lights. The nurses can answer but don't really." During interview with R14 on 2/5/25 at 10:02 a.m., R14 stated, "my light was on for almost an hour. I need them [staff] to get me up. I can't do it by myself. It is frustrating for me. I am late for my activity and am mad about it. They need more help here to get us all up and ready." During interview with NA-D on 2/5/25 at 10:04 a.m., NA-D stated, "we don't have enough to help with this floor so we have to ask for help from other units which takes a long time. The call light times are very long." Resident Council: Review of facility's Resident Council meeting minutes for January 2025, December 2024, October 2024, August 2024 and June 2024 identified concerns were verbalized from residents about inadequate staffing. During interview with resident council member attendees (R1, R13, R20 and R25) on 2/4/25 at 1:12 p.m., R1 stated, "on a lane (hall) with only one aide, [we are] bound to wait. It is like	F 725		

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F 725	Continued From page 58 Christmas out here when the lights are going." R13 stated, "Mornings are bad. Facility has not been responding real well. Nothing has really changed." R1 stated, "facility staff[sic] their hands are tied. Management are the ones who call the shots." Facility Assessment: The Facility Assessment (FA) reviewed 10/29/2024, identifies the facility is licensed for 60 beds with an average census of 48. The FA identified 80% of residents are totally dependent on staff for mobility needs and receive skilled nursing level care such as range of motion exercises, transfers, ambulation, dressing, feeding, including bed mobility assistance. The staffing plan includes direct care staff ratios of: -Day Shift: 4-6 nursing assistants with one to two RN or LPN Charge nurse -Evening Shift: 4-6 nursing assistants with one to two RN or LPN Charge nurse -Night shift: 3 nursing assistants with one RN or LPN Charge nurse. No other information was provided.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		3/21/25

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F 758	Continued From page 59 (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 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:	F 758		

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F 758	Continued From page 60 Based on observation, interview, and document review, the facility failed to ensure use of an as-needed (i.e., PRN) psychotropic medication was limited to a 14-day period and/or re-evaluated by the provider to ensure ongoing need and efficacy of the medication for 1 of 5 residents (R44) reviewed for unnecessary medication use. Findings include: R44's admission Minimum Data Set (MDS), dated 12/4/24, identified R44 had severe cognitive impairment but demonstrated no behavioral symptoms (i.e., physical, verbal, rejection of care). Further, the MDS identified R44 had depression, anxiety disorder, but consumed only anti-depressant medication (i.e., high-risk medication) during the review period. On 2/5/25 at 8:54 a.m., R44 was observed seated in a standard wheelchair in the television room by the central nursing station. R44 appeared calm and responded aloud, "Good," when asked about her day so far. R44 was unsure how long she had lived at the care center and responded again aloud, "Pretty good." R44 had no obvious physical symptoms of anxiety at this time (i.e., crying, worried expression). R44's Ridgeview Home Health Hospice Orders For Facility, dated 1/13/25, identified R44's name and listed an admitting diagnosis of senile degeneration of the brain. R44 was listed as being admitted to hospice the same day (1/13/25), and included a section labeled, "Above orders per hospice," with two orders written below this. These included an order for morphine as needed and, "2 [circled] Ativan [an anti-anxiety	F 758	1. Nursing staff (Nurse Manager, RN, LPN) will be retrained on Psychotropic Medication Use policy by 3/21/25. 2. R 44 is no longer a resident at facility. 3. Nurse Managers will review all current resident PRN medications. For any resident who is prescribed a PRN psychotropic medication that does not have an end date, an end date will be obtained from the prescriber by 3/21/25. 4. Ongoing compliance will be monitored by DON by auditing medication orders of 2 residents/month for 3 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 758	Continued From page 61 medication ... every 4 hours as needed for anxiety. Update hospice if ineffective." However, the completed order lacked any identified stop date for the medication. R44's Medication Administration Record (MAR), dated 1/2025 and 2/2025, respectively, were reviewed and identified the transcribed order for the PRN Ativan (ordered 1/13/25). R44 was recorded as receiving the medication two (2) times with doses recorded on 1/13/25 at 3:24 p.m., and the other on 1/17/25 at 12:03 p.m. For both administrations, the results were recorded as effective. R44's corresponding progress note, dated 1/13/25 at 3:24 p.m., identified the medication was provided and listed rationale, "Crying and very agitated." The note lacked what, if any, non-pharmacological interventions had been attempted prior to the medication being give. R44's other corresponding progress note, dated 1/17/25 at 12:03 p.m., identified the medication was provided and listed no rationale or record information on why the medication was provided; nor any information on what, if any, non-pharmacological interventions were attempted prior. R44's care plan, dated 1/31/25, identified R44 consumed anti-anxiety medication and wrote out, "NURSING: The resident uses anti-anxiety medications (lorazepam [Ativan] PRN per hospice order) r/t [related to] Anxiety." The care plan directed to administer the medication as ordered, monitor for effectiveness or side effects, and monitor and record occurrence for target behaviors and document per protocol.	F 758		

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F 758	Continued From page 62 On 2/5/25 at 8:59 a.m., registered nurse (RN)-F was interviewed and reviewed R44's medical record. RN-F explained R44 had most cares completed by the nursing assistant (NA) staff and needed help with most activities of daily living (ADLs). RN-F verified R44 was on hospice care and explained R44 "used to cry a lot" and, as a result, they had recently increased her anti-depressant medication and she "seems to be better." RN-F denied ever seeing physical or verbal behaviors from R44 and reiterated she just used to have "just like sad statements." RN-F verified R44 had an active order for PRN Ativan and expressed many people on hospice have the same order. RN-F stated the ordered PRN Ativan typically had a date listed when it "drops off [stop date]" and then it should be renewed by the provider. However, RN-F verified R44's current order for PRN Ativan lacked a stop date and remained active. RN-F reviewed R44's signed hospice order (dated 1/13/25) and verified they had co-signed it but did not request a stop date adding, "I should have probably checked for an end-date." RN-F reviewed R44's medical record and verified it lacked evidence of a stop-date being identified, nor evidence the provider had reviewed it since the medication had been ordered on 1/13/25 (over 14 days prior). When interviewed on 2/5/25 at 10:01 a.m., the consulting pharmacist (CP) verified they had reviewed R44's medical record and it had lacked a stop-date until that day when they obtained a six month extension of the medication. CP stated they were working with hospice providers to ensure stop-dates get listed and verified the medication needed a 14-day re-evaluation without a stop-date established. CP stated the order for the PRN Ativan happened between their reviews	F 758		

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F 758	Continued From page 63 of R44's medications so they were not aware of it. On 2/5/25 at 10:55 a.m., registered nurse manager (RN)-B was interviewed. RN-B stated the hospice agency should be ensuring a stop-date is listed, however, there had been some examples where it didn't happen and then they (hospice) wanted the care center's provider to write out a stop date which RN-B stated their provider "doesn't like that." RN-B verified the PRN Ativan should have had a "two week stop date" or been re-evaluated. RN-B stated it was important to ensure this happened as "we don't want a gap in their medications" and "patient could suffer" if the re-evaluation wasn't completed timely. A facility' policy on PRN psychotropic medication use was not provided.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		3/21/25

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F 761	Continued From page 64 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview and policy review, the facility failed to ensure medications were securely stored safely and under direct observation of authorized staff in areas where residents, staff and guests could access medications in 3 of 5 medication carts affecting 3 of 4 units of the facility. Findings include: During observation on 2/03/25 at 7:36 p.m., an unattended and unlocked medication cart was observed outside in the hallway of the unit named, "Eagle Lane." The unattended and unlocked cart was in the hallway against the wall between two resident rooms. At 7:40 p.m., registered nurse (RN)-E returned to medication cart. RN-E indicated they left the medication cart unlocked and unattended. RN-E stated a resident was hollering and they went to help them. RN-E stated it unattended medication carts should always be locked so residents couldn't get into it. During a continual observation on 2/05/25 at 11:08 a.m., an unattended and unlocked medication cart was observed in the hallway of the unit named, "Bluejay Lane." The cart was placed between the doors of resident rooms. During observation, numerous residents and	F 761	1. All nursing staff (CNA, TMA, LPN, RN, Nurse Managers) will be retrained on Storage and Expiration Dating of Medication and Biologicals policy by 3/21/25 or upon their next scheduled shift after. 2. Ongoing compliance will be monitored by DON/Nurse Managers by randomly auditing locking of medication carts and med storage room 1x/wk for 4 weeks then 2x/month for 2 months. Data from these audits will be submitted to QAPI team through a report at the next scheduled meeting after completing the audits. Should the audits indicate continued issues with compliance when performed, the DON will submit the data report via email to QAPI members to review and schedule a time to discuss as a group.	

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F 761	Continued From page 65 family members walked past the unattended and unlocked medication cart. At 11:39 a.m., licensed practical nurse (LPN)-B verified the medication cart was unlocked and unattended. LPN-B locked the medication cart. LPN-B state medication carts should be locked at all times when not in use, so resident's do not get in there and overdose and staff don't steal medications. During observation on 2/5/25 at 9:35 a.m., an unattended and unlocked medication cart was observed in the hallway of the unit named, "Cardinal Lane". The unattended and unlocked cart was in the hallway against the wall between two resident rooms. During interview with registered nurse (RN)-C on 2/5/25 at 9:37 a.m., RN-C stated, "it is unlocked because I forgot to lock it when I walked away. [It is] important to be locked and we have important medications that are deadly in there and we don't want anyone to get into there and take whatever they want." During an interview on 2/05/25 at 12:30 p.m., director of nursing (DON) stated all unattended medications carts should be kept locked at all times, to prevent people from getting into them that shouldn't as it could have ill effects. A facility policy titled Storage and Expiration Dating of Medications and Biologicals, revision date 8/1/24, section 5.3 indicates "Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors."	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		3/21/25

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F 883	Continued From page 66 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 67 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 1 of 5 residents (R37) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, "Adults [at or older than] 65 years old," outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above 65 years old) should have shared clinical decision-making between the resident and healthcare provider to determine if	F 883	1. Retraining has been provided to the Infection Preventionist and Nurse Managers on the resident pneumococcal vaccination policy. 2 R37 will have vaccination education and offered. Documentation will be obtained regarding consent or refusal of vaccination. If resident desires vaccination, it will be administered by 3/21/25. 2. IP will review all current residents to ensure documentation of vaccinations being offered and education provided as well as residents consent or refusal of vaccination. All residents affected will have pneumonia vaccination education provided and have been offered vaccination. Documentation is maintained in resident s chart 3. Ongoing, pneumococcal vaccinations will be offered to all new residents.	

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	245604	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 883	Continued From page 68 PCV20 was appropriate. R37's quarterly Minimum Data Set (MDS), dated 11/11/24, identified R37 admitted to the care center in August 2024, and had several medical conditions including dementia and high blood pressure. R37's electronic medical record (EMR) was reviewed which identified a section labeled, "Immunizations," along with R37's received immunizations or, if applicable, their refusal. This identified R37 as being 72 years old and having had received the PCV13 in 12/2017, and the PPSV23 in 3/2019 (over five years prior). However, it lacked evidence R37 had been offered or received the PCV20 as recommended by the CDC. On 2/4/25 at 12:58 p.m., a telephone call was placed to R37's family member to discuss what, if any, discussion the care center had with them about R37's immunization using PCV20. A message was left, however, a return call was not received. R37's medical record was reviewed and lacked evidence R37 or their representative had been offered or provided the PCV20 vaccination despite being admitted to the care center multiple months prior. On 2/5/25 at 10:25 a.m., licensed practical nurse (LPN)-B was interviewed. LPN-B verified they were the campus' infection preventionist (IP) and had reviewed R37's medical record. LPN-B stated R37 had not yet received the PCV20 and expressed her family member always "likes to sign the paperwork" so there was not a signed	F 883	Education and resident consent/refusal will be documented and maintained in the resident s records. 4. Ongoing compliance will be monitored by the DON via auditing 1 new admit chart/month for 3 months and PRN after. Results of audits will be brought to QAPI at least quarterly for review and recommendations.	

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F 883	Continued From page 69 consent or refusal to show. LPN-B stated they last spoke with R37's family member back in December 2024 about another vaccine series (i.e., RSV), however, at that time LPN-B did not have the PCV20 form for them to sign so, as a result, it had not been done. LPN-B stated they recalled R37's family member did not want R37 to get the vaccine, however, acknowledged the record lacked any documentation to support that conversation had happened. LPN-B verified all listed immunizations on R37's EMR were correct and current and expressed they would follow-up with R37's family member soon, adding, "I will make it a point to meet up with [them]." Further, LPN-B stated part of the reason for the delay in follow-up was possibly due to themselves repeatedly being pulled to work on the floor due to call-ins and other reasons adding such was, "The way it is now-a-days." However, LPN-B verified R37 should have been offered the vaccination and expressed it was important as pneumonia could be "a heft disease process" and impair the elderly. A facility provided Pneumococcal Immunization policy, last reviewed 4/2024, identified the care center would offer pneumococcal immunizations in accordance with MDH (Minnesota Department of Health) guidelines. The policy added, "The [immunization] will be administered per professional standards of practice and standing orders for administering pneumococcal vaccines to adults," adding further, "Document administration in the resident's medical record."	F 883		

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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 2/3/25 to 2/6/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with NO licensing orders: H56046260C (MN108323). 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 FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded to reflect actual restraint use for 4 of 4 residents (R2, R15, R26, R41) reviewed for MDS accuracy. In addition, the facility failed to accurately complete a Brief Interview for Mental Status (BIMS) assessment for 1 of 4 residents (R17) reviewed for MDS accuracy. Findings include: Restraint Use The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, outlined a section labeled, "SECTION P: RESTRAINTS AND ALARMS," which directed to record the frequency a resident	2 550	corrected	3/21/25

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2 550	Continued From page 3 was restrained by any of the listed devices during the seven-day look-back period. A definition of physical restraint was provided which outlined, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." R2's quarterly MDS dated 1/10/25, indicated R2 had severely impaired cognition and was dependent on staff for transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R2's order summary dated 8/5/24, indicated R2 had bilateral mobility bars that were used for turning, repositioning, and bed mobility. During an observation on 2/3/25 at 1:23 p.m., bilateral grab bars were observed affixed to R15's bed. During an interview on 2/4/25 at 10:04 a.m., NA-D stated she was the aide working with R2 today and was not aware of either having any restraints. NA-G stated R2 was not able to get out of bed whether the grab bars were in place or not. NA-G stated she felt the side rails were not stopping him from moving or attempting to get out of bed though. R15's quarterly MDS dated 11/15/24, indicated that R15 had moderately impaired cognition and required substantial assistance with transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily.	2 550		

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2 550	Continued From page 4 R15's Grab Bar Assessment dated 3/21/24, indicated the assessment was done on the resident's admission to the facility, and bilateral grab bars were used to assist the resident with moving side to side. The assessment indicated the grab bars "does not limit resident's freedom of movement" or the resident's "sensory stimulation". During an interview and observation on 2/4/25 at 9:59 a.m., R15 stated she used the grab bars to pull herself out of bed and confirmed she didn't feel they were restrictive or stopped her from moving in any way. Bilateral grab bars were observed affixed to R15's bed. R26's quarterly MDS dated 12/5/24, indicated R26 had severely impaired cognition and required substantial assistance with transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R26's order summary dated 8/4/24, indicated R26 had bilateral mobility bars that were used for turning, repositioning, and bed mobility. During an observation on 2/4/25 at 9:49 a.m., bilateral grab bars were observed affixed to R26's bed. During an interview on 2/4/25 at 10:04 a.m., nursing assistant (NA)-G stated she was the aide working with R26 and R15 today and was not aware of either having any restraints. NA-G stated she had observed both residents utilize the grab bars, and although neither resident could get out of bed independently, did not think the grab bars would stop them from attempting to do so.	2 550		

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2 550	Continued From page 5 R41's quarterly MDS dated 1/10/25, indicated R41 had intact cognition and required supervision for transferring out of bed. The MDS indicated in section, "P0100. Physical Restraints," that R15 had bed rails that were used as restraints daily. R41's Care Conference Review form dated 1/14/25, included the section, "restraint review", with "grab bars- not restraint" written next to it. During an observation and interview on 2/3/25 at 1:52 p.m., R41's bed was observed with affixed bilateral grab bars. R41 stated she did not use the grab bars, was able to sit up by herself, and denied being restrained while at the facility. During an interview on 2/4/25 at 10:15 a.m., NA-C stated R41 was able to carry out most of her cares by herself with supervision and set up help. NA-C stated she had observed R41 independently get out of bed and R41 didn't utilize the grab bars when doing so. R2's, R15's, R26's, and R41's medical records were reviewed, and evidence of restraint use was not found. During an interview on 2/4/25 at 12:05 p.m., registered nurse (RN)-G stated she was the offsite MDS coordinator for the facility. RN-G stated if a grab bar does not inhibit a resident's ability to move freely, it does not meet the qualification for restraint and should not be coded on the MDS. At 1:34 p.m., RN-G stated she was dependent on assessments that had been uploaded into the electronic medical record to determine if a resident was using a restraint as she was remote. RN-G stated she was not able to find grab bar assessments for R2, R15, and R26, so she had coded it as a restraint but confirmed	2 550		

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2 550	Continued From page 6 she had not further clarified with the onsite staff whether this was true. RN-G stated she would put in a correction for R41 as she had found a document stating the grab bars were not restraining her. BIMS Assessment The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, indicates Section C of the MDS is used to assess for signs of delirium as well as determining a resident's attention, orientation, and ability to recall information. The manual indicates the BIMS assessment should be stopped after completing C0300C, if all responses up to this point of the assessment have been nonsensical. The manual then indicates if the interview was stopped, dashes should be coded in C0400A, C0400B, and C0400C and then coded as 99 in the BIMS summary score. The assessor should then code yes in C0600 and complete the Staff Assessment for Mental Status. R17's annual MDS dated 1/2/25, in Section C-Cognitive Patterns, C0100 was coded as 1, indicating that R27 should have a BIMS assessment completed. The MDS sections C0200-C0400 were then all coded as zero, indicating none, no answer, or could not recall. C0500 of the R40's MDS indicated a BIMS summary score of 0/15. A Staff Assessment for Mental Status was not completed. The MDS indicated that there was no evidence of an acute change in mental status from the resident's baseline. R17's progress note dated 1/2/25 at 11:22 a.m.,	2 550		

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2 550	Continued From page 7 indicated all questions under C0200 and C0300 of the BIMS assessment had been asked to R17 with all "non[-]sensical" answers. During an interview on 2/4/25 at 1:36 p.m., RN-G stated the facility staff member completing the BIMS assessment for R17 had called her as they were unsure how to complete it as R17 was sometimes understood. RN-G stated she had them attempt the assessment, but it looked like they had not stopped when he had given non-sensical responses so it auto-populated the score and then a staff assessment was not completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		3/21/25

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2 565	Continued From page 8 by: Based on interview and document review, the facility failed to ensure an individualized comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 2 residents (R42) who required staff assistance with activities of daily living (ADLs) including prevention of pressure ulcers and care needs. Findings include: R42's significant change Minimum Data Set (MDS) assessment dated 12/23/24, indicated R42 had intact cognition. R42 required moderate staff assistance with personal hygiene and oral hygiene, maximum assistance from staff for upper body dressing, and was dependent on staff for bed mobility, sit to lying, lying to sitting on side of bed, footwear, lower body dressing and toileting. MDS indicated no behaviors present or rejection of care exhibited. R42's pertinent diagnoses included: displaced intertrochanteric fracture of right femur (a broken hip bone that has shifted or separated), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the heart), Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance and coordination) and weakness. Section M "Skin Conditions" indicated R42 was at risk for developing pressure ulcers and had one or more unstaged pressure ulcer at Stage 1 or higher. Furthermore, "M0300 Current Number of Unhealed Pressure ulcers at Each Stage" under section G; Unstageable-Deep tissues: suspected deep tissue injury in evolution, indicated one unstageable pressure ulcer with suspected deep tissue injury in evolution that was present upon admission/entry or reentry.	2 565	corrected	

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2 565	Continued From page 9 R42's care plan, printed 2/3/25, indicated the following: - "NURSING: The resident has potential for pressure ulcer development r/t [related to] advanced age, pain, weakness, immobility, use of anticoagulant, Foley catheter. Braden = 15" with the following interventions - "Administer treatments as ordered and monitor for effectiveness." - "Follow facility policies/protocols for the prevention/treatment of skin breakdown." - "Obtain and monitor lab/diagnostic work as ordered. Report results to MD [medical doctor] and follow up as indicated." - "Staff to assist with routine toileting and skincare for incontinence." - "Treat pain as per orders prior to treatment/turning etc. to ensure The resident's comfort." - "NURSING: The resident has indwelling Foley [urinary] catheter R/T urinary retention. Foley catheter to be removed on 11/22/24 for voiding trial, he F/U [follow up] with Urology on 12/4/24." - "CATHETER: Catheter - Change catheter bag, and cath kit (syringe & basin) once weekly, initial and date new supplies Q [every] Friday." - "CATHETER: last changed: (SPECIFY Date). Change catheter (FREQ). (SPECIFY Size) (SPECIFY Type)" -"CATHETER: The resident has (SPECIFY Size) (SPECIFY Type of Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door." - "Check tubing for kinks [# TIMES] each shift." -"NURSING: The resident has an ADL selfcare and mobility deficits r/t R hip FX S/P IM nailing	2 565		

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2 565	Continued From page 10 [right hip fracture after surgical repair], weakness, difficulty in walking, pain, Parkinson's disease, orthostatic hypotension, Foley catheter, precaution for WBAT RLE (weight bearing as tolerated right lower extremity)." -"TOILET USE: The resident requires is dependent on mechanical stand lift Ax2 [assist of 2] to transfer on/off toilet and dependent on staff to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. He has Foley Catheter, that will be removed on 11/22/24 for voiding trial. He F/U with Urology on 12/4/24." -"TRANSFER: The resident requires Mechanical Lift Ax2 with 3rd staff on standby assistance for transfers." R42's care plan lacked identification of history of pressure injury, resident specific interventions for prevention of pressure ulcers, removal of catheter and possible fluctuating ability to transfer. R42's care sheet, printed 2/5/25, identified the following: -"Repo[reposition]: Q 2 hours from side to side-encourage [R42] to stay off back, has open area to coccyx" -"Toilet: Toilet upon waking, after meals, before bed and NOC [night] as tolerated. Wheelchair to Bathroom assist of 2 with walker to toilet" -"Transfer Method: Assist of 1 with Walker for all transfers." R42's care sheet lacked need for air mattress, cushion in wheelchair or other interventions to prevent reoccurrence of deep tissue injury or pressure ulcer. Furthermore, lacked evidence that R42's deep tissue injury/pressure ulcer had healed on coccyx.	2 565		

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2 565	Continued From page 11 On 2/03/25 at 2:11 p.m., R42 was observed seated in his wheelchair with a cushion on the chair. R42 stated he had a "sore" on his "bottom," and was unsure when it started but knew he had it at the hospital. R42 indicated the staff were doing wound care on it. R42 stated he was unsure of if it was getting better or worse as he was unable to see it. R42's Order Recap Report, printed 2/4/25, indicated the following order: -"1. Cleanse with NS (nasal saline), pat dry 2. Apply skin prep to surrounding tissue and allow to dry. 3. Cover with a foam dressing 4. Change 3x week and PRN (as needed), D/C (discontinue) when healed as needed for DTI [deep tissue injury] sacrum and in the morning every Mon, Wed, Fri" with a start stated of 12/16/24 with and end date of 1/14/25. R42's February's Medication Administration and Treatment Record (MAR/TAR), printed 2/5/25, indicated the following: -"Complete weekly skin check and bath (according to shower schedule) every day shift every Friday with a progress note with findings" R42's January 2025 MAR/TAR, printed 2/5/25, indicated the following: -"Complete weekly skin check and bath (according to shower schedule) every day shift every Friday with a progress note with findings" -On 1/3/25, 1/17/25, 1/31/25 indicated it was completed by a check mark. -On 1/10/25, the box was left blank -On 1//24/25, the box was marked with a "9" which indicates "other/see progress notes" R42's January MAR/TAR lacked evidence of wound care order for listed above which was	2 565		

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2 565	Continued From page 12 started on 12/16/14, and discontinued on 1/14/25. R42's progress notes, dated 12/16/24 to 2/5/25, revealed the following: -1/31/25 at 11:04 a.m.: "skin check completed with no new skin issues." -1/29/25 at 1:03 p.m.: "uses the urinal and tolerates well" -1/25/25 at 11:05 p.m.: "continent of bowel and bladder" -1/24/25 at 1:48 p.m.: "shower was not done today." -1/23/25 at 9:11 a.m., "[R42] scored 22 on Braden, which is not at risk for skin impairment. His appetite is improved and he is much stronger moving more and is able to lift himself off the bed and up off the wheelchair. His continence is improved, though he does wear a brief for dribbling or "possible accidents.". His skin is intact, incision to rt [right] upper chest healed and steri strips are peeling off. His RT hip incision is healed and no redness noted. His bottom is pink and he still is having barrier cream applied." -1/20/25 at 1:12 p.m.: "is voiding well following removal of Foley catheter." -1/19/25 at 12:13 p.m.: "continent of bowel and bladder" -1/17/25 at 12:29 a.m.: : shower not given today ...shower to be done tomorrow." -1/9/25 at 11:02 a.m.: "Resident has appointment with Urology today regarding his urinary retention and Foley catheter use. Catheter removed at 0940 [9:40 a.m.,] per order." -12/30/24: "[R42] scored 15 on Braden he is at risk for skin breakdown related to his inability to independently move in bed or reposition himself without sliding in bed is not able to lift clear of mattress and chair surfaces. Has redness to bottom/coccyx area and redness to groin which is treated with nystatin powder and Barrier cream to	2 565		

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2 565	Continued From page 13 bottom." -12/20/24 at 2:25 p.m.: "Coccyx/perineal area MASD [moisture associated skin damage], 1 x 0.5 cm slough appearing area to right gluteal cleft. Foam dressing applied and barrier cream applied." -12/16/24 at 8:02 p.m.: "He has an open area to sacrum/coccyx are[a] ...he is chairfast and non ambulatory at this time and moves feebly on his own, he will root around in the bed to get off his side to his bed and to move around in bed with friction possible, He scored 12 on his Braden which he is high risk for Skin impairment. At this time there are orders for wound care daily and 3 times weekly ...Care Plan updated." R42's progress notes lacked ongoing assessment of pressure ulcer and interventions placed to prevent further development of pressure ulcers. R42's Weekly Wound Tool, dated 12/16/24, identified a suspected deep tissue injury (SDTI) located on sacrum with slough tissue present which was described as 100% thin white slough with a serous scan amount of drainage with no odor measuring at 25 millimeter (mm) in length by 8 mm in width with no tunneling or undermining. The peri-wound (tissue surrounding the wound) was described as red but blanching with defined edges with the treatment (listed above) being started. R42's electronic medical record (EMR) lacked any further weekly wound tool assessment completed. On 2/04/25 at 10:17 a.m., licensed practical nurse (LPN)-B stated she was responsible for the wound assessments. LPN-B stated skin checks	2 565		

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2 565	Continued From page 14 are to be completed weekly by nurses on the floor and a progress note entered in the EMR. LPN-B stated if a skin issue was identified, they put it on the 24-hour sheet, let her know along with the clinical coordinators for follow up. LPN-B stated she does a Weekly Wound Tool assessment weekly on residents with wounds which is the expectation. LPN-B stated she does not update the care plan as the care coordinators update the care plan. On 2/05/25 at 10:35 a.m., registered nurse (RN)-C stated if a wound was identified during a skin check, the wound nurse, family and provider would be notified. Furthermore, they would initiate interventions needed. RN-C stated floor nurses did not update the care plan. On 2/05/25 at 10:41 a.m., RN-F stated they did not remember doing any wound cares with R42 since he had returned from the hospital and stated they worked with RN-F numerous times. RN-F stated the only wound that they had known of was a healed incision on his hip. RN-F stated, "I was not aware of that one," when asked about a wound on his coccyx when returning from the hospital. RN-F indicated R42 did have some "moisture related issues in his groin area but not his coccyx of sacrum." R42 was assessed by RN-F at 10:53 a.m., and did not have a pressure sore on his coccyx. On 2/05/25 at 11:01 a.m., nursing assistant (NA)-F stated nursing assistants got their information from the care plan. NA-F stated they pulled up a document on the computer that pulls resident information from the care plan for their care guide/sheet. NA-F reviewed R42's sheet and stated R42 care sheet indicated that R42 did not have a cushion in wheelchair or air mattress.	2 565		

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2 565	Continued From page 15 Furthermore, indicated had an open area to coccyx. On 2/04/25 at 9:28 a.m., LPN-A indicated when any skin issue was noted on a skin assessment, the wound nurse was notified after documenting anything found in a progress note. LPN-A stated "they" (clinical coordinators) updated the care plan. During a follow up interview on 2/05/25 at 9:55 a.m., LPN-B she was able to review R42's EMR and stated R42's care plan had not been updated to reflect identification of DTSI on 12/16/24. LPN-B stated no wound assessments had been completed except for the initial assessment on 12/16/24, and no progress notes indicated the sacrum wound was monitored. LPN-B stated the progress notes lacked documentation of details of skin assessments the MAR indicated were completed. LPN-B stated the clinical care coordinators updated the care plans. On 2/05/25 at 12:20 p.m., director of nursing (DON) stated she would expect care plans to reflect residents' care. DON reviewed R42's care plan and stated R42's care plan lacked specific interventions for pressure ulcer prevention such as turning and repositioning, type of mattress, history of pressure injury, etc. A facility policy titled Person-centered Care Planning, dated 4/2024, indicated "person-centered care plan will be sued by al personnel involved in the care of the resident." Furthermore, "comprehensive care plans must be reviewed and revised quarterly and as needed by the interdisciplinary team."	2 565		

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2 565	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff and leadership to meet assessed resident needs and facility processes for 2 of 2 residents (R5, R37) reviewed for pressure ulcer prevention, for R7, R42 reviewed for activities of daily living who were dependent on staff for their care, for R1 who was left exposed and nude on	2 800	corrected	3/21/25

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2 800	Continued From page 17 the toilet, and R18 who utilized an indwelling catheter reviewed for dignity. In addition, the facility failed to reassess and implement proactive interventions to reduce the risk of falls and injuries for R26 and R44 who sustained falls at the facility. Additionally, the facility failed to address ongoing staffing and long call light concerns identified during resident council meeting minutes. Also, during survey, one family (FM-A) and four residents (R4, R5, R14, and R33) expressed ongoing concerns with not enough staff and significant wait times for cares. These findings contributed to several associated deficiencies and the lack of sufficient and/or competent staff had the potential to affect all 45 residents within the care center. Findings include: Refer to F550. Based on observation, interview and document review, the facility failed to ensure toileting and personal care were provided in a dignified manner for R1 who was left exposed and nude on the toilet facing window to facility courtyard. The window was not closed for privacy. In addition, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who utilized an indwelling catheter. Refer to F656. Based on interview and document review, the facility failed to ensure an individualized comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 2 residents (R42) who required staff assistance with activities of daily living (ADLs) including prevention of pressure ulcers and care needs. Refer to F677. Based on interview and document review, the facility failed to ensure routine bathing	2 800		

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2 800	Continued From page 18 was completed in accordance with identified wishes for 1 of 4 residents (R7) reviewed for activities of daily living (ADLs) and who was dependent on staff for their bathing care. Refer to F686. Based on observation, interview and document review, facility failed to provide 2 of 2 residents (R5, R37) with care, consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and underlying soft tissue) who were identified as risk for pressure ulcers/pressure injuries. Refer to F689. Based on observation, interview, and document review, the facility failed to comprehensively reassess and, if needed or able, develop proactive interventions to reduce the risk of falls and injury for 2 of 2 residents (R44, R26) reviewed who had sustained falls at the care center. R1 R1's quarterly Minimum Data Set (MDS), dated 11/25/24 identified R1 with intact cognition, impairment of one side for upper extremities and required partial to moderate assistance with toileting and upper body dressing. In addition, R1 medical diagnoses include spinal stenosis (narrowed space around the spinal cord causing irritation and compression of the spinal cord), heart failure, and arthritis. R4 R4's admission MDS assessment, dated 1/6/25, indicated R4 had moderately impaired cognition. R4 required maximal staff assistance for dressing, bathing, toileting and bed mobility. R4 required moderate staff assistance for transfers and personal hygiene. In addition, R4's medical diagnoses include osteoporosis, seizures, muscle	2 800		

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2 800	Continued From page 19 weakness, and history of breast cancer. R5 R5's quarterly Minimum Data Set (MDS) dated 10/1/24 identified R5 with intact cognition, was dependent on staff for all toileting, bathing, and dressing and did not reject care. In addition, R5 identified as a risk of developing a pressure ulcer/pressure injury. R5's medical diagnoses include bipolar, anxiety, depression, and chronic pain. R7 R7's quarterly MDS, dated 12/12/24, identified R7 with severe cognitive impairment, was dependent on staff for personal hygiene care and did not reject care. R7's medical diagnoses include stroke, peripheral vascular disease, diabetes, arthritis, aphasia (impairment in speaking), hemiplegia (paralysis on one side of body), and depression. R14 R14's quarterly MDS dated 11/29/24, identified R14's with intact cognition, was dependent on staff for all toileting and dressing and required substantial assistance with personal hygiene and bathing. In addition, R14 did not reject cares. In addition, R14 medical diagnoses include spinal cord compression, neurogenic bladder, diabetes, arthritis, paraplegia (paralysis on one side of the body), and depression. R18 R18's quarterly MDS dated 12/6/24 identified R18 with moderate cognitive impairment, was dependent on staff for toileting hygiene and lower body dressing, and did not reject care. In addition, R18 with indwelling catheter (tube to drain urine from bladder to a bag outside of the body). In	2 800		

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2 800	Continued From page 20 addition, R18 medical diagnoses include diabetes, peripheral vascular disease, arthritis, and depression. R26 R26's quarterly MDS dated 12/5/24, identified R26 had severely impaired cognition and required assistance for nearly all ADLs. In addition, R26 did not reject cares. In addition, R26 medical diagnoses include dementia, heart failure, kidney disease, diabetes, aphasia (difficulty speaking), seizures, anxiety and depression. R33 R33's admission MDS dated 1/16/25 identified R33 with intact cognition, required substantial assistance with dressing, bathing, and mobility such as rolling from side to side in bed, lying to sitting, sitting to stand and transferring from bed to chair. In addition, R33 did not reject cares. R33's medical diagnoses include hip fracture, and Parkinson's Disease. R37 R37's quarterly MDS dated 11/11/24 identified R37 with significant impairment to cognition, impairment to lower extremities, was dependent on staff for all efforts of self-care. Also, R37 identified as a risk of developing a pressure ulcer/pressure injury. In addition, R37's medical diagnoses include Alzheimer's, dementia, depression, and bipolar and did not reject care. R42 R42's Significant change in status MDS dated 12/23/24 identified intact cognition, no impairment in upper and lower extremity range of movements, was dependent on staff for mobility, toileting, and lower body dressing and required assistance with personal hygiene. R42's medical	2 800		

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2 800	Continued From page 21 diagnoses include hip fracture, coronary artery disease, heart failure, urinary tract infection, and Parkinson's disease. R44 R44's admission Minimum Data Set (MDS), dated 12/4/24, identified R44 had severe cognitive impairment, demonstrated no behavioral symptoms (i.e., physical, verbal, rejection of care) and required assistance for nearly all activities of daily living (ADLs). In addition, R44's medical diagnoses include dementia, hypertension, kidney disease, anxiety and depression. Resident and family interview: During interview with family member (FM)-A of R44 on 2/3/25 at 3:51 p.m., FM-A stated R44 had sustained a few falls since she admitted to the care center from her prior assisted-living setting, and the falls led him to believe the facility did not have enough staff to provide R44 with adequate supervision. During interview with R4 on 2/3/25 at 5:12 p.m., R4 stated she, "feels the facility [sic] understaffed" and "it takes a long time and sometimes they don't come." R4 expressed frustration as when she admitted to the facility she needed more assistance from staff and "wasn't receiving it." During interview with R33 on 2/3/25 at 2:22 p.m., R33 stated she got "very frustrated" when she put her call light on for staff assistance as "it just takes forever". R33 stated she used her call light for staff assistance to get in and out of bed, any transfers, and to go to the bathroom. R33 stated the time of day did not impact how fast the call lights were answered. R33 stated it could take up to an hour for her call light to be answered. R33	2 800		

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2 800	Continued From page 22 stated facility's lack of call light response has caused her to "have an accident [incontinent of urine]" and added, "what if I fall and no one comes for how long?" During interview with R5 on 2/3/25 at 2:44 p.m., R5 stated, "not enough help to answer call lights". Staff interviews: During interview with trained medication aide (TMA)-A on 2/4/25 at 7:31 a.m., TMA-A stated "I don't feel there is enough staff to meet the needs of the residents. I have twenty-five residents. If aides show up it is four to five aides per morning shift. They recently reduced staffing to 'cut costs' apparently" and "people have missed showers" and answering call lights has been "delayed". During interview with licensed practical nurse (LPN)-A on 2/4/25 at 7:46 a.m., LPN-A stated, "I have twenty-one residents. They need help today. Normally I have more than that. Some days I don't have time to get my work done. Range of motion exercises (ROM's), sometimes I don't get to it." LPN-A stated they were "not surprised" if showers weren't done due to staffing. During interview with licensed practical nurse (LPN)-B who was also the facility infection control/wound nurse, stated she was responsible to complete weekly wound assessments and document results in the resident electronic medical record (EMR). LPN-B stated an initial Weekly Wound Tool assessment had been completed for R42's wound on 12/16/24, and should have been completed weekly thereafter until healed. LPN-B stated she was out sick for thirteen days in December (2024) and "it fell off my radar.". Furthermore, LPN-B stated, "I get pulled to the floor a lot."	2 800		

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2 800	Continued From page 23 During interview with registered nurse (RN)-B on 2/5/25 at 12:36 p.m., RN-B stated, "Staffing is always a concern here. If we have five aides working on a shift and three are agency aides, then the two facility aides have to chart on all of the residents because we don't allow the agency aides to document. It is too much." Also, RN-B stated, "due to staffing, the range of motion exercises and other personal cares won't be done." RN-B stated she had seen aides in the past "have a tendency to leave residents in their beds to eat meals" instead of assisting them up out of bed and transporting them to the dining room. During interview with RN-B on 2/5/25 at 10:31 a.m., (RN)-B reviewed R44's fall reports dated 12/23/24, and 1/2/25, and stated, "I am just going to be honest with you," and stated she was not sure if all of R44's fall reports had been brought to IDT for review. RN-B reviewed R44's fall on 12/23/24, and verified it lacked any new interventions being recorded or outlined. RN-B stated the lack of completion with the report could possibly be related to being "pulled to the floor so much" due to staff call-ins adding, "Often, I don't [get them done]." RN-B stated it was "a chore and a struggle" to get all assigned things such as fall reports and admissions done timely, adding they felt, at times, new interventions had been done but just "not been documented." During interview with staffing coordinator (SC) on 2/5/25 at 10:09 a.m., SC stated she worked in the position for ten to eleven years. SC stated she directed staff concerns regarding low staffing to the DON. SC stated call lights "should be answered within ten to fifteen minutes. No more than fifteen minutes". SC stated she was	2 800		

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2 800	Continued From page 24 expected to follow guidance from management to staff nursing assistants with one aide per 10 residents and, "it used to be one aide per 8 residents". SC stated she recently was informed that she was responsible for staffing both the skilled nursing facility and the assisted living facility portion of the building. During interview with director of nursing (DON) on 2/5/25 at 10:45 a.m., DON stated expectation of, "Call lights are to be answered as soon as the staff are able to answer them. Everybody should answer call lights. Not just one role. Time range acceptable ideally within half an hour to forty-five minutes. Half an hour is common. Things happen and we want to answer them right away. Sometimes we cannot. It is frustrating." DON stated staffing for 2/5/25, was "impacted" due to a call in from a nurse so the DON had to fill in for the empty shift and administer morning medications and treatments until a nurse from the evening shift agreed to come in early to relieve her. DON stated the facility did not have access to call light logs and did not do call light audits to determine length of time call lights were on. Call lights: During continuous observation and interview on 2/5/25 starting at 9:20 a.m., the call light was illuminated outside room of R14. -At 9:39 a.m., registered nurse (RN)-D stood outside of room and did not answer it. RN-D entered another resident room. -At 9:40 a.m., RN-C walked past the room and entered another resident room. -At 9:41 a.m., Another staff member walked past the room. -At 9:43 a.m., RN-C walked to medication cart outside of R14's room and typed into computer and walked away.	2 800		

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2 800	Continued From page 25 -At 9:44 a.m., RN-D obtained hand sanitizer from outside R14's room and walked across the hall to another resident room. -At 9:46 a.m., RN-D obtained surgical gloves from medication cart outside R14's room and walked back across the hall to another room. -At 9:46 a.m., a laundry staff person knocked on the door and brought in clean clothes to R14 room and said, "Oh I don't do that. Did you get your light on?" Staff walked outside of R14 room and saw the illuminated call light on above R14's door. Staff walked back into the room and spoke a few words and walked down the hall toward the nursing station. -At 9:48 a.m., laundry staff entered room again and brought in more clothes. Call light was still illuminated. At this time an activities staff member walked past R14's room. -At 9:50 a.m., RN-D walked past R14's room and entered another resident room. -At 9:51 a.m. nursing assistant (NA)-G walked out of another resident room and obtained an EZ stand from the hall and entered R14's room. NA-G stated, "Sorry I didn't know your light was on". During interview with NA-G on 2/5/25 at 10:00 a.m., NA-G stated, "I don't know how long it was on. I help with answering call lights." NA-G stated R14 "had choir practice in activities. Since we are short staffed, I am working on another unit and part of this one. I have an agency aide with me so this is slowing things down and we can't answer all the lights when we should. There is no one to help us". NA-G stated, "I have to prioritize. That was unacceptable for her to wait that long. We are responsible for answering call lights. The nurses can answer but don't really." During interview with R14 on 2/5/25 at 10:02	2 800		

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2 800	Continued From page 26 a.m., R14 stated, "my light was on for almost an hour. I need them [staff] to get me up. I can't do it by myself. It is frustrating for me. I am late for my activity and am mad about it. They need more help here to get us all up and ready." During interview with NA-D on 2/5/25 at 10:04 a.m., NA-D stated, "we don't have enough to help with this floor so we have to ask for help from other units which takes a long time. The call light times are very long." Resident Council: Review of facility's Resident Council meeting minutes for January 2025, December 2024, October 2024, August 2024 and June 2024 identified concerns were verbalized from residents about inadequate staffing. During interview with resident council member attendees (R1, R13, R20 and R25) on 2/4/25 at 1:12 p.m., R1 stated, "on a lane (hall) with only one aide, [we are] bound to wait. It is like Christmas out here when the lights are going." R13 stated, "Mornings are bad. Facility has not been responding real well. Nothing has really changed." R1 stated, "facility staff[sic] their hands are tied. Management are the ones who call the shots." Facility Assessment: The Facility Assessment (FA) reviewed 10/29/2024, identifies the facility is licensed for 60 beds with an average census of 48. The FA identified 80% of residents are totally dependent on staff for mobility needs and receive skilled nursing level care such as range of motion exercises, transfers, ambulation, dressing, feeding, including bed mobility assistance. The staffing plan includes direct care staff ratios of:	2 800		

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2 800	Continued From page 27 -Day Shift: 4-6 nursing assistants with one to two RN or LPN Charge nurse -Evening Shift: 4-6 nursing assistants with one to two RN or LPN Charge nurse -Night shift: 3 nursing assistants with one RN or LPN Charge nurse. No other information was provided. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		3/21/25

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2 830	Continued From page 28 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and, if needed, develop proactive interventions to reduce the risk of further falls and injury for 2 of 2 residents (R44, R26) reviewed who had sustained falls at the care center. Findings include: R44 R44's admission Minimum Data Set (MDS), dated 12/4/24, identified R44 had severe cognitive impairment, demonstrated no behavioral symptoms (i.e., physical, verbal, rejection of care) and required assistance for nearly all activities of daily living (ADLs). Further, the MDS outlined R44 had sustained a fall within the month prior to admission, however, sustained no falls since she admitted to the care center. R44's care plan, revised 12/20/24, identified R44 was at risk for falls with dictation, "NURSING: The resident is at risk for falls [related to] weakness, impaired mobility ... [as evidenced by] H/O [history of] fall prior to admission." The plan listed a goal which read, "The resident will be free	2 830	corrected	

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2 830	Continued From page 29 of falls through the review date," along with several interventions including anticipating/meeting R44's needs, ensure the call light is within reach, encouraging participation is activities which promote exercise, and ambulating R44 twice daily. The care plan interventions each listed a date implemented and, if applicable, revision. This identified only one revision to a single intervention on 12/20/24, the remainder of interventions being listed as having the same start-date as the problem statement. On 2/3/25 at 3:53 p.m., R44's family member (FM)-A was interviewed. FM-A stated R44 had sustained a few falls since she admitted to the care center from her prior assisted-living setting. FM-A stated they were not sure exactly what, if any, new interventions were being done between the falls. Later, on 2/5/25 at 8:54 a.m., R44 was observed seated in a standard wheelchair which had metallic anti-roll brakes installed. R44 was in the television room by the central nursing station and she appeared calm and responded aloud, "Good," when asked about her day so far. R44 was unsure how long she had lived at the care center and responded again aloud, "Pretty good." R44's medical record was reviewed which identified R44 had sustained multiple falls since the care plan had last been revised (12/20/24), and these included: R44's progress note, dated 12/23/24 at 11:44 p.m., identified R44 had been found on the floor at 11:20 p.m. when R44 turned on their call light to alert staff. The note outlined, "Resident found on floor sitting on buttocks next to her bed. Gripper sock on right foot, left foot bare." R44 denied pain and had confusion per baseline. The note continued, "First[,] resident stated she was	2 830		

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2 830	Continued From page 30 getting up to use the toilet, then stated she was getting up to get a drink of water." The note identified R44 was assisted to the restroom and provided water, along with a voicemail left for R44's family member and the provider adding, "Will continue to monitor." The note lacked any further information on what, if any, future interventions would be done to reduce R44's risk of falls. R44's corresponding incident report titled, "#20 Unwitnessed Fall," dated 12/23/24, identified text from the completed progress note and outlined R44 was oriented to person only. The report listed multiple sections to record various data points including pre-disposing factors, environmental factors, and statements from staff about the event. The report included spacing to record what, if any, actions (i.e., interventions) were assessed or implemented after the event; however, this was left blank with no new interventions being listed or rationale for the lack thereof. A subsequent Fall Risk Evaluation, dated 12/26/24, identified R44 scored 19.0 which was labeled, "At Risk." The evaluation identified a total of nine (9) questions to be answered by the evaluator including level of consciousness, history of falls, vision status, and medication (changes). However, the completed evaluation lacked information on what, if any, proactive interventions had been assessed or implemented to reduce R44's risk of continued falls. R44's progress note, dated 1/2/25 at 10:30 p.m., identified R44 was again found sitting on the floor. The note outlined, "Noted to be sitting on floor next to wheel chair near locked exit door in hallway. No injury noted. Later stated that she wanted to go outside." The note identified R44's family member and provider were contacted.	2 830		

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2 830	Continued From page 31 However, again, the note lacked information to identify what, if any, additional interventions were determined or assessed to reduce R44's risk of continued falls and injury. R44's corresponding incident report titled, "#23 Unwitnessed Fall," dated 1/2/24, identified text from the completed progress note and the space to record R44's mental status was left blank and not completed. The report placed a checkmark next to a pre-disposing environmental factor of, "Other (Describe)." However, the report lacked further information on what this factor had been or was. The report, again, listed multiple sections to record various data points but, again, lacked information on what, if any, actions (i.e., interventions) were assessed or implemented after the event. A subsequent Fall Risk Evaluation, dated 1/8/24, identified R44 scored 18.0 which was labeled, "At Risk." The evaluation, again, identified nine (9) questions to be answered by the evaluator including level of consciousness, history of falls, vision status, and medication (changes). However, the completed evaluation lacked information on what, if any, proactive interventions had been assessed or implemented to reduce R44's risk of continued falls. On 2/5/25 at 10:31 a.m., registered nurse manager (RN)-B was interviewed, and they explained when a fall happens, the floor staff respond and assess them for pain or injury then help them back to a surface. The staff ask the resident several questions, such as what happened, and then document them on the incident reports located in the system's risk management section. The report then is uploaded to the system for others, including management and leadership, to see and update.	2 830		

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2 830	Continued From page 32 RN-B stated a Fall Risk Evaluation is also triggered and completed by the floor staff in the record. RN-B stated the report should then be reviewed by the interdisciplinary team (IDT) "as soon as possible" to help determine what, if any, new ideas or interventions are needed. RN-B then reviewed R44's reports in the system (dated 12/23/24, and 1/2/25), and verified the section labeled, "Action," would be where new interventions or rationale would be recorded. RN-B then expressed aloud, "I am just going to be honest with you," and stated they were not sure if all R44's fall reports had been brought to IDT for review. RN-B reviewed R44's fall on 12/23/24, and verified it lacked any new interventions being recorded or outlined. RN-B stated the lack of completion with the report could possibly be related to being "pulled to the floor so much" due to staff call-ins, adding aloud, "Often, I don't [get them done]." RN-B stated it was "a chore and a struggle" to get all assigned things, such as fall reports and admissions, done timely, adding they felt at times new interventions had been done but just "not been documented." RN-B verified both of R44's reviewed falls, dated 12/23/24, and 1/2/25, did not have the report completed and lacked documentation to support what, if any, new interventions had been assessed or implemented but reiterated they felt things were discussed but "not formally in IDT." RN-B verified they didn't recall reviewing R44's falls with IDT but expressed they recalled adding the wheelchair brakes at some point. RN-B reviewed R44's fall care plan and verified it had not been revised since 12/20/24, despite R44 having two falls since then. RN-B again attributed the lack of updated care plan to being pulled repeatedly to the floor but verified it should be updated with any new interventions adding, "We're supposed to review that on a regular basis	2 830		

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2 830	Continued From page 33 and update it." RN-B stated it was important to ensure falls were assessed and new interventions developed and recorded as, "We want to keep our residents safe." R26 R26's quarterly MDS dated 12/5/24, indicated R26 had severely impaired cognition and required assistance for nearly all ADLs. The MDS indicated R26 had no falls since the prior MDS assessment. R26's progress note dated 8/11/24 at 1:00 p.m., indicated R26 was found lying on the floor next to his bed and could not communicate to staff what had happened. R26's quarterly fall risk assessment dated 12/5/24, indicated R26 was at a "high risk" for falls based on an assessment of factors such as mental state, history of past falls, ambulation status, medications, and predisposing diseases. R26's care plan dated 12/12/24, indicated R26 was at risk for falls related to dementia, heart failure, and a previous stroke. The care plan included multiple fall interventions such as Anti-rollback breaks and a dropped wheelchair seat, encouraging proper footwear, keeping the wheelchair by the bed/recliner when R26 was not using it, encouraging R26 to use a call light to call for assistance, etc. The care plan did not indicate any fall interventions had been added or revised since 9/11/24. R26's Fall Scene Investigation Form dated 1/16/25 at 11:50 p.m., indicated R26 had an unwitnessed fall from his bed. The form included possible environmental factors or causes that staff had assessed such as R26's call light was in	2 830		

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2 830	Continued From page 34 reach, bed wheels were locked, glasses were off, and R26 was wearing gripper socks. The form indicated that R26 was unable to account for his fall. The form indicated R26's new/immediate fall interventions that were implemented were a wheelchair placed close to the bed, "doing safety checks", and reminding R26 to call for help. The form included a section for "IDT Team Review Notes" which was left blank. R26's progress note dated 1/17/25 at 12:23 a.m., indicated R26 was found lying on the floor of his room with his bedding partially on the floor. The note indicated that R26 was unable to account for his fall. During an interview on 2/4/25 at 1:12 p.m., RN-F stated she was R26's and R44's nurse today. RN-F stated she was unsure if either resident had fallen recently but if they had she would expect these new fall interventions to be put on their care plan as that is how they communicate changes from shift to shift. During an interview on 2/5/25 at 12:33 p.m., RN-B stated she thought a fall investigation form had been filled out for R26's fall on 8/11/24, and given to the director of nursing (DON) but was unsure if the fall had been reviewed by IDT. The 8/11/24, fall scene investigation form was requested and not received. RN-B stated after reviewing the 1/17/25, Fall Scene Investigation Form, she did not think IDT had reviewed the fall as that part of the form was left blank. RN-B stated the expectation was that R26's care plan and nursing assistant care sheet be updated to reflect each fall and new interventions and that was not completed for R26. A facility' provided Accident: Managing Resident	2 830		

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2 830	Continued From page 35 Falls policy, reviewed 4/2024, identified the center would evaluate and analyze hazards and/or risks for potential resident' falls on admission, quarterly and as needed. The policy outlined, "The IDT will monitor for accidents and recommend modifications to improve accident interventions." A section labeled, "Resident Fall Guideline," listed a procedure for a fall including providing first aid (if needed) and documenting it within the medical record. The policy directed, "IDT will review all falls including the fall scene investigation form and immediate interventions implemented. Interventions may be changed or added to further reduce the risk of additional falls." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician	2 905		3/21/25

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AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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2 905	Continued From page 36 has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to provide 2 of 2 residents (R5, R37) with care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and underlying soft tissue) who were identified as risk for pressure ulcers/pressure injuries. Findings include: R5 R5's annual Minimum Data Set (MDS) dated 12/31/24 identified R5 with intact cognition, was dependent on staff for all toileting, bathing, and dressing and did not reject care. In addition, R5 was identified as at risk of developing a pressure ulcer/pressure injury. R5's electronic medical record (EMR) nursing assistant task form titled "TRANSFER: SELF PERFORMANCE-How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)" and documented from 1/22/25, to 2/4/25, identified R5 as requiring, "TOTAL DEPENDENCE-Full staff performance". R5's EMR nursing assistant task for titled, "BED MOBILITY: SUPPORT PROVIDED-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture" and documented from 1/22/25, to 2/4/25, identified R5 as requiring "One person	2 905	corrected	

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2 905	Continued From page 37 physical assist". R5's nursing assistant care sheet identified R5 as requiring "Repo[repositioning]: Q 2 hours and PRN-AVOID lying on RT side". During observation on 2/3/25 at 2:47 p.m., R5 lying in bed on her back watching television. During observation and interview with R5 on 2/3/25 at 5:44 p.m., R5 laying in bed on her back watching television. R5 stated, "I don't recall when they asked me to turn or get off my back. It hasn't been since lunch time today. I am pretty stiff". During observation and interview with R5 on 2/3/25 at 7:20 p.m., R5 lying on bed on her back. "They don't move or turn me. Haven't done it all day. They don't even ask me." During interview with nursing assistant (NA)-A on 2/3/25 at 7:26 p.m., NA-A stated he was R5's nursing assistant for the evening shift from 2:30 p.m. to 11:00 p.m., "I don't know when [R5] was last turned." NA-A stated "[R5] can get pressure sores so she needs to turn." NA-A stated expectation of nursing assistants to follow the nursing assistant care sheet to inform them of what the residents require with cares including turning and repositioning. NA-A stated expectation of nursing assistants to document cares and refusals in the EMR under Tasks. During interview with licensed practical nurse (LPN)-A on 2/4/25 at 8:27 a.m., LPN-A stated she was familiar with R5. LPN-A stated, "[R5] moves a little in the bed but not completely." LPN-A stated expectation of nursing assistants to follow the nursing assistant care sheet to inform them of	2 905		

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2 905	Continued From page 38 what the residents requires with cares including turning and repositioning. LPN-A stated R5 required assistance to turn and reposition "at least every 2-3 hours". LPN-A stated she was not aware of when R5 was turned or repositioned last. R37 R37's quarterly MDS dated 11/11/24 identified R37 with significant impairment to cognition, impairment to lower extremities, was dependent on staff for all efforts of self-care, had diagnoses of Alzheimer's, dementia, depression, and bipolar and did not reject care. In addition, R37 identified as a risk of developing a pressure ulcer/pressure injury. R5's nursing assistant care sheet identified R37 as requiring "Repo: Q 2 hours and PRN. Offer/enc to lay down in bed for at least short period of time after breakfast & lunch bathroom". During observation on 2/3/25 at 1:38 p.m., 2:13 p.m., 2:20 p.m., R37 sleeping on recliner lying on her back. At 5:42 p.m., R37 still sitting in recliner sleeping lying on her back but the lights to the room were turned off. During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated expectation of nursing assistants to use the nursing assistant care sheet to inform them of what the residents requires with cares including turning and repositioning. NA-E stated R37 "is not on turning repositioning program. Usually, we wait about 2 hours to try to get them [residents] to shift weight because if they are in the same spot too long the skin can break down." Also, "we [aides] don't document it anywhere".	2 905		

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2 905	Continued From page 39 During interview with registered nurse (RN)-B on 2/5/25 at 12:36 p.m., RN-B stated expectation of staff to reposition residents per care sheet. RN-B stated progress note from nurses should reflect refusals. RN-B verified EMR lacked documentation for both R5 and R37 were turned, repositioned, or provided range of motion exercises. "If it is not documented then we cannot be sure that the ROM or turning or repositioning was done". In addition, RN-B stated both R5 and R37 were high risk for skin breakdown if not turned or repositioned regularly. During interview with director of nursing (DON) on 2/4/25 at 10:03 a.m., DON stated expectation of nursing assistants to document in the Task section of EMR "on what they do for the resident like turning, toileting, etcetera". During interview with DON on 2/5/25 at 1:57 p.m., DON stated, "expectation is we should still be offering to offload[sic] should be documented in progress note for refusals". DON stated, "[residents] are dependent on staff for turning and repositioning and transfers. We do not have a system in place to actually see if [residents] are being turned and repositioned every 2-3 hours." DON stated R5 and R37 were considered high risk for pressure ulcers and their EMRs lacked documentation of refusals. Facility policy requested for pressure ulcer prevention and not received. 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	2 905		

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2 905	Continued From page 40 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 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.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine bathing was completed in accordance with identified wishes for 1 of 4 residents (R7) reviewed for activities of daily living (ADLs) and who was dependent on staff for their bathing care. Findings include:	2 920	corrected	3/21/25

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2 920	Continued From page 41 R7's quarterly Minimum Data Set (MDS), dated 12/12/24, identified R7 had severe cognitive impairment but demonstrated no delusional or rejection of care behaviors. Further, the MDS identified R7 was dependent on staff for personal hygiene care. On 2/3/25 at 5:31 p.m., R7 was asked about her baths at the care center. R7 stated aloud, "I'm missing those," while making a back and forth motion using her hands. R7 struggled with word-finding but reiterated, when pointedly asked, she was not getting her baths every week adding aloud, "Yea [affirm]." R7's care plan, dated 9/16/24, identified R7 had a self-care deficit and needed assistance with ADLs due to weakness and other past medical history or conditions. The plan listed a goal which read, "Will be clean and neatly dressed with assistance," along with multiple interventions including, "Bathing: Assist X1." The care plan lacked information on how often bathing was scheduled or preferred. On 2/4/25 at 9:41 a.m., nursing assistant (NA)-D was interviewed. NA-D explained they had worked with R7 prior, including for bathing, and stated the staff followed a "shower list" which was on their internal computer system. NA-D stated R7 was scheduled for a twice-a-week shower and preferred only female caregivers with it. NA-D verified R7 was supposed to be getting a twice weekly shower and stated she (R7) had been scheduled with that for many months now. NA-D stated they always strived to get R7's shower done but added doing so could be more challenging in the Summer months with staffing. NA-D stated all showers or baths would be charted in the medical record and the nurse's do	2 920		

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2 920	Continued From page 42 a corresponding skin check but only "one of the two days." NA-D stated the care center had recently adjusted to only five NA working on the morning shift and, as a result, there were times when they'd be on the unit "by myself" and residents would then get only "quick bed baths" and no showers. NA-D stated if baths or showers weren't completed, they could try to re-schedule them but with the workload, it would be tough adding aloud, "We don't have time to do an additional shower." NA-D stated they felt R7 was consistently getting her second evening-shift shower but then expressed aloud, "I don't always know if they do it." R7's POC (Point of Care) Response History, dated 2/4/25, identified a 14-day look-back period. The data provided space to record what level of bathing assistance R7 needed (i.e., independent, supervision, dependent) along with a date and time for each episode. The data had two recorded data points, on 1/22/25 and 1/29/25, however, both of these were recorded as, "Not applicable." R7's progress notes, dated 1/1/25 to 2/3/25, identified the following note(s) recorded under a label, "Nurse's Note." On 1/13/25, R7 was recorded as having received a shower and skin check. R7 was recorded as having 1+ edema to her foot. On 1/20/25, R7 was recorded as having received a shower and skin check. On 1/27/25, R7 was recorded as not having a shower. The note had dictation which read, "Shower not completed today." The note lacked any rationale or reason why the shower was not	2 920		

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2 920	Continued From page 43 done. The completed progress note(s) and medical record both lacked any further evidence R7 was receiving a twice weekly shower and/or bath as was scheduled per the direct care staff. On 2/4/25 at 2:32 p.m., registered nurse manager (RN)-A was interviewed. RN-A reviewed R7's medical record and verified R7 was scheduled to receive a twice weekly shower. RN-A stated they were unsure why the nurse' charted the shower was not completed on 1/27/25, and verified the NA should be charting all completed showers or baths in the record (i.e., POC). RN-A acknowledged the lack of charting or documentation to show the second shower was being completed and expressed staff typically didn't chart a second skin check note when multiple baths are scheduled. RN-A stated staff had "not consistently" reported issues with getting showers or baths completed but expressed some days were "very challenged" with workload and call-ins. RN-A stated they were not "personally" checking or auditing charting to ensure it was completed but expressed showers and baths should be done and recorded as the lack of them "can cause all kinds of skin problems." A provided Standard ADL Protocol, undated, identified a procedure for each respective discipline to complete ADLs. This included for the NA, "Offer weekly bath or shower per individual preferences, [NA] to be present during tub bath or shower." The policy lacked information on how completed baths or showers would be recorded or tracked.	2 920		

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2 920	Continued From page 44 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure bathing is offered and provided; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	corrected	3/21/25

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21426	Continued From page 45 facility failed to ensure tuberculin skin testing (i.e., TST) and/or an IGRA (test used to determine presence of Tuberculosis) was completed upon admission and in a timely manner for 1 of 3 residents (R44) reviewed for tuberculosis practices. Findings include: The Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Car Settings Licensed by MDH, dated 7/2024, identified data within the State of Minnesota on incidence of TB cases. This identified< "2.8 /per 100,000," and listed a reference period, "2023." The worksheet listed a section titled, "TB Screening of Patients," which affirmed TB screening of all patients upon admission would be completed. R44's TB Risk Assessment, dated 11/27/24, identified R44 admitted on the same date (11/27/24) and had no active symptoms of TB (i.e., coughing up blood, night sweats). A section was listed which read, "E. TB skin test recommended?[,]" which had a radio-button style answer marked, "2. Yes." The evaluation was signed by the campus' infection preventionist whom was identified (on entrance) as licensed practical nurse (LPN)-B. However, R44's medical record was reviewed and lacked evidence either an IGRA or TST series had been completed for R44 despite admitting to the campus multiple months prior. On 2/5/25 at 1:05 p.m., LPN-B was interviewed. LPN-B verified they had reviewed R44's medical record and acknowledged it lacked documentation to demonstrate a TST or IGRA had been completed. LPN-B stated the floor	21426		

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21426	Continued From page 46 nurses were supposed to provide the TST and record it on the Medication Administration Record (MAR), however, this was not done. LPN-B stated they would do it now and expressed they were "not quite sure" why R44's TST had been missed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for tuberculin skin testing (i.e. TST), educate the direct care staff, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview and policy review, the facility failed to ensure medications were securely stored safely and under direct observation of authorized staff in areas where residents, staff and guests could access medications in 3 of 5 medication carts affecting 3 of 4 units of the facility. Findings include: During observation on 2/03/25 at 7:36 p.m., an unattended and unlocked medication cart was	21610	corrected	3/21/25

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21610	Continued From page 47 observed outside in the hallway of the unit named, "Eagle Lane." The unattended and unlocked cart was in the hallway against the wall between two resident rooms. At 7:40 p.m., registered nurse (RN)-E returned to medication cart. RN-E indicated they left the medication cart unlocked and unattended. RN-E stated a resident was hollering and they went to help them. RN-E stated it unattended medication carts should always be locked so residents couldn't get into it. During a continual observation on 2/05/25 at 11:08 a.m., an unattended and unlocked medication cart was observed in the hallway of the unit named, "Bluejay Lane." The cart was placed between the doors of resident rooms. During observation, numerous residents and family members walked past the unattended and unlocked medication cart. At 11:39 a.m., licensed practical nurse (LPN)-B verified the medication cart was unlocked and unattended. LPN-B locked the medication cart. LPN-B state medication carts should be locked at all times when not in use, so resident's do not get in there and overdose and staff don't steal medications. During observation on 2/5/25 at 9:35 a.m., an unattended and unlocked medication cart was observed in the hallway of the unit named, "Cardinal Lane". The unattended and unlocked cart was in the hallway against the wall between two resident rooms. During interview with registered nurse (RN)-C on 2/5/25 at 9:37 a.m., RN-C stated, "it is unlocked because I forgot to lock it when I walked away. [It is] important to be locked and we have important medications that are deadly in there and we don't want anyone to get into there and take whatever they want."	21610		

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21610	Continued From page 48 During an interview on 2/05/25 at 12:30 p.m., director of nursing (DON) stated all unattended medications carts should be kept locked at all times, to prevent people from getting into them that shouldn't as it could have ill effects. A facility policy titled Storage and Expiration Dating of Medications and Biologicals, revision date 8/1/24, section 5.3 indicates "Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a	21805		3/21/25

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21805	Continued From page 49 health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure toileting and personal care were provided in a dignified manner for R1 who was left exposed and nude on the toilet while facing a window to facility courtyard. The window was not closed for privacy. In addition, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who utilized an indwelling catheter. Findings include: R1 R1's quarterly Minimum Data Set (MDS), dated 11/25/24 identified R1 with intact cognition, impairment of one side for upper extremities and required partial to moderate assistance with toileting and upper body dressing. In addition, R1 had diagnoses of spinal stenosis (narrowed space around the spinal cord causing irritation and compression of the spinal cord), heart failure, and arthritis. During observation on 2/4/25 at 8:08 a.m., R1 was sitting on the toilet naked. R1 was left alone by nursing assistant (NA)-C while NA-C left room to obtain supplies. The bathroom had a shower curtain as a separator between the bathroom and resident's bedroom which was left opened. The window of bedroom faced facility courtyard, and the window blinds were not closed for privacy. R1 faced the courtyard and shrugged, reaching for a small towel to cover her breasts. Trained medication aide (TMA)-A walked into room and saw R1 on the toilet, walked to the window, and	21805	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00335	A. BUILDING: _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 50 closed the blinds to the courtyard. "I closed the curtains[blinds] because [R1] was being exposed. I would be super embarrassed." TMA-A stated, "I could tell [R1] was uncomfortable". During interview with NA-C on 2/4/25 at 8:13 a.m., NA-C stated she had worked for an agency and that "I left the window shade open. I left to get wipes. Yes, I left her on the toilet naked." Also, "the window blinds were open enough for anyone outside the window to see inside the room.". During interview with R1 on 2/4/25 at 8:20 a.m., R1 stated, "there was a curtain. I usually ask to have the blinds closed. It is not a pleasant thing being left alone on the toilet naked and feeling exposed here." R1 stated NA-C was "new" and was "not prepared" to assist with bathing. R1 stated, "I have given up a lot of my dignity while being here. It does bother me when I am left exposed but don't say anything because it doesn't change." During interview with DON on 2/4/25 at 12:41 p.m., DON stated, "That is unacceptable. We want [R1] to be comfortable. I would offer a drape or something to cover her body before leaving the room." During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated, "I would not leave anyone naked on the toilet and leave the room. I would cover them and shut the blinds for privacy and dignity. I would be very upset if someone did that to me." R18 R18's quarterly (MDS) dated 12/6/24, identified R18 had moderate cognitive impairment, was	21805		

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	00335	A. BUILDING: _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 51 dependent on staff for toileting and lower body dressing and had an indwelling catheter (tube to drain urine from the bladder into a collection bag). During observation and interview on 2/3/25 at 6:03 p.m., R26 was in wheelchair while nursing assistant (NA)-A transported him to his room. NA-A wheeled R26 down the hall past another resident and staff member into R26's room. A large urine drainage bag was visible from under R26's wheelchair and was uncovered. NA-A stated he had been assigned to assist R26 from facility's dining room to his bedroom. NA-A stated the drainage bag "should be covered" and was unable to locate a privacy cover in the residents' room. NA-A stated importance of covering the bag was "privacy". During interview with director of nursing (DON) on 2/4/25 at 12:47 p.m., DON stated urine drainage bags, "should always be covered. We have dignity covers and pillowcases to cover up the urine drainage bags." Undated facility policy titled Quality of Life-Dignity stated, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." And "Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered". SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts, are offered	21805		

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	00335	A. BUILDING: _____ B. WING _____	C 02/06/2025

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AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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21805	Continued From page 52 and assisted to appropriately cover their exposed skin and to ensure personal hygeine is maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: During observation and interview, the facility failed to ensure 3 of 3 (R14, R19, R149) resident records that contained private, medical, and personal information were not accessible to unauthorized personnel. Findings include: During observation on 2/3/25 at 7:25 p.m., an unattended laptop identified three residents and their care sheet information. The care sheet information contained their names, diagnoses, assistance needs for dressing and showering, oxygen status, diet, toileting, repositioning, and special instructions such as preferences. Two	21855	corrected	3/21/25

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	00335	A. BUILDING: _____ B. WING _____	C 02/06/2025

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21855	Continued From page 53 staff walked past the unattended laptop. During interview with nursing assistant (NA)-B on 2/3/25 at 7:29 a.m., NA-B stated, "that should not be open for anyone to see. Privacy is why." During interview with NA-A on 2/3/25 at 7:33 p.m., NA-A stated he was responsible for the unattended laptop. NA-A stated unattended laptop contained visible, "patient confidentiality [information]" and "it should not be left open for everyone to see." During interview with Trained Medication Aide (TMA)-A on 2/4/25 at 7:55 a.m., TMA-A pointed to laptop and stated, "It has their [resident] information on the screen and people can walk by and look at the information. We always must close the screen for privacy." During interview with director of nursing (DON) on 2/4/25 at 12:39 p.m., DON stated, "that should not occur due to a HIPPA (Health Insurance Portability and Accountability Act) violation. Someone could walk by and see the private information." During interview with NA-E on 2/4/25 at 1:07 p.m., NA-E stated, "patient information should not be visible to stop [others] from being nosey". Undated facility policy titled HIPAA Privacy Policies and Procedures state "all staff and associates act in an appropriate and compliant manner to protect patient information under the HIPAA privacy regulations." SUGGESTED METHOD OF CORRECTION: The	21855		

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21855	Continued From page 54 administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of complaince with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21855		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	**501 OAK STREET** **CHASKA, MN 55318**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/04/2025. At the time of this survey, Auburn Manor 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 | 02/28/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. AUBURN MANOR is a 1 story building with no basement. The original building was constructed in 1988, a one-story Type II (111) construction. In 1992 a one-story addition was added and determined to be of Type II (111) construction. In 2006 a one-story addition was added and determined to be of Type V (111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K 000		

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K 000	Continued From page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 60 beds and had a census of 45 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 226	1. The areas of penetration to the	2/28/25

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K 226	Continued From page 3 facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/04/2025 at 10:33 AM, it was revealed by observation that there were two penetrations into the firewall near the front desk that separated the assisted living facility from the care center that were not sealed. An interview with the Facility Services Manager verified this deficient finding at the time of discovery.	K 226	firewall by the front desk has been sealed with flame stopper 5000 on 2/5/25. 2. Ongoing, all firewalls will be visually inspected annually and PRN to ensure any areas of penetration are sealed and that all previously sealed areas remains in good condition. 3. To ensure ongoing compliance, the Maintenance Director will audit 1 fire barrier per month for 3 months	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/04/2025 between 09:30 AM and 11:30 AM, it was revealed by a review of available documentation at the time of the survey the	K 291	1. Forms were created to properly document monthly emergency lighting testing as well as annual 90 minute test. 2. Annual 90 minute emergency lighting test was completed on 2/5/25. 3. Ongoing compliance will be monitored by the Maintenance Director by reviewing documentation on facility risk management meetings.	2/28/25

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K 291	Continued From page 4 facility could not provide documentation showing that the emergency lighting in the facility had been tested since 05/29/24. An interview with the Facility Services Manager verified this deficient finding at the time of discovery.	K 291		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings	K 353	1. Wires and conduit that was attached to the sprinkler pipe was removed on 2/6/25. 2. Ongoing compliance will be monitored by the Maintenance Director by randomly auditing 2 sprinkler pipes per month for 3 months.	2/28/25

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K 353	Continued From page 5 could have a widespread impact on the residents within the facility. Findings include: On 02/04/2025 at 10:39 AM, it was revealed by observation that there were wires and flexible conduit attached to the sprinkler pipe above the ceiling near resident rooms 1211/1214. An interview with the Facility Services Manager verified this deficient finding at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/04/2025 at 10:39 AM, it was revealed by observation that there were wires and flexible conduit attached to the sprinkler pipe above the	K 355	1. Wires and conduit that was attached to the sprinkler pipe was removed on 2/6/25. 2. Ongoing compliance will be monitored by the Maintenance Director by randomly auditing 2 sprinkler pipes per month for 3 months.	2/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 6 ceiling near resident rooms 1211/1214. An interview with the Facility Services Manager verified this deficient finding at the time of discovery.	K 355		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 30, 2025

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: CCN: 245604
Cycle Start Date: February 6, 2025

Dear Administrator:

On April 9, 2025, we notified you a remedy was imposed. On April 23, 2025 the Minnesota Department of Health 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 April 22, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 24, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 9, 2025, 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 April 24, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 22, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 30, 2025

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Re: Reinspection Results
Event ID: 83LJ13

Dear Administrator:

On April 23, 2025 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 February 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us